ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Rodney Morton

Date: 31/05/2024

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

The statement has been made in my role as former Executive Director of Nursing Midwifery and Allied Health Professions (AHPs) in the Public Health Agency (PHA) and in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be Exhibit 1.

1. In preparing my statement I have sought to accurately respond to the questions set out by the Inquiry Team within the context of Module 8. In doing so, with the time available I have relied on my recollection and have also reviewed a range of information and documents made available to me by the PHA.

2. I have also engaged with previous colleagues who had operational responsibility for the areas covered by this statement. I have also sought to address the wider context aimed at improving professional leadership, professional organisation and oversight in respect of nursing and midwifery services, which I believe may be pertinent to Module 8.

3. The Inquiry team will note that my statement will primarily reflect the period I was Executive Director of Nursing Midwifery and Allied Health Professions, (EDON) in the PHA commencing in January 2020. There may be some aspects of the questions asked, that I may be unable to address in full or part as they related to actions which predate my appointment.

4. I would like to take this opportunity as a nurse to express my profound apologies to all those citizens and their families who have been impacted by the events at MAH. As a nursing family, we did not protect you in the way that we should have. It is my sincere hope that the measures we have, and are, putting in place will prevent any reoccurrence and safeguard the most vulnerable in our society.

Qualifications

5. I am qualified Registered Mental Health Nurse (RMN) since May 1989. In addition, I hold the following qualifications:
    a. Social and Behavioural Science Diploma University of Ulster 1989.
    b. Post Graduate Certificate in Health and Social Care Open University 1996.
    c. Post Graduate Diploma in Health and Social Care Management. University of Ulster 1998.
    d. Master Business Administration with Specialism Health and Social Care. Ulster University 1999.
    e. Institute of Health Care Improvement; Improvement Advisor Graduate 2011.
    f. Post Graduate Certificate Leadership in Health Care London South Bank University 2019.

6. I have held the following positions across the course of the Inquiry Period:
    a. I am currently the Head of Nursing for Innovation and Sustainability at NHS England (from September 2022 to the present). The role is part of the Chief Nursing Office's Directorate for Quality, Safety, Innovation, Sustainability, and Women's Health in England. My job role encompasses the strategic leadership of nursing and midwifery in the delivery of innovation and sustainable health care.
    b. I was Executive Director of the Nursing, Midwifery, and Allied Health Professions (AHP) in the Public Health Agency (PHA) from January 2020 to September 2022. As one of the PHA Executive Directors reporting to the PHA Chief Executive, I was also professionally

responsible to the Chief Nursing Officer for Northern Ireland. **Exhibit 1** sets the 'Director of Nursing Midwifery and AHP' job description for this role, its core purpose, functions, and responsibilities. The role was also designed to be part of a wider network of collective nursing and midwifery leadership.

c. The PHA was established in 2009 under the Health and Social Care (Reform) Act (Northern Ireland). As set out in the 2011 DHSSPS (HSC) Framework Document (**Exhibit 2**), the PHA was required to protect the community (or any part of the community) against communicable disease through its health protection functions. It was also required to design and commission programmes and initiatives designed to improve the health and wellbeing of the population of Northern Ireland and reduce health inequalities between people in Northern Ireland. This involved partnerships with local authorities through community planning approaches. The PHA was also required to provide professional and clinical input to the design and commissioning of services to meet safety and quality standards. The PHA staff were also members of local commissioning groups (LCGs). LCGs were required to influence and shape commissioning in response to the needs of their local populations. LCGs are coterminous with the Five Trust Boundaries but also work closely with local authorities through a wide range of health and wellbeing initiatives.

d. As part of the PHA and Health and Social Care Board's (HSCB) combined responsibilities for overseeing the commissioning of health and care services in Northern Ireland, the Executive Director of Nursing (EDON), along with the PHA Director of Public Health, were also members of the Health and Social Care Board Senior Management Team (HSCB SMT). This included attending meetings of the Health and Social Care Board. Similarly, the HSCB Director of Children and Social Services was a member of the PHA Agency Management Team and was in attendance at the PHA Board.

e. The role in the PHA involved membership in the Chief Nurse Midwifery Advisory Committee (CNMAC) and the CNO regional Executive Director of Nursing Business Meeting. Within the context of the Northern Ireland

HSC Collective Leadership Strategy. (**Exhibit 3**) and as set out in the Nursing and Midwifery Task Group Report (**Exhibit 4,** Pages 53–54 on Visible Leadership at All Levels), it was the ambition of then-CNO Professor Charlotte Mc Ardle, working through EDON's, to strengthen the nursing and midwifery leadership infrastructure (at all levels) across the Health and Social Care System in order to drive reform in nursing and midwifery care.

f. My role and that of my team of nursing, midwifery, and AHP consultants in the PHA was to provide professional nursing, midwifery, and AHP leadership within and across programmes of care regionally. This included not only contributing to public health programmes within the PHA but also being core members of multidisciplinary, integrated HSCB commissioning teams, providing professional advice on the design, planning, and commissioning of services across all programmes of care. This also included professional advice on other aspect of HSCB role, for example, Extra Contractual Referrals.

g. It is within this context and in line with the role of the PHA that my primary focus was to maximise the contribution of nursing, midwifery, and AHPs in improving health and social care outcomes for people across the lifespan. This included strengthening the public health role of nursing and midwifery as well as improving the role of nursing and midwifery in delivering effective, safe, and high-quality care. My role also involved working to improve co-production by amplifying the personal and public involvement of people and that of their families or carers in the design, planning, and evaluation of health care experience, from a lived experience perspective.

h. In summary, as the PHA's Executive Director of Nursing, Midwifery, and AHP, I have held strategic leadership and professional responsibility within the PHA and HSCB for a wide range of programmes, including:

    - Public and population health nursing and midwifery developments.
    - Acute, emergency, and unscheduled care service development.

- Midwifery, Child, and Young People's Health, Including Safeguarding Services.
- Older People and Physical Disability Services.
- Mental Health and Learning Disability Services.
- Primary Care Nursing and Community District Nursing.
- Regional specialties such as prison health care nursing and custody health care services.
- Quality, Safety, Patient Experience, and Public Involvement. `
- Digital health and informatics.
- Nursing, midwifery, and AHP workforce planning.
- Professional Nursing Support to Health Protection Nursing and Infection Prevention Control

i. To fulfil this responsibility in my role as EDON I was supported by Assistant Directors of Nursing, Midwifery and AHP who provided me subject matter expertise across these areas:

- Older People, Primary and Community Nursing
- Workforce, Elective Unscheduled & Prison Custody Health Care.
- Quality and Safety
- Children, Young People, & Midwifery
- Mental Health and Learning Disability
- Allied Health Professional including Personal Public Involvement.
- Digital Health.

j. In Mental Health and Learning Disability, the Assistant Director was supported by three substantive nurse consultants; however, prior to 2020/21, there was one substantive nurse consultant post in this team (although some additional non-recurrent staff support). However, following investment through the Mental Health Strategy in 2021, an additional MH nurse post was recruited, and through NMTG investment, a dedicated Learning Disability Nurse Consultant was also recruited. This investment was critical in developing the PHA

Team's capacity to respond to the growing demand for regionally led improvement in these service areas.

k. I was Deputy Chief Nursing Officer, Department of Health, June 2017 to December 2019. This involved supporting the Chief Nursing Officer, providing professional nursing advice on older people, mental health, and Learning Disability working in partnership with the Northern Ireland Learning Disability Nursing Collaborative. It also involved leading the development of the co-production policy and the development of nursing and midwifery task group reports and recommendations under the leadership of the independent chair for NMTG.

l. I was Head of Quality Improvement for Mental Health Services (Health and Social Care Board, June 2014–May 2017). This involved leading care pathway development and quality improvement programmes across mental health, child and adolescent mental health services, autism, dementia, and neuro-disability services.

m. I was Regional Mental Health Services Improvement Lead HSCB May 2009 – May 2014.

7. For the purposes of my statement, my response primarily covers my time as Executive Director of Nursing Midwifery and AHP's which amounts to one year and six months of the period described in the Inquiry Terms of Reference (1st January 2020–14th June 2021).

8. I took up my post in the PHA following the formation of the NI Executive in January 2020. While I was substantively employed in the PHA as EDON from January 1, 2020, with the agreement of the PHA/HSCB Chief Executive, I continued to support the CNO from January 2020 to March 2020, with the finalisation of the Nursing and Midwifery Task Group Report (NMTG). This was in recognition of my previous leadership role as Deputy Chief Nursing Officer in the development, formulation, and delivery of the NMTG Report. During this time, the person who held the interim EDON post prior to me taking up my post continued in this role, providing operational leadership within PHA until I finalised the NMTG report.

9. As detailed later, the NMTG set out a 10-year strategic road map for the transformation of nursing and midwifery services in Northern Ireland (**Exhibit 3**). The NMTG report was fundamental to my EDON role in the PHA & HSCB given its focus on public health, safety, and quality, as well as addressing many of the challenges facing the provision of nursing care.

10. I have cited the NMTG report (**Exhibit 4**) and the NMTG action plan (**Exhibit 5**) to demonstrate the key ambitions and actions intended to reform the strategic, operational, and professional responsibilities of nursing and midwifery in Northern Ireland. The NMTG was the culmination of a three-year programme of work led by Sir Richard Barnet. The report sets out a vision and a plan for addressing the many competing challenges that had evolved in nursing over the last decade, particularly in terms of workforce, clinical leadership, and the development of quality, safety, and effective assurance systems in nursing and midwifery.

11. The report incorporated much of the knowledge learned from care failures, and the recommendations were built on the best evidence available. When the recommendations are fully implemented, they should help address many of the previously identified safety and quality challenges in nursing, specifically, within the context of the NMTG report, investing in and developing expert clinical roles, advanced therapeutic models of practice, rigorous clinical oversight, and embedding high-fidelity, person-centred practice models within learning disability.

12. While I would draw the Inquiry's attention to all the recommendations of the NMTG Report, outlined on pages 83–84 of the NMTG Report, there are several recommendations that I believe are pertinent to the reform of learning disability and to the Inquiry. In summary:
    a. Recommendation 2: Sustaining a minimum of 1000 undergraduate nurse & midwife placements for next five years until a position of oversupply is achieved.
    b. Recommendation 7: Seeks to build advanced nurse, specialist nurse, and nurse consultant roles across all branches of nursing and midwifery.

c. Recommendation 8: Increase the number of clinical academic career roles across all midwifery and all branches of nursing.
d. Recommendation 9: Delivering Care Policy (Safe Staffing) on a Statutory footing.
e. Recommendation 11: Develop a person-centred practice policy framework for all nursing and midwifery services.
f. Recommendation 12: Develop and prepare nurses and midwives for leadership positions.
g. Recommendation 13: Invest in improvement science training and increase the role of leadership in nursing and midwifery in quality improvement initiatives.
h. Recommendation 14: Develop a new statutory assurance framework for nursing and midwifery to underpin quality, safety, and effectiveness.

13. The work of the NMTG was seminal to my role, as it set out the programme of reform. It was anticipated following the launch of the NMTG report in March 2020 that the CNO, in partnership with the EDON, for the PHA would establish an NMTG implementation infrastructure to oversee the action outline in the NMTG five-year action plan (**Exhibit 5**). However, this launch coincided with and was impacted by the onset of the COVID-19 pandemic.

14. The onset of the pandemic in March 2020 had a profound impact on the capacity of the nursing, midwifery, and AHP teams as the PHA went into business continuity. This was the case for most of my time as Executive Director of Nursing, Midwifery, and AHP in the PHA.

15. Throughout 2020, 2021, and into 2022, the capacity of my team was affected as part of the public health emergency response, as staff were redeployed into various COVID-19 response roles during this time, for example.
    - Staffing Contact Tracing Rotas
    - Covering the PHA Emergency Duty Room
    - Care Home Response Cell

- Children, Young People, and Schools Cell
- Surge and Critical Care Planning
- Vaccination
- Infection Prevention and Control
- Maternity
- Mental Health Surge Planning and Learning Disability Rebuild Guidance
- Guidance Cell

Module

16. I have been asked to provide a statement for the purpose of Module 8: Professional Organisation and Oversight.

17. My evidence relates to paragraphs 9,10-13,17 and 18-19 of the Inquiry's Terms of Reference.

18. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn.

Serious adverse incidents and concerns regarding MAH

Q1. What was the role of PHA Nurse Consultants in the investigation of level 3 serious adverse incidents?

19. In responding to this question, I sought to contextualise the role of nurse consultants in level 3 Serious Adverse Incidents (SAI) reviews by outlining the extant policy and procedural guidelines that governed their role as Designated Review Officers (DRO) and that of the PHA. The details of this for ease of reference is covered from paragraph 13 to paragraph 15 of my statement.

20. The role of the PHA and its DRO's is outlined in the Department of Health Circular HSC SQSD 08–10, 'The transfer of SAI reporting to HSCB' (**Exhibit**

6), and the 'HSCB SAI Procedure for The Reporting and Follow-up of Serious Adverse Incidents in 2016' (**Exhibit 7**).

21. The 2010 circular (**Exhibit 6**) and the 2016 HSCB SAI Procedure (**Exhibit 7**) detail the respective roles of the HSCB, PHA, HSC Trusts, and RQIA. While the HSCB had the lead role in the governance and administration of the SAI procedure, the PHA, as part of its integrated commissioning, shared responsibilities with the HSCB in: -

    a. **Maintaining systems for managing SAI's**. The PHA's Quality and Safety team worked in partnership with the HSCB/SPPG Quality and Governance team to ensure effective oversight of the SAI procedure. The HSCB was primarily responsible for administrative functions, including recording SAI notifications, maintaining SAI Data Management Systems (Datix), scrutinising compliance, producing reports and assigning a lead Designate Review Officer (DRO)' to each SAI incident reported. The Datix system is used by HSCB to record all actions, decisions, and outcomes. DROs collaborate with the HSCB Governance Team to maintain records for all SAIs that they manage. Paragraph 13 of my statement explains some of the system changes that the HSCB and PHA made together to improve the management of SAIs.

    b. **Identify, formulate, and disseminate regional learning**. Upon submission of the completed SAI report to the HSCB by the reporting organisation, DRO's scrutinise the findings to ensure the adequacy of the review and to identify any regional learning. If learning was identified, it was subsequently considered by the relevant professional or service group for onward approval by the HSCB/PHA Quality Safety and Experience Committee (QSE) outlined in (**Exhibit 9**). However, previously, QSE only met quarterly. The process was changed during the pandemic, so all learning was approved weekly at the newly formed HSCB/PHA Safety Briefing Meeting, as outlined in paragraph 23C of this statement.

Once the learning has been agreed upon, it is formally distributed to all Trusts, typically in the form of a letter. In accordance with the recommendation outlined in the learning letter, Trusts must examine their own systems, policies, protocols, and/or practices and provide documented evidence of action or assurance that the highlighted learning has been implemented.

c. **Holding HSC Trust to account for the discharge of their responsibilities**. The HSCB, in partnership with PHA, has a role in monitoring compliance with the SAI procedure, including prompt notification of SAI's and ensuring SAI reviews are carried out and submitted within designated timescales. The HSCB Governance Team provided regular updates on provider (HSC Trusts) compliance at HSCB SMT. Repeated non-compliance resulted in an escalation letter being sent by the HSCB Chief Executive to the Trust Chief Executive requiring action. Within the SAI procedure, the DRO, working through the HSCB governance team, also had a role in ensuring the SAI review was conducted in line with the SAI 2016 procedure. This includes, as appropriate, escalating concerns as set out in Section 7.3 of the Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) (**Exhibit 8**).

22. While the design, leadership, and governance of SAI processes and procedures predated my role as Executive Director of Nursing at PHA, when I started, I sought to collaborate with the HSCB Governance team to update our internal mechanisms for managing SAIs. This was prompted by the need to manage an ever-increasing backlog of SAI reports, strengthen scrutiny, enable more meaningful trend and thematic analysis, and fortify support systems for Designated Review Officers (DRO).

23. My Assistant Director of Nursing for Safety and Quality, in collaboration with the HSCB Governance Team, sought to strengthen the PHA and HSCB oversight of SAIs, as detailed in **Exhibit 9**. In summary, the report providing an overview

of the Quality and Safety Processes relating to SAIs, Early Alerts and SQAs aimed to give PHA AMT and HSCB SMT assurance about the systems and processes in place for managing serious adverse events (SAIs), early alerts (EAs), and safety and quality alerts (SQAs) throughout the HSCB and PHA. The paper addressed governance and accountability systems, offered a strategic review of SAI data, identified areas of concern, work being done to mitigate risk, the impact of COVID-19, and proposed process improvements. This includes describing six key interconnected governing processes aimed at improving our approach. This approach was approved by PHA AMT in November 2020, as well as HSCB SMT. **Exhibit 10** depicts a flow chart of the processes implemented to improve our internal management of SAIs. This included establishing several mechanisms to enable more timely and targeted action, such as:

A. **Introducing a daily triage process,** for all serious adverse incidents and early alert notifications. Prior to the introduction of a system of daily triaging, individual SAI and early alert alerts were sent automatically to a large distribution list without any prior screening. The implementation of a daily screening enabled a more targeted approach, ensuring that the appropriate professional and/or service lead got SAIs and early alerts pertinent to their field of practice. The daily report was distributed to relevant professional leads to improve examination, follow-up, and escalation to the appropriate director(s) (see **Exhibit 11** for an example of a daily report). DRO receive their own notification as part of the DRO allocation process.

B. **Development of multidisciplinary (MDT) weekly Incident Review Group (IRG).** During the pandemic, and in recognition of the impact on PHA, DRO's who were required to support the PHA public health response, as a contingency, we established a multiprofessional weekly incident review group under the leadership of the PHA Nursing Directorate. The purpose of this approach was to maintain a proactive overview of all SAI notifications during this time. As detailed in **Exhibit 12,** the aim of this Weekly Incident Review Group is to provide

assurances that all notifications submitted to the HSCB's Serious Incidents mailbox are reviewed and managed in line with guidance. This was a multiprofessional group that scrutinised all incidents reported in that week to identify any urgent action required and/or escalate any areas of concern to the relevant director(s) or programme head. It also provides assurance to the safety brief on a weekly basis that any urgent action is taken following the receipt of notifications and that any areas of concern are promptly escalated. This was a very successful way of having oversight of all notifications and added an additional layer of governance, which has now been mainstreamed as part of the SAI management process and is co-chaired by PHA and SPPG. Previously, an SAI may have only been reviewed by a single professional; however, the changes we made have resulted in multi-professional scrutiny. Some of the members of this group are nurse consultant DRO's.

C. **Establishment of Weekly Safety Brief Meeting**. The Director of Nursing, PHA, and PHA Safety and Quality Team met weekly with the Director of Strategic Planning, HSCB Quality and Safety, and HSCB Governance Team to review and discuss any escalations received from the Incident Review Group. **Exhibit 13** outlines the terms of reference for this group, its core purpose and objectives. The primary aim of the joint SPPG/PHA Safety Brief meeting was to enable oversight of all safety and quality issues emerging, and to connect and where possible triangulate learning arising from SAIs, complaints, confidential enquiries, RQIA recommendations and any other intelligence we received. This weekly "safety brief" afforded an opportunity to consider and review actions required to address emergent concerns, including the identification of patterns and trends that may necessitate additional action. This weekly meeting also gave an opportunity to review, approve, or modify regional learning proposed by the Multiprofessional Group, as well as to determine if a thematic analysis was required. For illustrative purposes, **Exhibit 14** provides an example of the thematic analysis undertaken and the subsequent learning matter report (**Exhibit 15**) developed in response to this thematic review. In this context, nurse

consultants with subject matter expertise would also be involved in formulating learning.

D. **Reconfiguring and Strengthening SAI Professional Groups.** These groups were organised around a programme of care and include all DROs relevant to those programmes of care. So, for example, the Mental Health and Learning Disability group included nursing, social work, and AHPs. Previously, designated review officers largely performed their roles autonomously. This often meant single-profession oversight of SAI reports received by Trusts. Therefore, to strengthen, support, and improve professional scrutiny, all SAI reports are now reviewed by a multiprofessional group. **Exhibit 16** details the terms of reference for SAI professional groups. The primary purpose of these groups was to ensure collective, multidisciplinary decision-making on the management of SAI reviews and the identification of regional learning in line with the 'Procedure for the Reporting and Follow-Up of Serious Adverse Incidents 2016' (**Exhibit 7**). These terms of reference set out the roles and responsibilities of the DRO's professional group in relation to levels 1, 2, and 3 SAIs. These groups were designed to provide a systematic process for reviewing incidents to identify and agree on potential regional learning to be disseminated across the wider service to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation but across health and social care as a whole. In addition, these professional and programme groups not only provided an opportunity for MDT learning within the DRO group but were also designed to enable the identification of patterns and trends that may require regional action and quality improvement.

E. **Establishment of bi-monthly Trust HSCB/PHA Quality and Safety Performance Meetings.** To improve HSC Trust performance in managing their SAIs, the PHA Quality and Safety Teams and the HSCB Governance Team formally established monthly performance improvement meetings with HSC Trusts. The purpose of these meetings was to scrutinise HSC Trust's SAI improvement plans. These meetings

were also used to ensure that HSC Trusts were also keeping their respective boards up to date with their compliance with SAI policy and procedures, including notifying them of any non-compliance.

F. **Safety Framework**: It became obvious in analysing how a range of safety data is managed that there was a need to develop systems capable of triangulating a range of safety and quality data. It was clear to me that data relating to adverse incidents held on the Datix system, data on complaints, data on serious adverse incidents, data on patient experience, compliance data, findings from RQIA reports, etc. needed to be collated and systematically analysed. This led to discussion between the HSCB Governance Team, the PHA Quality and Safety Team, and the Department Safety team on the potential for the development of a regional safety and quality framework. The development of this was delayed largely due to the impacts of the pandemic. However, preliminary work was undertaken. **Exhibits 17 and 18** outline our initial thinking**.** The primary goal was to create a dashboard that would enable the triangulation of data and the identification of quality, safety patterns, and trends. As part of the PHA improvement plan, a PHA AMT quarterly update on safety was initiated in July 2022. This first quarterly position report (**Exhibit 19**) sought to bring information together into a single report covering SAIs, Safety and Quality Alerts, RQIA reports, complaints, NICE Guidelines, and National Confidential Enquiry into Patient Outcomes and Death. This paper also sets out the three strategic components of the framework that were under development. Using an outcomes-based accountability approach, these included: 1. streamlining leadership and governance to improve safety; 2. building or designing a safety surveillance system to improve outcomes; and 3. improving outcomes for people through systemic learning (**Exhibit 20**)**.**

G. It is my understanding that the development of a safety framework is currently paused, following the RQIA SAI review published in June 2022 (**Exhibit 21** RQIA SAI Review), which in summary recommended that

the Department of Health should work collaboratively with patient and carer representatives and the Health and Social Care System to design a new regional SAI procedure. An SAI redesign process is underway. I understand from colleagues that within this context, this may involve the potential for the development of a NI Patient Safety Strategy led by the Department of Health.

24. Having outlined some of the work in progress (in partnership with HSCB) to the internal management of SAI's, I will set out specifically the role that PHA nurse consultants have in relation to Level 3 serious adverse incidents.

25. At this juncture, it is important to reiterate that nurse consultants in the PHA undertake the role of Designated Review Officer as part of a wider range of duties within the PHA. The role of DRO is set out in the 2016 HSCB procedure for the reporting and follow-up of serious adverse incidents (**Exhibit 7).** Whilst the role of the DRO is referenced throughout this procedure, Section 11, Page 24, details their precise role in managing SAI's.

26. A DRO is a senior professional or officer within the HSCB or PHA who may come from a range of professional backgrounds, including nursing, medicine, AHP, and social work. DROs may also possess professional, subject-matter, safeguarding, and/or service expertise in the areas reported as SAIs. For instance, a professional with mental health or learning disability experience or expertise would often be allocated to SAI's in these areas. However, if a DRO requires a particular clinical view on an SAI review, this would be sourced where possible.

27. It is important to clarify from the outset that nurse consultants who are DROs do not have a role in conducting the actual investigation of level 3 serious adverse incidents. Responsibility for the investigation of level 3 SAI remains with the reporting organization. In line with the procedure for the reporting and follow-up of serious adverse incidents (**Exhibit 7**), a level 3 investigation must have an independent chair or be entirely independent, depending on the level

of complexity. It is within this context that DRO will seek assurance of the makeup of the panel prior to approving level 3 SAI Review terms of reference.

28. DRO's have a key role in the implementation of the SAI process, namely:
    i. Liaising with reporting organisations on any immediate action to be taken following notification of a SAI and where a DRO believes the SAI review is not being undertaken at the appropriate level.
    ii. Agreeing the Terms of Reference for Level 2 and 3 Root Cause Analysis Reviews.
    iii. Reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for Level 2 and 3 RCA Reviews, as well as liaising with other professionals (where relevant).
    iv. Liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented.
    v. Identification of regional learning, where relevant; and surveillance of SAIs to identify patterns, clusters, and trends. This, as covered in paragraph 23D of this statement, is undertaken with the support of the professional SAI Group.
    vi. To escalate any areas of concerns to relevant Directors.

29. In summary, the DRO plays a fundamental role in partnership with the HSCB governance team in working with reporting organisations to ensure the SAI is managed in line with the SAI procedure in **Exhibit 7**.

30. In support of the procedure for the reporting and follow-up of serious adverse incidents (**Exhibit 7**)**,** a 'Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) Allocated to a Serious Adverse Incident (SAI) (**Exhibit 8**) was developed. This protocol defines the role and function of DROs. Section 6 (pages 6–8) and Appendix 4 (pages 14–16) of this guidance outline the essential five steps to guide DRO through the SAI process, which include:
    i. Notification processes,
    ii. Immediate action is required upon notification.

iii. DRO's role in reviewing the SAI reports identified learning and actions being taken.
iv. Closure of SAI and identification of regional learning.
v. Section 7.3 (Pages 9–10) outlines the relevant process for escalation.

31. All DROs are trained by the HSCB Governance and PHA Quality and Safety Nursing Teams. **Exhibit 22** summarises the core training delivered. This, as noted in **Exhibit 8** also reflects the guidance set out in the Protocol for the Role of an HSCB/PHA Designated Review Officer (DRO) assigned to a Serious Adverse Incident. Revised, March 2017.

Q2. Did the PHA Nurse Consultants have any role in post-investigation actions regarding serious adverse incidents? If they did, please describe their role.

32. As set out in the procedure for the reporting and follow-up of serious adverse incidents (**Exhibit 7**)**,** the DRO contributes to ensuring reporting organisations learn from SAIs and, because of this learning, improve the safety and quality of services as well as reduce the risk of incident recurrence, both within the reporting organisation and across the HSC. The dissemination of learning following a SAI is therefore core to achieving and ensuring shared lessons are embedded in practice and the safety and quality of care provided (**Exhibit 7**, Section 8, page 21).

33. It was within this context that DRO (who in some cases is a PHA Nurse Consultant) working with the support of their professional SAI Group (Nurse Consultants are members of this group) and collaborating with the HSCB Governance Team ensure regional learning from SAIs has been identified and disseminated for implementation in a prompt manner; this may include:
    i. Issuing an immediate learning letter for action while awaiting the outcome of the SAI review.
    ii. Developing post-review learning letters. (**Exhibit 23** illustrates the template used to issue learning.)
    iii. Re-issuing reminders of best practices for learning previously identified. (**Exhibit 24** illustrates the template used for re-issuing learning**.**)

iv. Development of subject-specific ‘Learning Matters’ drawing on best practices (**Exhibit 25:** Illustrative**.**)

v. Conducting a thematic review.

34. DROs play a significant role in scrutinising and reviewing level 3 SAI reports submitted by reporting organizations. This involves:

i. Comparing the findings, outcomes, and learning from the SAI review as set out in the agreed terms of reference prior to the commencement of the SAI review.

ii. Reviewing the reporting organisation's proposed action and improvement plan.

iii. Clarifying with the reporting organisation any ambiguity in the report, including any findings that have not been linked to learning or learning that has not been linked to action,

iv. Sharing the findings and learning from the SAI review within the relevant professional SAI group as referenced in paragraph 23D of my statement. This provides an additional layer of scrutiny and facilitates the identification of regional learning including any action that may be required as a result of the professional group identifying recurring themes across a number of SAI’s.

v. Identifying and formulating any regional learning and, if necessary, seeking expertise and advice from relevant professional groups in the development of this learning. This may include developing a 'Learning Matters publication' and/or working with relevant professional or programme teams or networks to progress learning.

vi. Once learning has been formulated, it is reviewed at the HSCB/PHA Weekly Safety Brief for approval before being forwarded to Trusts for action.

vii. As required by the HSCB Governance Team, DRO’s and their professional group will be involved in quality assuring/ reviewing HSC Trusts responses to any learning issued.

35. In relation to the dissemination of learning, this is usually done via written correspondence to trusts through a standard template, as illustrated in (**Exhibit**

23). HSC Trusts are required to provide a written response providing assurance of actions taken. The PHA does not have a role in auditing HSC Trust assurance actions.

36. It is important to note that before closure, the DRO and the professional group working in partnership with the HSCB Governance Team must also be satisfied that all learning recommendations have been addressed through the development of a robust improvement action plan by the HSC Trust. The process for the closure of an SAI is outlined in 12.7 (page 27) of the HSCB Procedure for the Reporting and Follow-Up of Serious Adverse Incidents, **Exhibit 7**, and in the Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) Allocated to a Serious Adverse Incident (SAI). Revised: March 2017, **Exhibit 8**. The criteria for the closure of an SAI are set out in Appendix 3, pages 12–13 of this protocol.

37. There may also be occasions that, while not as part of the role of DRO, Nurse Consultants who are DRO's may, as part of their wider portfolio, be involved in leading or participate in quality improvement work, or pathways redesign or developing new service models as result of the learning and recommendations of the SAI review. This may include making recommendations for training and/or advocating for change in models of care, as well as advocating for resources as part of their role in the planning and commissioning of services.

38. The Muckamore Abbey Hospital MDAG HSC action plan is an example of this approach (**Exhibit 26**). This action plan sets out the key actions for the HSC system in responding to the learning and recommendations identified in the Way to Go SAI report and the subsequent recommendations of the Leadership and Governance Review. In this context, the establishment of the Muckamore Abbey Departmental Assurance Group (MDAG) became the primary mechanism to drive improvement. The Inquiry will be aware that the Muckamore Abbey Departmental Assurance Group was established to monitor the effectiveness of the Health and Social Care System's (HSC) actions. In support of the HSC action plan, the DOH also set up a Regional Learning Disability Operational Group chaired by HSCB to oversee the delivery of the

HSC action plan. The work of this group was operationalized through the HSCB Mental Health and Learning Disability Improvement Board, whose membership included key leads from all the trusts, the PHA Assistant Director of Nursing for Mental Health and Learning Disability, and also nurse consultants within that team.

Q3. Were you informed about the number and type of incidents? If so, how were you informed?

39. Prior to 2017, I was not in a role that involved oversight of learning disability services; therefore, I would not have been informed of the number and type of incidents in learning disability services.

40. Within the HSCB and PHA, there were a number of notification systems in place, primarily through the DOH early alerts process and the SAI process.

41. It is important to note that while all serious adverse incidents were routinely reported, adverse incidents are not reported to the HSCB or PHA.

42. In my role as Deputy Chief Nursing Officer in the Department of Health, I did begin to learn about events from 2017. I was initially informed about emerging incidents by the CNO and subsequently notified through the Department of Health Early Alert Processes, which were updated during 2018–19 whenever more cases related to MAH came to light. Furthermore, there were ongoing updates provided at MDAG from 2019, which I attended in both my role as Deputy Chief Nurse Officer in NI and as PHA Executive Director of Nursing, Midwifery, and AHP's.

43. In line with the procedure for the reporting and follow-up of serious adverse incidents (**Exhibit 7**)**,** the HSCB Governance team provided a daily update on all reported serious adverse incidents. As stated in paragraph 23a of my statement, SAI’s and early alerts were collated into a daily report, which was screened by the PHA Nursing Quality and Safety Team and distributed to the relevant staff. DROs or leads would also receive individual notifications for their

area and would have assessed the information, acted in accordance with SAI procedures, and/or escalated it to the appropriate director as needed.

44. All incidents, including the type and number, are reviewed at the Weekly Incident Review Group, as outlined in paragraph 23B of my statement.

45. I was kept appraised by the Assistant Director of Quality and Safety, who maintained an overview of all incidents being reported. I was also kept appraised by the Assistant Director of Mental and Learning Disability on incidents and actions being taken specifically in relation to MAH.

46. The Assistant Director of Quality and Safety at the HSCB/PHA provided an overview of incidents during the Weekly Safety Brief, as detailed in Section 23C of my statement.

Q4. If the answer to question 3 is yes, was this reported to the PHA Board? If so, how and by whom was this reported?

47. It is my understanding that in 2017 the HSCB Director of Social Care and the PHA Director of Nursing briefed the PHA Board regarding the emergence of serious adverse incidences at MAH.

48. The PHA Board is not usually notified of individual SAIs. The primary mechanism for informing the PHA Board of SAI's was through the provision of the PHA/HSCB annual quality report. For example, The Annual Quality Report for the period April 2019 to September 2020 was presented to the PHA Board on April 15, 2021 (**Exhibit 27**).

49. This report was presented by me with the help of my Assistant Director of Nursing for Quality and Safety. To illustrate the PHA/HSCB Annual Quality Report 2019/2020, **Exhibit 27** section 3 under Leadership and Quality Governance (page 5) sets out the Quality and Safety Management structures, and under ‘Transforming the Culture’ section 1.4 (page 11) provides an overview of activity in respect of the HSCB/PHA learning actions taken in

relation to SAI's throughout the preceding year. This section also included high-level data relating to SAI's, broken down by programme of care. This report also provided details on the various learning actions taken in response to SAI's, for example (pages 12–15).

50. The HSCB Executive Director of Social Care, with support from my Assistant Director of Nursing for Mental Health and Learning Disability, briefed the PHA Board members on the findings of the leadership and governance review during the confidential session of the Board meeting on August 20, 2020. The Board cover paper and PowerPoint presentation set out the background of the information shared with the Board (**Exhibit 28**). The confidential minutes (**Exhibit 29**) of this meeting outlined how PHA Board members sought clarity regarding the PHA's involvement in this Leadership and Governance Review and in SAI's more generally. The HSCB Executive Director of Social Care clarified that the PHA's involvement was in the context of the DOH letter asking the HSCB and PHA to commission the Leadership and Governance review and the PHA's wider role in SAI's.

51. In the PHA Board Meeting of September 17, 2020, a further discussion took place within the confidential session of the Board (**Exhibit 30**). The discussion focused again on the role of the PHA and HSCB in SAI's and highlighted the need for SAI's to be on the PHA Board Agenda. There was also recognition of the capacity challenges facing PHA staff at this time. The PHA Board noted the recommendations of the Leadership and Governance Review and that the recommendations would be addressed through the HSC (Muckamore Abbey) Action Plan and monitored through the Muckamore Abbey Departmental Assuring Group (MDAG).

52. In the confidential session of the PHA Board on April 15, 2021 (**Exhibit 31**)**,** there was a further discussion regarding the BHSCT breach in reporting historical safeguarding incidents as SAI's. From a review of the minutes of the meeting, it is my recollection that this refers to the Leadership and Governance Review findings regarding Ennis Ward and BHSCT's failure to report these safeguarding incidents as SAI's. The details of the Leadership and Governance

Review, as detailed above, were previously shared with the PHA Board. The primary question being asked was: did this mean the PHA Board needed to report this as a divergence within its governance statement? I clarified for PHA Board Members that this related primarily to BHSCT and was not a PHA divergence in terms of its role in SAI's as it relates to this matter. I further reminded the PHA Board members of the Permanent Secretary Letter to Executive and Boards regarding the recommendations of the Leadership and Governance Review (**Exhibit 32**) and the need for Boards to seek assurance that their governance reporting arrangements were being effectively implemented. I also outlined the steps being taken by HSCB/PHA to continue to seek assurance from HSC Trusts that they were escalating SAI matters to their boards, as detailed in paragraphs 144-149 of my statement.

53. At several points throughout my tenure at the PHA, the PHA Board sought clarification regarding the role of the PHA and their involvement with SAI management. In response to this request for clarification, I provided a briefing paper on the 2016 SAI procedure and the function of PHA DROs. This paper summarises the procedure, the various levels of SAI's, the role of DRO's, and that of the PHA as set out in the Department of Health Circular HSC SQSD 08-10 transfer of SAI reporting to HSCB 2010, including the role of the PHA in the dissemination of learning. This paper was shared with the PHA Board members via the PHA Board Chair on 18 January 2021, (**Exhibit 33**).

54. It was also in this context that the HSCB and PHA Governance and Audit committees jointly collaborated in commissioning an internal audit to review the HSCB and PHA internal SAI processes. This audit was conducted in the spring or summer of 2021 and completed in January 2022. This internal audit provided limited assurance (**Exhibit 34**). Among a range of improvement actions, Internal Audit recommended that the PHA Board be provided with a more detailed analysis of SAI, including the dissemination of learning. These recommendations were accepted by the PHA, and as a result, an improvement plan was developed.

Q5. Did you have concerns about safeguarding at MAH before September 2017 and, if so, what were the nature of your concerns? What action, if any, was taken in relation to those concerns?

55. As indicated prior to 2017, I was not in a role that involved oversight of learning disabilities at this time.

Q6. Did you or your team make any recommendations about education and training of staff at MAH? If so, please provide details of your recommendations and describe whether those recommendations were implemented.

56. After 2017 and as part of the work of MDAG, I did become aware of concern about safeguarding, which resulted in two reviews.

57. One review was conducted by HSCB and completed in November 2019, and the second commissioned by DOH in August 2021.

58. Nevertheless, the PHA Assistant Director of Nursing for Mental Health and Learning Disability commissioned the British Institute of Learning Disability Positive Behavioural Support Coach Training (PBS) in 2018-19 to assist staff working in learning disability services across the region, including MAH staff. This training was prioritised in acknowledgement of the need to improve the scope of therapeutic nursing skills and contribute to the creation of practice models that decrease the need for or dependence on isolation and/or restrictive practices.

59. Crucially, embedding PBS into learning disability nursing practice was critical for ensuring adherence to NICE Guideline NG11 Challenging Behaviour and Learning Disability Prevention and Intervention for adults with learning disabilities whose behaviour challenges (**Exhibit 35**).

60. The goal of integrating positive behavioural support (PBS) in nursing practice was to enable evidence-based, therapeutic, and ethical support for individuals with learning disabilities who present with behaviours of concern. PBS utilises

applied behaviour analysis approaches, which are guided by a strong values framework and provided in a person-centred and highly personalised manner.

61. It is my understanding that nineteen staff attended a three-day British Institute of Learning Disability PBS Coach's Training, and twelve staff from across the five HSC Trusts successfully completed this training and are now accredited British Institute of Learning Disability PBS Coaches. Funding was secured to offer a further two coaching programmes in 2018–2019, which enabled each Trust to train four members of staff as PBS coaches.

62. In support of this training, the PHA established a Positive Behavioural Support ECHO, which began in 2019/20, 2020/21, and continued into 2021/22. These sessions focused on person-centred practice, behavioural analysis, restraint reduction, trauma-focused practice, positive behavioural support competencies, sensory integration, and promoting quality of life. **Exhibits 36, 37, and 38** demonstrate the content of these sessions over the last three years. **Exhibits 39 and 40** provide an overview of the impact and benefit of these programmes on practice.

63. Project ECHO (Extension for Community Health Care Outcomes) is a tele-mentoring scheme that promotes peer-to-peer learning sessions. The ECHO strategy aims to connect healthcare providers in a network to facilitate shared learning, knowledge transfer, and skill development, as well as to strengthen practitioners' capacity to offer safe, effective care across the continuum of need through case studies. **Exhibit 41,** Project Echo Evaluation 2018–2020, provides more information on the impact of this method in NI. The PBS ECHO network's evaluation results are reported on pages 16, 30, and Appendix 2, page 42, and include information about the PBS Echo Network's influence on learning disability services in Northern Ireland.

64. This was the first ECHO in NI with a specific focus on meeting the health and social care needs of people with a learning disability, and as evidenced by the programme evaluations indicated at paragraph 58, this approach proved to be

an effective tool for improving the development of PBS practice in learning disability settings.

65. In 2018, the PHA collaborated with CNO teams to commission the Foundation of Nursing Studies: Creating Caring Cultures for Registered Nurse Learning Disability (RNLD). RNLD's working in a range of services across all five HSC Trusts took part. The primary purpose of commissioning this course was to create a quality-improvement learning environment for learning disability nurses to come together as a community of practice. **Exhibit 42** outlines the Foundation of Nursing Studies Creating Caring Cultures Programme. We believed this was important in light of the cultural challenges identified in the aftermath of MAH. The programme, Creating Caring Cultures, focused on disability nurses to:
    - Explore values and beliefs and agree on a shared purpose.
    - Look at what is happening in practice and identify gaps between what we say and what we do.
    - Develop action plans through shared decision-making.
    - Enable teamwork and staff wellbeing.
    - Commit to learning in and from practice.
    - Celebrate success and maintain momentum.

66. In October 2020, I contacted the Crisis Prevention Institute (CPI), which had previously delivered MAPA (Management Actual Potential Aggression) training in Northern Ireland. MAPA had become the standard training for restraint throughout HSC Trusts. Previously training has been directly provided to Trusts and to the Clinical Education Centre (CEC), which previously provided in-service MAPA training. I did so because of the concerns which had surfaced about restrictive practices and how Management Actual Potential Aggression (MAPA) was being applied.

67. Following my interaction with CPI, it became clear that they had updated their training methodologies. While MAPA has always emphasised the significance of prevention and de-escalation, the new course placed a greater emphasis on

responding to distress and behaviours of distress, conflict resolution, non-restrictive practice, evidence-based de-escalation techniques, and trauma-informed care.

68. I hosted a workshop with a collective leadership group including HSC Mental Health and Learning Disability Leads, staff from the Clinical Education Centre, the Learning Disability Nursing Officer from DOH, the Northern Ireland Practice Education Council, and academically approved institutes along with staff from CPI. **Exhibit 43** outlines the proposal. Following agreement that the proposed model would assist in improving practice, a similar presentation was delivered to the DOH Future Nurse Future Midwifery Programme Board. I outlined the opportunity to embed Prevention First training in all undergraduate nursing programmes, establish an advance practice model (Advance MAPA Instructors), and establish a community of practice hosted by CEC. I was convinced that we needed an environment that encouraged excellence while also providing practice oversight.

69. On March 4, 2021, the Future Nurse and Future Midwife Programme Board recognised the importance of a regional and trauma-informed approach to practice. Embedding the Prevention First concept throughout nursing would enable consistency of approach in education, training, and practice settings. It was agreed that the CPI model could assist in the delivery of care that protected both patients and staff.

70. As a result, the PHA was asked by the Future Nurse Future Midwife programme board to establish an implementation group to progress the CPI proposal, Prevention First and Safety Intervention Education and Training, with the intention of rolling out by September/October 2021.

71. Under the leadership of the then PHA Interim Assistant Director of Nursing for Mental Health and Learning Disability, a Prevention First and Safety Intervention Task and Finish Group was established (**Exhibit 44**), which was co-chaired by Professor Owen Barr, Professor of Nursing from Ulster University with the Assistant Director of Mental Health and Learning Disability in the PHA.

The group was supported by the Department of Health, QUB, UU, OU, CEC, and NIPEC. This group oversaw the development of a regional plan for the implementation of Prevention First Training in undergraduate nurse education in Northern Ireland.

72. The Prevention First and Safety Intervention programme was commissioned by DOH as part of the undergraduate nurse training programme in Autumn 2021. **Exhibit 45** provides evidence of DOH approval.

73. It was also envisaged that a cohort of staff from practice and education would also undertake advanced CPI education and training, as well as the potential to develop a community of practice hosted by CEC.

74. It is my recollection that the DOH also established a group to develop a regional policy on restrictive practices in health and social care settings and regional operational procedures for the use of seclusion. It was anticipated that the development of this new policy would influence the development of Phase 2 of my proposal. I understand the development of the CPI model is still under active consideration.

75. More broadly, my recommendations on learning disability and mental health focused on the importance of developing psychological and behavioural skills as well as expanding the role of learning disability nursing in physical and mental health. This was the direction I gave to my mental health and learning disability nursing staff. This suggestion was included in the CNO-commissioned review of learning disability nursing, which was led by the DOH learning disability nursing officer. This review was critical to building a learning disability nurse education and workforce plan.

76. In addition, the five Health & Social Care (HSC) Trusts have access to post-registration education programmes from various providers, including clinical education centres and Approved Education Institution. Some of these programmes are funded through the DOH (nursing) Education Commissioning Budget (ECG).

77. The PHA does not have a budget for regional nurse education commissioning; rather, the DOH Education Commissioning Group (ECG) routinely identifies and commissions regional nurse education and training priorities after consulting with Trust Education and Workforce Nursing leaders. The committee is made up of Trusts, AEIs, and CEC, along with DOH nursing officers. ECG was previously chaired by the PHA Director of Nursing and AHP, which is now chaired by NIPEC's CEO on behalf of the CNO.

78. The ECG process involved trusts, DOH, PHA, and AEI determining post-registration education priorities. Executive Directors of Nursing, through their different assistant directors of nursing for education and workforce, identified their respective educational and training needs across all fields of practice on a yearly basis. These were considered, programmes prioritised, and commissioned in accordance with health and social care strategic and professional priorities. It is important to note that, as part of the NMTG recommendations for 2021, ECG funding was restored to its previous level.

79. The work of ECG also operated under the direction of the Central Nursing and Midwifery Advisory Workforce and Education Community, whose role was to ensure that workforce and education priorities were aligned with policy directives. This subgroup operated on behalf of the Central Nursing and Midwifery Advisory Committee (CNMAC). CNMAC is a statutory advisory body established in 1974 under Article 24 of the Health and Personal Social Services (Northern Ireland) Order 1972. Its function is to provide relevant, timely, and resolved advice to the Department and the Chief Nursing Officer (CNO) on matters concerning nursing and midwifery in Northern Ireland.

Q7. Were you or your team aware of serious adverse incidents relating to safeguarding for any person resettled out of MAH from 2008 onwards? If so, please provide details, including the number of serious adverse incidents and the PHA response.

80. During my period of tenure as Executive Director of Nursing in the PHA from January 2020 to September 2022, there were no reported safeguarding incidents relating to any person resettled that I am aware of.

81. I am aware of discussions at MDAG concerning the difficulties encountered when a resettlement plan fell through. According to what I recall, all HSC Trusts took steps to ensure that every effort was made to limit the likelihood of resettlement placements failing.

Q8. As an attendee at the HSCB, were you present at any Board discussion regarding concerns about MAH? If yes, please provide details, including details of the professional advice given, if any.

82. I am aware that the previous HSCB Executive Director of Social Care, in partnership with the previous Executive Director of Nursing, PHA, briefed the HSCB Board on MAH incidents as they emerged and on the subsequent recommendations made following the Way to Go SAI report. I further believe the work of MDAG, and the HSC plan were discussed with the HSCB.

83. During my tenure as EDON, I recall several discussions in the confidential session of the HSCB following the publication of the Leadership and Governance report. These discussions took place at the HSCB Board meeting in August 2020 and again in September 2020. This briefing would have been similar to the briefing provided to the PHA Board as outlined in paragraph 53 & 54 of my statement.

84. As far as I can recall, any professional advice would have been around the findings and recommendations made by the "Leadership and Governance Review" and the steps being taken to address the lessons learned, as outlined in the HSC Action Plan (**Exhibit 26**), which MDAG was overseeing.

Commissioning

Q9. What advice did PHA provide about the commissioning of learning disability services?

85. To set the context, the PHA held joint responsibility for the commissioning services. This meant the PHA and HSCB had interdependent roles in

undertaking population health needs assessment, the development of commissioning solutions, and the improvement of health and social care services in Northern Ireland.

86. In this context, the PHA Director of Nursing, along with the PHA Director of Public Health, attended the HSCB Senior Management Team and HSCB Board, where they were expected to not only bring their professional perspective but also reflect the PHA's health improvement priorities in the HSCB work.

87. The HSCB and PHA Commissioning Teams were MDT and were largely configured around programmes of care. This meant that PHA Nursing, Midwifery, and AHP consultants provided professional nursing, midwifery, and AHP expertise in relation to the design, development, and commissioning of services through these teams. This also included the development of commissioning investment plans, the scrutiny of HSC Trust delivery plans (TDPs), and, as appropriate, contributing to service improvement plans and performance management of services in line with the commissioning plan directions.

88. These commissioning teams were primarily hosted by the HSCB, usually chaired at the Assistant Director level. The work of commissioning teams was also directed and influenced the HSCB Director of Commissioning, the HSCB Director of Performance Management and Services Improvement, and the HSCB Director of Finance. These Directors also had critical responsibilities for overseeing the delivery of Commissioning Plan Direction.

89. Each commissioning team oversaw the development of a commissioning work plan in response to DOH Commissioning Plan Direction and other key health and social care services strategies. It was within this context that the PHA and HSCB were jointly responsible for approving the regional Commissioning plan and agreeing the Trust Delivery Plan.

90. The HSCB, operating under Bamford Structures, has a specific MDT learning disability planning and commissioning team for learning disabilities. PHA Nurse Consultants for learning disability and mental health were essential members of this team. The PHA provided recommendations on the commissioning of learning disability services primarily through this team.

91. Despite the changes in organisational structure, PHA Mental Health and Learning Disability Nurse Consultants still offer expert nursing advice on all matters pertaining to the design of learning disability services, including the development of the learning disability service model, learning disability workforce review, community assessment, and treatment models, as well as a wide range of policy development, for example, policies on seclusion and restrictive practice.

92. Over time, the structure of this team changed in line with strategic and policy changes. It is my understanding that the learning disability Bamford group evolved into a learning disability services improvement board. The Learning Disability Service Improvement Boards were chaired by the HSCB. This board included representation from the PHA and key leads from Trusts. This reflected the shift towards a more collaborative commissioning model. The work of this board was driven by the DOH Commissioning Plan Direction and, more laterally, the programme of improvement outlined in the MDAG action plan (**Exhibit 26**).

Changing Landscape of Commissioning

93. For the purpose of my statement and for the period of my tenure as Executive Director of Nursing, the commissioning landscape and roles of HSCB and PHA were evolving both as a result of the pandemic and the anticipated formation of SPPG. While the extant legislation remained in place at the time of my appointment (January 2020), it is important to note that the mechanisms for developing and making commissioning decisions were progressively changing. This was primarily a result of the decision to close the HSCB, and transfer its functions into the Department of Health, now overseen by SPPG.

94. In 2021, the Health and Social Care Bill was introduced, and the Health and Social Care Act Northern Ireland came into effect in 2022. According to this statute, the SPPG is responsible for planning, improving health care outcomes, and supervising the delivery of effective, high-quality, safe, and effective health and social care. The inception of SPPG altered the Executive Director of Nursing's role and PHA staff's involvement in service commissioning. This shift resulted in the PHA Board no longer signing off on the commissioning plan, and the PHA Directors no longer attended SPPG executive management meetings. Furthermore, the PHA (which was being reviewed at the time) was increasingly emphasising its public health contribution to the commissioning agenda.

95. The rapid, focused external review of the Public Health Agency's (PHA) resource requirements to respond to the COVID-19 pandemic over the next 18–24 months (Hussey Review, **Exhibit 46**) highlighted the need for the PHA to be further resourced to strengthen its public health functions. This led to a joint DOH and PHA review of the PHA structure to support its key functions. I understand from former colleagues that this work has been completed and a change programme is underway.

96. As part of its commitment to implementing the strategic measures identified in Delivering Together 2026, the DOH initially established a Transformation Implementation Group (TIG). TIG brought together senior decision makers from Trusts, HSCB, PHA, and DOH to oversee and make decisions about the design, development, and implementation of health and social care reforms.

97. In June 2020, the DOH launched the Strategic Framework for Rebuilding HSC services (**Exhibit 47**), which resulted in the establishment of a new Rebuilding Management Board (RMB). Like TIG, the Regional Management Board has monitored the rebuilding, design, and delivery of ministerial priorities and directed key service decisions and service development.

98. As a result of the pandemic, the 2019–20 commissioning plan was rolled forward to 2020–21 and subsequently 21–22. Therefore, the priorities detailed

in this plan remained the extant commissioning directions for HSCB, PHA, and Trusts during my role in the PHA.

Commissioning advice on Learning Disability

99. Within the context of learning disabilities, the Department established MDAG in August 2019. The Muckamore Departmental Assurance Group was established to monitor the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH, including the subsequent recommendations made in Leadership and Governance, and to oversee resettlement commitments.

100. In 2019, following the formation of MDAG, the DOH sought to bring together all of the key recommendations emerging from MAH SAI. This resulted in the development of an HSC action plan (**Exhibit 26**). This plan directed HSCB and PHA commissioning and service improvement priorities. It is within this context that MDAG became the primary mechanism for improvement and for shaping decisions in relation to the design, development, and delivery of learning disability services. As such, the PHA Assistant Director for Mental Health and Learning Disability and Nurse Consultant provided professional input into the development of new service models for learning disabilities.

101. I recall at this time recommending that the acute care model for specialist learning disability service should include community-based MDT crisis care, including options to provide enhanced or intensive wrap-around support for citizens and their families or carers who present with acute, or crisis care needs in the community. It was my view that the development of an acute model for learning disabilities should not need to be exclusively reliant on a place-based solution, i.e., hospital care, but needed to provide step-up care and, in partnership with families, provide acute and enhanced care at home. I was also acutely aware that the service model needed to be capable of responding to a wide range of needs, including mental health, neurodiverse, and physical health and wellbeing interventions. This is why I was a strong advocate for the

development of MDT, which optimised the skills of all professionals. Equally with the development of these models, with a focus on assessment and treatment on outpatient bases where possible, and only as inpatient when absolutely required and for shortest time, I saw an opportunity to enhance the role of learning disability nursing, specifically in the delivery of community-based care.

102. I further recommended at MDAG that the work of the acute care model needed to be integrated within the work of the new service model. I saw this as a necessity in order to ensure a person- and family-centred continuum of care. In my view, this model needed to be capable of responding flexibly to any change in need, regardless of setting. It is my view that these perspectives were absorbed into the proposed model.

103. I also advised MDAG in June 2021 that with the investment being made in learning disability nursing, there was potential to work with the HSC Trusts to utilise one of these posts to develop a learning disability liaison nurse (**Exhibit 48** MDAG Minutes, June 2021, Point 22).

104. Turning specifically to commissioning advice and action in respect of nursing, my commissioning advice and that of my team were framed around the key recommendations of the NMTG March 2020 (**Exhibit 3 & 5**).

105. It was within this context that I sought to maximise the contribution of learning disability nursing, particularly as part of the MDT response to managing acute and complex learning disability needs across a range of settings, including enhancing the public health role of Learning Disability Nursing.

106. The NMTG report sets out a 10-15-year road map for nursing. This report and its action plan (**Exhibit 5 NMTG Action Plan**) were approved by the Minister of Health in March 2020. The ambitions and recommendations outlined in this report are fundamental to addressing many of the issues that emerged from the MAH SAI, particularly those that relate to nursing leadership, governance, quality, and therapeutic practice. The report sought to underpin

the strategic development of nursing as detailed in paragraph 96, 99 and 110 of my statement.

107. **NMTG Ambition 1- Maximising the contribution of nursing and midwifery in the delivery population health and wellbeing**. This ambition seeks to enhance the public health role of the profession, particularly in tackling health inequalities.

108. It was within this context, I sought strengthen role of nurse consultant in the PHA and in Trusts. As detailed in **Exhibits 49 -51** 'Delivering Care Strategic Investment Plan' 21/22, I recommended and secured investment in five Population Health Nurse Consultant posts. It was envisaged these Nurse Consultants would build a public health nursing network with the explicit goal of developing and improving public health nursing interventions throughout the life course. This was part of the CNO vision to grow a range of Nurse Consultant roles who would work together in improving health and care outcome. It was anticipated in time that these Public Health Nurse Consultants would work with Learning Disability Nurse Consultants to develop a coherent learning disability public health nursing approach.

109. In addition, I also recommended strengthening the PHA mental health and nursing team with an additional nurse consultant. This new nurse consultant was to have a specific and dedicated focus on learning disabilities, which also included developing a public health approach within Learning Disabilities Nursing. I secured funding for this post in October 2020 (**Exhibit 52:** PHA Job Description for Public Mental Health and Learning Disability Health Nurse Consultant in PHA).

110. **NMTG Ambition 2- Maximise the contribution of nursing and midwifery to deliver safe and effective person and family centred care**. This ambition focuses on stabilising the workforce, building models for safe and effective staffing, and creating Advance Nurse Practitioners and Consultant Nurse roles across all programmes of care, with the ultimate goal of enhancing outcomes for care, clinical expertise, and clinical leadership. This was in

recognition of the NMTG's findings that the profession was heavily reliant on Band 5 nurse practitioners, and consequently, there was a significant need to develop roles that not only offered pathways for career progression and improved retention but also developed new ways of working that delivered the nursing contribution to the vision outlined in the DOH Health and Wellbeing Delivering Together 2026 Strategy.

111. Under the New Decade New Approach agreement, and Framework Agreement CNO Professor Charlotte Mc Ardle secured £60 million to support the implementation of the first five years of the NMTG action plan (**Exhibit 5**). As result, £5 million was allocated for 2020/21, and an additional £20 million was allocated for 2021/22 to address the funding gap across multiple Delivering Care Phases that had been complete.

112. I have enclosed a copy of Delivering Care Strategic Investment Plan (**Exhibits 48-50**) which outlines the key priorities and rationale for this investment. This plan was presented as part of the nursing commissioning priorities for 2021/22. The priorities outlined in this investment plan were approved by the HSCB SMT and PHA AMT on 6th July 2021.

113. The priorities set out in this commissioning plan for nursing were formulated in discussion with CNO Professor Charlotte McArdle. We jointly agreed that while this investment was aimed at addressing the funding gaps in existing delivery care phases, considering other workforce and service priorities, we needed to use the opportunity of this investment to support the development of clinical leadership and advance nurse practice roles in order to drive improvement in the quality and safety of nursing care. In this context, we took the opportunity to prioritise investment in LD clinical leadership and specialist nursing roles. We also agreed these key priorities following discussion with DON in Nursing in Trusts and with the Regional Delivering Care Steering Group in a workshop on 22 April 2021 (**Exhibit 53**). Following on from this workshop and discussion at CNO business meeting on 29 April 2021, I wrote to the CNO on 21 May 2021 seeking approval for the indicative

commissioning plan. The CNO wrote back on 10th June 2021 with her approval of the plan (**Exhibits 54A, 54B 54C and 54D**).

114. The CNO and I agreed to invest in learning disability nursing roles, head of the Delivering Care Phase 9 Normative Staffing Model being completed, which had been delayed due to the pandemic. This investment provided the first opportunity to strengthen the clinical leadership, as recommended by previous PHA Director of Nursing Mary Hinds in her reports on Mental Health and Learning Disability Nursing Governance Review (March 2018). As a result, we decided to commission Learning Disability Nurse Consultant roles across all Trusts.

115. As evidenced in the Delivering Care Investment Plan (**Exhibits 49–51**), commissioning Learning Disability Nurse Consultant Posts was "in recognition of the need to improve and reform learning disability nursing services, as outlined in the Muckamore Abbey review, and to effectively respond to the new emerging learning disability services model." This was also important in the context of the CNO-commissioned regional review of learning disability nursing and underlined the need to invest in and develop senior clinician leadership roles in learning disability nursing in order to improve governance and care outcomes as well as strengthen and maintain clinical expertise in this area. This approach was also predicated on ensuring effective bio-psycho-social care delivered by RNLDs which was viewed as important both in addressing health inequalities and in responding to the changing health demographics of the learning disability population.

116. This led to investments in 20 WTE learning disability nursing posts, five Nurse Consultant positions, five Advance Nurse Practitioner roles and ten learning disability band 7 specialist nurse roles, as shown in Annex B Strategic Investment Plan (**Exhibit 49**).

117. In recognition of the role of MDAG and following the discussion outlined in point 27 of the MDAG minutes of June 2021 (**Exhibit 47**), I confirmed that the Chief Nursing Officer had prioritised investment in learning disabilities. It

was acknowledged at MDAG, that these new specialist roles had the potential to enable HSC Trusts to develop their own staff and also created the potential to attract nurses back into learning disability nursing roles.

118. This investment marked the beginning of efforts to systemically strengthen MH and LD nursing clinical leadership and practice infrastructure. While Delivering Care Phase 9 was delayed due to the pandemic, it was anticipated that these Consultants Nurses could lead and support the framing of Delivering Care Phase 9 and the development of learning disability KPIs/care indicators, as well as support the development of the new Learning Disability Services Model and the Learning Disability Workforce Review. Future investment was still needed to grow both the core Learning Disability nurse and specialist practice roles. In this context, the CNO also maintained the increase in undergraduate learning disability-commissioned places for 2020–21.

119. In discussion with the Executive Directors of Nursing in Trusts and the Regional Delivering Care Steering Group, we collectively agreed that investing in Nurse Consultant and Advance Nurse Practitioner roles (in line with NIPEC Nurse Consultant and Advance Nurse Framework, **Exhibits 55 & 56**) would help to create the conditions for effective clinical leadership in MH and LD nursing as well as develop clinical expertise within these respective fields of practice.

120. It was our strategic ambition that once these roles were appointed, we would create a nurse consultant leadership network both in MH and LD in order to drive regional, strategic, and professional practice. We further envisaged this network taking the lead in the development of care indicators and supporting the development of quality assurance systems across MH and LD.

121. **NMTG Ambition 3- Doing the right thing in the most effective way**. This ambition focused on developing professional leadership, embedding quality improvement, and developing quality assurance systems in order to underpin the quality, safety, and effectiveness of nursing and midwifery care. Page 84 of the report outlines the key recommendation. These

recommendations at pages 53–54 of the NMTG report outline the findings around the need to provide visible leadership at all levels and pages 75–77 on the need to create leadership for quality and innovation.

122. As outlined in the Delivering Care Investment Plan 2021 (**Exhibit 49**) we also prioritised investment in the commissioning of Six Nursing and Midwifery Assurance Nurse Consultant roles. The purpose of these roles was to support directors of nursing and midwifery in the development of their quality and safety approaches.

123. It was also envisaged that these Six Nursing and Midwifery Assurance Nurse Consultant roles would form a network and, working with other nurse consultant roles commissioned as part of the Delivering Care Investment Plan to support the development of nursing KPIs and nurse-sensitive indicators.

124. Within the context of this ambition, it was also anticipated that these Nursing and Midwifery Assurance Nurse Consultants would support the development of a bespoke nursing and midwifery assurance framework in accordance with recommendation 14 on page 84 of the NMTG, which would result in the development of a new statutory assurance framework for nursing and midwifery to underpin quality, safety, and effectiveness. We also saw the development of this assurance framework as a driver to integrate and triangulate a range of nursing and midwifery data in order to underpin the scrutiny of professional practice, drive improvement, and support Executive Directors of Nursing in providing more robust assurance to their boards on the safety and quality of nursing care.

125. I understand from former colleagues that the current CNO has been working through NIPEC on developing a New HSC Excellence Framework in support of this objective.

Q10. Was that advice always incorporated into the commissioning plan?

126. I sought, as indicated above, to demonstrate the advice provided and how this advice was subjectively embedded in commissioning actions set in the context that, during my tenure as Executive Director of Nursing, no new Commissioning Plan direction was issued for 20/21 or 21/22 and that my team was also substantially focused on responding to the pandemic.

PHA and Ennis investigation

127. In relation to the PHA and Ennis investigation, I was not employed by the PHA when the Ennis investigation was undertaken in 2012.

128. I became aware of the existence of the Ennis Report in 2018 whilst working as Deputy Chief Nursing Officer in DOH and through the provision of a synopsis of the Ennis report which provided by the BHSCT and circulated to MDAG Members detailed in MDAG Minutes of November 2019.

129. I again became aware of the details of Ennis through the findings following the publication of the Leadership and Governance Review Report in August 2020 (**Exhibit 57**).

Q11. Was PHA provided with Ennis report? If it was received?

(i) Who received it?

(ii) When was it received?

(iii)How did it come to be received?

130. Per paragraph 127 of this statement, I was not employed by the PHA at the relevant time.

Q12. If PHA was provided with the report, what action, if any, did PHA take upon receipt?

131. Per paragraph 127 of this statement, I was not employed by the PHA at the relevant time.

Q13. Was the report shared with the PHA Board or any of its sub-committees? If so, please provide full details.

132. From the information available to me, it appears the PHA never received a copy of the Ennis Investigation, and therefore I am not aware that it was discussed by the PHA Board or its subcommittees in 2012/13.

133. It is also my understanding that the Ennis investigation was never reported as an SAI. The details of this were confirmed by the Leadership and Governance report (**Exhibit 57**) paragraph 6–19, page 30, point 8.31, pages 103–104, which highlight that Ennis was never reported as SAI to HSCB and Trust accepted a breach of the SAI procedures.

134. As a result of the leadership and governance findings, the previous Director of Social Care, in the confidential session of PHA, updated the Board on the findings of the learning and governance review. This also included details on the Ennis Report (outlined in paragraphs 39 & 40 of this statement). This briefing provided details on the historical context and the conclusion made by the Leadership and Governance Review Teams regarding the Ennis report and its implication for safety of people being cared for in MAH.

Q14. In correspondence from RQIA to the Hospital Services Manager dated 03 December 2012 (concerning Ennis Ward), it is stated that a review of staffing levels at MAH had been requested by Molly Kane, Regional Lead Nurse Consultant at the PHA. Was this review carried out? If so, please provide details of and evidence relating to this exercise.

135. I am unable to comment as I was not involved or aware of any review of Learning Disability staffing at this time.

136. I understand the PHA does not appear to have any records of the outcome of this review.

PHA and the Leadership and Governance report

Q15. At pages 163-165 of "A Review of Leadership and Governance at Muckamore Abbey Hospital", dated 31st July 2020, the Review Team made a series of recommendations concerning PHA and other bodies (the Department of Health, the Belfast Trust and the HSC Board). The Inquiry would invite any comments that you wish to make regarding those recommendations.

137. In my role as Deputy Chief Nurse in DOH, I was part of the Departmental Team that recommended, following the publication of the SAI report 'A Way to Go', that the leadership and governance arrangements in BHSCT warranted further analysis. Consequently, the HSCB and PHA were asked to commission and oversee an independent review of these arrangements. The terms of reference were agreed upon at MDAG. The Terms of Reference are outlined in Leadership and Governance Report Appendix 1, pages 167–I72 (**Exhibit 57**).

138. The HSCB Director of Children and Social Care and the PHA Interim Executive Director of Nursing provided the necessary organisational leadership. It is my understanding that both the HSCB and PHA Boards were briefed in the confidential sessions of their board meetings about the need for a leadership and governance review prior to it being commissioned.

139. The recommendations pertaining to Leadership and Governance review sought to build on and enhance many of the areas of improvement already outlined in the HSC action plan (**Exhibit 26**) overseen by MDAG.

140. It was agreed at MDAG in September 2020 that the leadership and governance review recommendation would be added to the HSC action plan

and would be monitored through MDAG**. (Exhibit 58 MDAG Minutes, September 2, 2020.)**

141. It is my view that the Leadership and Governance Review recommendations emphasise the need for strong governance and quality assurance mechanisms from the point of care to the boardroom. These recommendations are consistent with the NMTG's goal of promoting quality, safety, and effectiveness.

Q16. What action, if any, did PHA take in relation to those recommendations? Please provide dates and details of any action taken.

142. On August 20, 2020, and again on September 17, 2020, the leadership and governance review findings were discussed in the confidential session of the PHA Board, as detailed in paragraphs 50 and 51 of this statement.

143. The PHA accepted the recommendations, noting that these would be overseen and monitored via MDAG.

144. In respect of the recommendations assigned to the HSCB/PHA:

"The HSCB and PHA should Ensure that any Breach of requirements brought to its attention has in the first instance been brought to the attention of the Trust Board."

145. This recommendation was considered by the HSCB/PHA Safety and Quality Safety Experience Group (QSE) on February 3, 2021 (which had been paused during the pandemic). **Exhibit 59** outlines the agenda for QSE, Item 4e. The PHA Assistant Director for Mental Health and Learning Disability brought this issue to QSE to explore mechanisms for seeking assurance on a breach of requirements.

146. Following discussion (**Exhibit 60, page 14**), it was agreed on the back of correspondence between the HSCB Chief Executive and Trusts regarding their SAI improvement plans and establishing a bi-monthly SAI improvement

performance meeting between the HSCB/PHA Quality Safety and Governance Teams and Trust Quality and Safety Governance Teams to add “non-compliance of requirements relating to SAI’s, as a standing item for these meetings. This was predicated on the rationale that this needed to be raised as a continuous issue. This approach was noted in the MDAG HSC action plan update for June 2021.

147. In preparation for these Quality and Safety Performance Meetings, colleagues in the HSCB Governance team would review all data pertaining to SAI notification, identify any issues of non-compliance, and identify HSC Trust’s current SAI management performance, including actions being taken by HSC Trusts to address any outstanding SAI reports. This also included seeking assurance from HSC Trusts that any non-compliance in notifying the HSCB of SAIs, along with any outstanding SAI reports, had been reported to their respective HSC Trust Boards. **Exhibit 61** provides an example of an agenda used for these meetings and for seeking assurance about HSC Trust mechanisms for informing their respective Trust Boards in relation to non-compliance with SAI notifications.

148. From the onset of these Quality and Safety Performance meetings in March 2021, HSC Trusts were requested to verify (via official minutes from HSCB) that they had put in place mechanisms to ensure that any instances of non-compliance with the SAI procedure were reported via their internal governance process to Trust Boards. At these meetings, HSC Trusts confirmed that their Trust Boards are informed of any issues of non-compliance with the 2016 SAI Procedure (**Exhibit 7**).

149. It is my understanding that the SPPG and PHA leads continue to validate HSC Trust compliance as a standing item on their SAI Performance and Improvement Meetings (**Exhibit 62**). Under agenda item 3c HSC Trusts continue to provide assurance that Risks in relation to Outstanding SAI reports have been escalated within internal governance arrangements including to their Trust Board.

150. Within the context of the RQIA SAI review, the DOH is in the process of redesigning the SAI procedure. I understand from colleagues that there will be a greater focus on the role of boards.

"Pending the Review of Delegated Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any area where there is non-compliance."

151. This action was progressed through the Social Care Directorate in HSCB/SPPG. It is my understanding that the review was completed, and the process now involves greater scrutiny by HSCB/SPPG.

"Specific care sensitive indicators should be developed for inpatient learning disability and community care environments."

152. From a PHA nursing perspective, it was initially intended to respond to this recommendation by building on the Learning Disability Nursing Key Performance Indicator, which was created in collaboration with PHA, NIPEC, and the NI Learning Disability Nursing Collaborative. However, because of pandemic-related pressures and an associated loss of capacity in the nursing mental health and learning disability team, we were unable to progress further with this work at the time.

153. The development and delivery of this recommendation has been impacted by number of factors.

i. The pandemic reduced the capacity of the nursing team, which meant the development of learning disability nursing key performance indicators was delayed.

ii. Furthermore, discussions within MDAG also influenced the approach. It was agreed at MDAG that the development of these care-sensitive indicators needed to be shaped and aligned with the development of the New Learning Disability Service Model and needed to be developed on a multidisciplinary basis (**Exhibit 26:** June 21 HSC Action Plan Update). I understand from colleagues that it was subsequently determined by MDAG that the care-

sensitive indicators would be absorbed within the LDSM workstream being led by the DOH.

iii. Additionally, it was anticipated that five newly appointed Learning Disability Nurse Consultants would also be involved in supporting the development of these care-sensitive indicators (Reference: **Exhibit 63,** HSC Action Plan Update, October 2021).

iv. It was further acknowledged that the Learning Disability Nurse Sensitive Indicator needed to be shaped by the CNO-commissioned review of learning disability nursing. I understand from colleagues that NIPEC is currently leading the development of a new learning disability nursing professional framework of practice. I further understand that this framework will be instrumental in shaping the development of learning disability nursing care indicators.

154. The PHA Assistant Director of Mental Health and Learning Disability has been actively involved in the work of MDAG, including providing professional input to both the development of the new Learning Disability Services Model and the development of the new learning disability nursing framework being led by NIPEC.

General

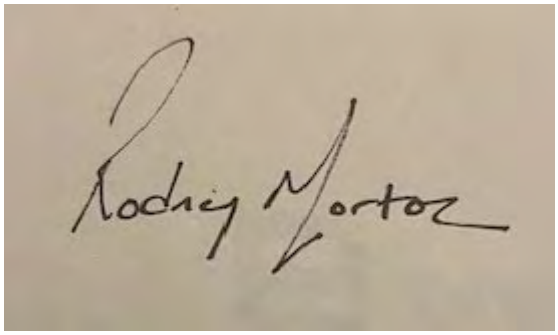
Q17. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of paragraphs 9, 10-13, 17 and 18-19 of the Terms of Reference?

I do not wish to add anything further to the information already provided in this statement at the present time.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are

necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 31/05/2024

List of Exhibits (Rodney Morton)

Exhibit 1: PHA EDON Job Role and Function

Exhibit 2: HSC Collective leadership strategy

Exhibit 3: NMTG report and recommendations

Exhibit 4: Dhssps Framework Document September 2011

Exhibit 5: NMTG Implementation framework

Exhibit 6: HSC (SQSD) 08-10 SAI 2010 Circular Transfer to HSCB

Exhibit 7: HSCB SAI Procedure 2016

Exhibit 8: DRO HSCB Protocol March 2017

Exhibit 9: PHA AMT 9 1 SMT Paper QSE Processes

Exhibit 10: SAI Oversight Flow Chart

Exhibit 11: Example Daily SAI Report

Exhibit 12: TOR Incident and Learning Review Group

Exhibit 13: Safety Brief Terms of Reference

Exhibit 14: Example Summary Paper Choking Learning Review

Exhibit 15: Example Learning Matters Chocking Issue 18

Exhibit 16: SAI Professional Group Terms of Reference

Exhibit 17: Draft Safety framework initial thoughts.

Exhibit 18: Initial Draft Safety Framework Document.

Exhibit 19: PHA Item 07 1 Safety and Quality Update Cover Paper & PHA Paper Safety and Quality Paper Appendix 1

Exhibit 20: PHA Safety Framework update August 22

Exhibit 21: RQIA SAI review report of SAI systems processes.

Exhibit 22: PHA HSCB Training Presentation for SAI’s.

Exhibit 23: Example of PHA SAFETY AND QUALITY LEARNING LETTER

Exhibit 24: Example of REMINDER OF BEST PRACTICE GUIDANCE

Exhibit 25: Example of Learning Matters - Special Edition

Exhibit 26: MDAG 10 21 MAH HSC Action Plan June 2021 (002)

Exhibit 27: PHA Board Paper Item 10 1 Annual_Quality_Report_Cover & Annual Quality Report 2019-2020

Exhibit 28: PHA Board Item 5 1 Muckamore_Update & PHA Board Item 5 2 Presentation on the Review of Leadership and Governance MAHSeptember 2020

Exhibit 29: Confidential Board Minutes August 2020 FINAL

Exhibit 30: Confidential Board Minutes September 2020 FINAL

Exhibit 31: Confidential PHA Board Minutes April 2021

Exhibit 32: Permanent Secretary Letter to HSC Trusts Item 3 4 Letter re Muckamore Abbey Hospital Review Report

Exhibit 33: PHA Internal Audit SAI Progress Report April 2022

Exhibit 34: Briefing Paper for PHA Board on SAI process final (3)

Exhibit 35: NICE challenging behaviour and learning disabilities prevention and interventions for people with learning disabilities whose behaviour challenges

Exhibit 36: ECHO Learning Disability PBS Programme 2019 20

Exhibit 37: PBS ECHO Learning Disability PBS Programme 2020 21

Exhibit 38: PBS ECHO Learning Disability PBS Programme 2021 22

Exhibit 39: PBS ECHO Learning Disability Evaluation results summary

Exhibit 40: PBS ECHO Learning Disability Final Survey Year 3

Exhibit 41: Project Echo Regional Evaluation 2018 2020 Report FINAL

Exhibit 42: Foundation of Nursing Studies Creating Caring Cultures 2nd Edition

Exhibit 43: MAPA WORKSHOP Email & PHA CPI Presentation 28th October 2020

Exhibit 44: Prevention First Intervention Task and Finish Group Terms of Reference July30 Final DraftV6

Exhibit 45: Costs for Prevention First Training Approval Email

Exhibit 46: Hussey PHA Review NI Report FINAL

Exhibit 47: DOH rebuilding HSC Framework 2020

Exhibit 48: DoH June 2021 MDAG Minutes

Exhibit 49: PHA AMT & HSCB SMT Item 8 1 Delivering Care Strategic Investment Plan Cover Paper

Exhibit 50: PHA & SMT Item 8 3 ANNEX B Nursing and Midwifery Task Strategic Investment Plan

Exhibit 51: PHA & HSCB Item 8 4 ANNEX C NMTG Investment Accountability Structure

Exhibit 52: PHA Nurse Consultant Learning Disability Nurse Band 8B Amended September 2023

Exhibit 52: Delivering Care (NMTG) Investment Allocation Workshop Agenda

Exhibit 54A-D:NMTG and Delivering Care 2122 Investment Plan

Exhibit 55: NIPEC advanced nursing practice framework

Exhibit 56: NIPEC professional guidance consultant roles framework

Exhibit 57: MAH Leadership and Governance Review Report

Exhibit 58: MDAG minutes Sept 2020 Agenda item 5

Exhibit 59: PHA & HSCB QSE Agenda 03.02.21.

Exhibit 60: PHA & HSCB QSE Notes 03.02.21.

Exhibit 61: Example PHA HSCB BHSCT QSE Agenda - 22.03.21.

Exhibit 62: MAH HSC Action Plan - October 2021 (004)

Exhibit 63: Example SPPG PHA Safety and Quality Performance Meeting Standing Agenda

RM Exhibit ①

HSC Public Health Agency

Director of Nursing and Allied Health Professions

Candidate Information Pack

Closing date: 12:00 noon Tuesday 9 July 2019

Introduction from the Chief Executive of the PHA and the Chief Nursing Officer of the Department of Health

Dear Applicant

Thank you for your interest in the Director of Nursing and Allied Health Professions (AHP) post and for taking the time to read this information pack.

The Director of Nursing and AHPs is a critical role in the Public Health Agency (PHA), Health and Social Care Board (HSCB) and will also be a member of the collective professional nursing and allied health professions structure within Northern Ireland led by the Chief Nursing Officer of the Department of Health.

We are seeking a nurse leader who has the ability to support and lead teams within the PHA/HSCB and throughout NI. They will provide leadership to public health nursing, midwifery and AHP at a time of change, with new and exciting opportunities for these professions to make a real difference to health outcomes in Northern Ireland.

They will have the ability to work across all organisations and professional boundaries demonstrating integrity, value based leadership and person centred care, while upholding the values of the Public Health Agency.

We want a leader that inspires our nurses, midwives and allied health professionals, who understands the operational reality and challenges staff face, and a leader that cultivates a culture where patient safety, quality care and user and carer experience is a priority.

You will be a strong voice of professional practice across professional boundaries, and therefore being a credible leader for both the Nursing and AHP workforce is crucial.

We hope this exciting and rewarding role catches your imagination and that you are encouraged to apply.

We are an inclusive organisation that celebrates diversity and welcomes everyone – all talents and backgrounds. Should you wish to have an informal discussion about the role feel free to contact Mary Hinds, Director Nursing and Allied Health Professions on 028 9536 3505.

We look forward to receiving your application.

Yours sincerely

Valerie Watts

Charlotte McArdle

Valerie Watts
Interim Chief Executive
Public Health Agency

Professor Charlotte McArdle
Chief Nursing Officer
Department of Health

About the Public Health Agency

The Public Health Agency (PHA) was established in April 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland. The PHA is a major regional organisation for health protection and health and social wellbeing improvement, with a commitment to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing.

The PHA works to support staff at the frontline, improve the quality of services, reduce inconsistencies in standards of care and help support learning when things go wrong.

The values of the Public Health Agency

- We put individuals and communities at the heart of everything we do in improving their health and social wellbeing and reducing health inequalities.
- We act with openness and honesty and treat all with dignity, respect and compassion as we conduct our business.
- We work in partnership with individuals, communities and other public, private, community and voluntary organisations to improve the quality of life of those we serve.
- We listen to and involve individuals and communities.
- We value, develop and empower our staff and strive for excellence and innovation.
- We are evidence-led and outcomes-focussed.

In all its work the PHA works in close collaboration and partnership with the Health and Social Care Board (HSCB), HSC Trusts, third sector partners, patients, clients and members of the public and other government agencies.

STRATEGIC DIRECTION

Health and Wellbeing 2026: Delivering Together.

In Health and Wellbeing 2026: Delivering Together, published in 2017, building on the work of Quality 2020, described a new direction for quality improvement.

This challenged the HSC system to, 'establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. There needs to be a greater alignment between quality improvement, partnership with those who use our services, and how we regulate those services.'

The ambition is to fully integrate quality improvement into the work of every HSC organisation.

A key objective is to improve the capacity of the HSC system to foster local innovation, scale and spread initiatives that make a positive impact and seek to

and the involvement of both individuals and communities in the development of new services and the changes required in new services.

The team works across the PHA and HSCB and in support of HSC Trusts as well as the Independent and third sector, and other government agencies.

The team also lead on a number of key transformation projects including:

- Intermediate Care
- Palliative and End of Life Care
- Nursing Home support and in reach
- Development of nurse Endoscopists
- Family Nurse Partnership
- Testing of transfer of immunisations to General Practice
- OPAT
- Dysphasia
- Neighbourhood District Nursing Services
- Frailty Services
- AHP Workforce

The PHA Business Plan provides further details of work in progress, https://www.publichealth.hscni.net/sites/default/files/2019-05/ANNUAL%20BUSINESS%20PLAN%202019.pdf

KEY RESULT AREAS:

Setting Direction

- Liaise and work closely with relevant Departmental colleagues in respect of appropriate policy development programmes.
- Participate fully in strategic planning processes for the health and social care system.
- Contribute to the development of strategies for the future of nursing, midwifery and allied health professions leading in specific areas of practice at the direction of the DoH.
- Lead appropriate programmes of work relating to the reduction in healthcare acquired infections across the HSC system.
- Ensure effective working relationships are in place with bodies such as Nursing and Midwifery Council (NMC) and the Regulation and Quality Improvement Authority (RQIA) for all relevant professional matters.
- Through professional leadership networks ensure the maintenance of rigorous systems to sustain high professional standards across HSC.
- Lead appropriate programmes of work relating to public health nursing to ensure full coverage of departmental policy, e.g. school nursing, health visiting etc.

Professional Leadership

- Provide high quality professional advice on public health nursing, midwifery and AHPs.
- Act as champion for health improvement across the life course.
- Provide professional nursing leadership for public health nurses, midwives, heath visitors and school nurses and developing and extending the public heath role for all nurses, midwives and AHPs.
- Provide highly visible and inspiring professional leadership for nursing, midwifery and AHP staff throughout the PHA/HSCB championing a professional and open culture which empowers staff to consistently deliver high quality, safe and effective care, acting as a role model for the behaviours

Commissioning/Planning

- Lead in partnership with HSCB colleagues specific commissioning teams as required including for example; palliative care, intermediate care, older people and frailty and elements of unscheduled care.

- Contribute to the full cycle of commissioning including needs assessment, service design and planning, performance management, service improvement and assessment of value for money and impact.

- Facilitate the provision of appropriate professional input and advice into commissioning processes ensuring that commissioning plans are developed in accordance with professional standards and departmental direction.

- Lead and take responsibility for development, implementation and delivery of identified elements of commissioning directions, commissioning plans and Quality improvement Plans including the development of specifications and frameworks with a clear focus on regional Safety, Quality and Patient / Client experience.

- Ensure the existence of appropriate networks of and support for nurses, midwives and allied health professionals playing a central role in commissioning teams.

- Ensure the ongoing development of a multi-professional commissioning skills base.

- Contribute to planning processes relating to improvements in public health and social wellbeing.

- Ensure the nursing and allied health professional workforce is engaged with health improvement programmes and equipped to play a full part in their implementation.

- Promote ongoing development of professional practice in line with best evidence.

Quality, Safety and Experience

- Provide corporate leadership and support for an agreed portfolio of quality safety and improvement initiatives.

- Lead, in partnership with the Director of Quality Improvement, and other Director colleagues, on the development of systems to improve safety and quality of service.

- Lead in the management of a range of Quality, Safety and patient/client experience initiatives including for example; management of serious adverse incident reviews, identification of learning, management of quality safety alerts reminders of best practice and thematic reviews.

- Chair, in partnership with the Director of Social Care, the Community Ehealth Programme Board to support of the implementation of the Ehealth Strategy and further coordination and links to Encompass.

- Lead in the continued development of education, support and training to nurses working in primary care.

Partnership working/ Co-Production/Patient, Client and User Experience

- Lead the development of partnership working including co-production and professional input to community development approaches to health improvement.

- Lead the PHA Personal and Public Involvement strategy development and implementation, meeting the requirements as set out in legislation and direction from the DoH.

- Lead the delivery of regional monitoring and performance management arrangements for involvement within the HSC, to support HSC compliance with statutory functions and responsibilities as set down in legislation.

- Ensure appropriate processes of engagement and involvement are in place to enable an understanding of patient, client and user expectations and satisfaction levels.

- Lead work programmes relating to the development of standards and promotion of good practice in relation to patient, client and user experience.

- Lead and co-ordinate enabling work to ensure the delivery of health and social care services in a manner which meets patient, client, provider and user experience.

- Focus particularly on service frameworks, patient pathways, interdisciplinary team working and issues relating to diversity and personalisation of services.

- Lead the 10,000 Voices initiative.

Financial Management

- Be accountable for the management of the Directorate's budget (pay and non-pay) and the meeting of all financial targets by each division and service.

- Advise and assist the Boards of the PHA/HSCB on determining its expenditure

- Participate in contract and service level negotiations with Trusts and other providers, leading specific Programmes of Care (POCs) as required.

- Develop robust evaluation methods to measure the effectiveness and outcomes of the nursing, midwifery and AHP professions. The post holder will be required to develop, implement, monitor and manage (where appropriate) the local and regional systems to achieve this.

- Maintain an up to date knowledge base of relevant research, information and evidence and use this to inform the design, development and implementation of best practice to support planning, commissioning and the development of best practice.

General Responsibilities

Employees of the PHA will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and treat those with whom they come in contact in a courteous and respectful manner.

- Demonstrate their commitment by their regular attendance and efficient completion of tasks allocated to them.

- Comply with the PHA's confidentiality policy.

- Comply with the PHA's No Smoking policy.

- Comply with the HPSS Code of Conduct

Carry out duties and responsibilities in compliance with health and safety policy and statutory regulations.

Records Management

All staff are responsible to the Director for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

Equality

To assist the Public Health Agency to fulfill its statutory duties under Section 75 of the Northern Ireland Act 1998, the Human Rights Act 1998, and other equality legislation.

HSC Public Health Agency

Personnel Specification

Director of Nursing and Allied Health Professionals

Public Health Agency

Salary: Senior Executive Level 3 £ 83,098 - £110,801 p.a.

ESSENTIAL CRITERIA		
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.		
Factor	**Criteria**	**Method of Assessment**
Qualifications	On the NMC Live Register. And Have a degree or relevant specialist qualification in Nursing/Health Visiting/Midwifery or another appropriate subject (e.g. health service management, health studies etc.);	Shortlisting by Application Form
Experience and knowledge	A minimum of three years' experience in a senior management[1] role in a major complex organisation[2] AND clear significant[3] personal evidence of:- • managing major service improvement and transformation; • management of systems to support quality, safety and improved patient/client experience	Shortlisting by Application Form and interview

[1] *'senior management' is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation*
[2] *'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders*
[3] *'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.*

	innovation. • We are evidence-led and outcomes-focused.	
Skills / Abilities	Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The dimensions concerned are given in the Healthcare Leadership Model. Particular attention will be given to the following: • Inspiring shared purpose • Leading with care • Evaluating information • Connecting our service • Sharing the vision • Engaging the team • Holding to account • Developing capability • Influencing for results Excellent communication skills both orally and in writing	Assessment Centre and Interview

As part of the Recruitment & Selection process it may be necessary for the organisation to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

THE ORGANISATION IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the organisation's Smoke Free Policy

Information for Applicants

Please read the following before completing your application form.

- We require all sections of the application form to be completed in full. We do not accept Curriculum Vitae (CVs) in lieu of the application form.

- The PHA is under no obligation to take account of your holiday arrangements.

- Please pay particular attention to the essential criteria detailed on the Personnel Specification and make sure you address these requirements when completing your application form. Shortlisting will be carried out on the basis of the information contained on your application form. We cannot make any assumptions about such information, and failure to address the requirements of the Personnel Specification will result in you not being shortlisted.

- The application form must be completed on-line. Postal applications will not be accepted for this post.

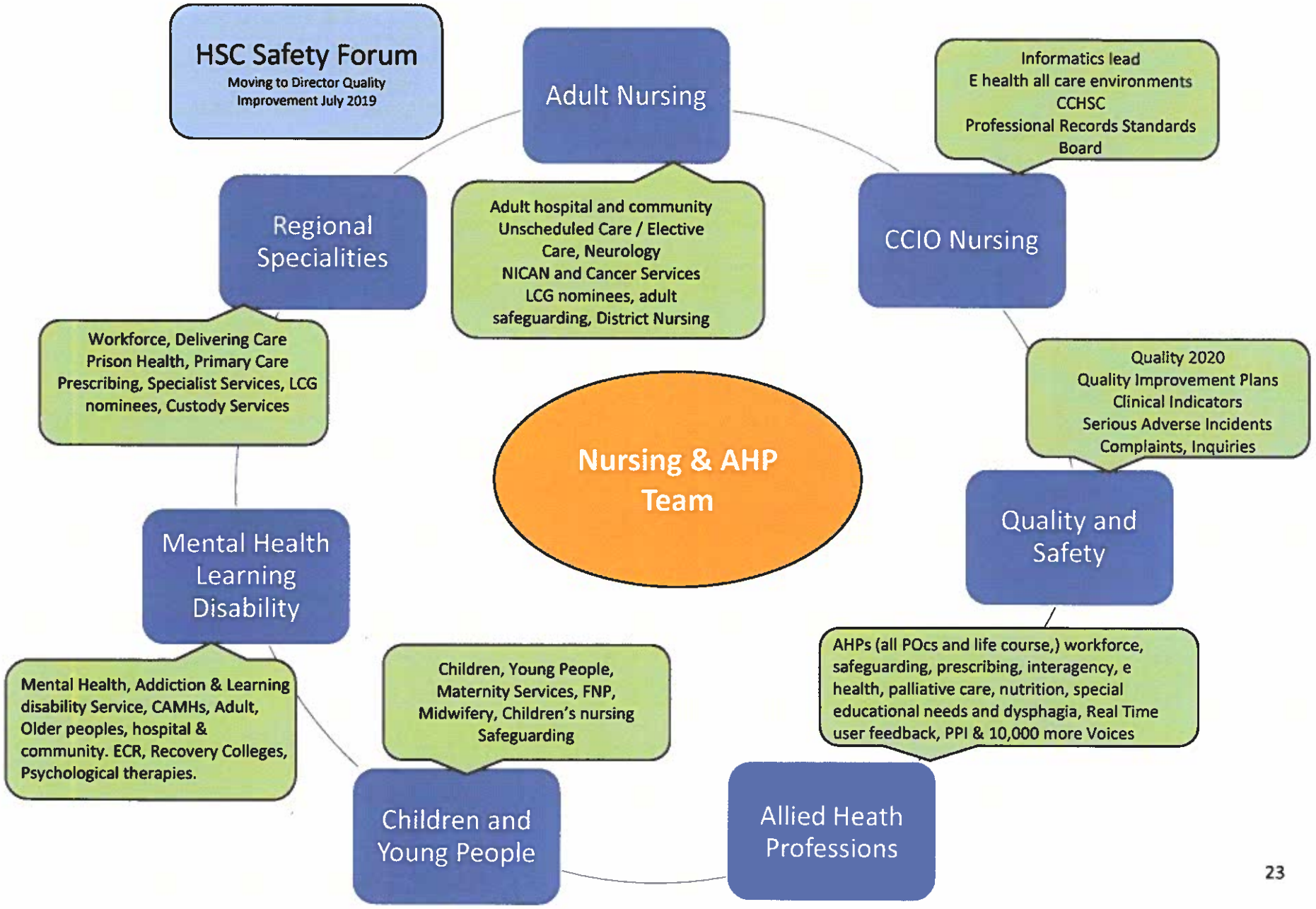
- You must provide the names and addresses of two referees. At least one of the named referees must be your current or most recent employer. Please note that relatives must not be used.

- Please give full details of all qualifications requested including the level, grade and date of the examination. If professional registration or membership is a requirement on the Personnel Specification, you must record the name of the Professional Body and your registration or PIN number in the appropriate boxes. If you are successful at interview, you will be required to produce original documentation of all qualifications / professional registration prior to commencing the post.

- The monitoring section of your application form will be removed and held separately from your application form. All sections of the monitoring questionnaire must be completed. The information is treated as strictly private and confidential and is used for statistical purposes only. Panel members do not have access to this information.

- We will consider any request for this information pack in another format or language. Please contact us at 028 95 363001 (option 4).

- If you have a disability and you feel you may have difficulty with car parking or access arrangements at interview, please contact the Human Resources Department immediately when you receive your letter calling you to interview, to discuss any special requirements.



DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

FRAMEWORK DOCUMENT

Index

1. INTRODUCTION

1.1. The Department has produced this Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

Background

1.2. The reform of the health and social care system in Northern Ireland has its origins in the Review of Public Administration (RPA) which was initiated by the Northern Ireland Executive in June 2002. The purpose of RPA was to review Northern Ireland's system of public administration with a view to putting in place a modern, citizen-centred, accountable and high quality system of public administration.

1.3. The need to reform the health and social care system at the earliest possible opportunity was widely supported. The new design is more streamlined and accountable and aimed at maximising resources for front-line services and ensuring that people have access to high quality health and social care. Another key feature is that public health and wellbeing is put firmly at the centre of the new system, with a greater emphasis on prevention and support for vulnerable people to live independently in the community for as long as possible.

1.4. The Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the Reform Act") provides the legislative framework within which the new health and social care structures operates. It sets out the high level functions of the various health and social care bodies. It also provides the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the

effective delivery of health and social care in Northern Ireland.

Framework Document

1.5. The Health and Social Care (Reform) Act (NI) 2009, Section 5(1), requires the Department of Health, Social Services & Public Safety ('the Department') to produce a 'Framework Document' setting out, in relation to each health and social care body:

i the main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;

ii the matters for which the body is responsible;

iii the manner in which the body is to discharge its functions and conduct its working relationship with the Department and with any other body specified in the document; and

iv the arrangements for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC bodies.

1.6. Section 1 (5) of the Reform Act defines "health and social care bodies" as:

i Regional Health and Social Care Board (known as Health and Social Care Board);

ii Regional Agency for Public Health and Social Well-being (known as Public Health Agency);

iii Regional Business Services Organisation (known as Business Services Organisation);

iv HSC Trusts;

v Special Agencies (i.e. Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency);

vi Patient and Client Council; and

vii Regulation and Quality Improvement Authority

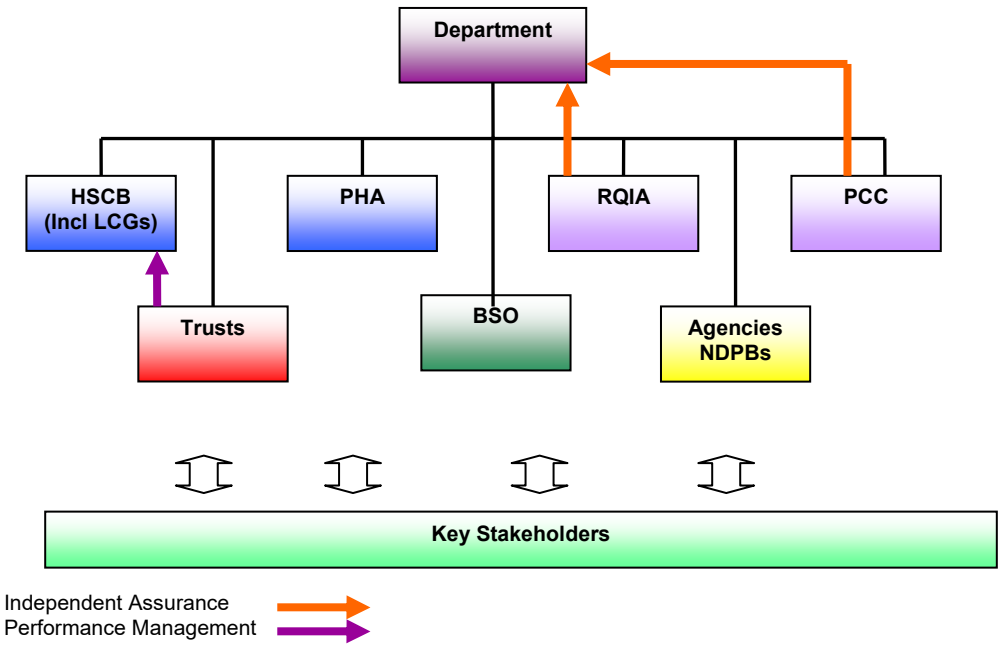
1.7. The focus of the Framework Document is the health and social care system in Northern Ireland and, although not covered by the Reform Act, the Northern Ireland Practice and Education Council and the Northern Ireland Social Care Council are included in the document for completeness. The Northern Ireland Fire and Rescue Service is outside the scope of the Framework Document.

1.8. All of the HSC bodies referred to above remain ultimately accountable to the Department for the discharge of the functions set out in their founding legislation. The changes introduced by the Reform Act augment, but do not detract from, that fundamental accountability.

1.9. Independent family practitioners also play a significant role in the delivery of health and social care. Health and social care objectives can only be achieved with the engagement of a high quality primary care sector that is accessible, accountable and focused on the needs of patients, clients and carers.

2. STRUCTURES, ROLES AND STATUTORY RESPONSIBILITIES

2.1. This section outlines the roles, responsibilities and relationships between the Department and health and social care (HSC) bodies. The diagram below shows the structure of the health and social care system.



Key: HSCB = Health and Social Care Board
LCGs = Local Commissioning Groups
PHA= Public Health Agency
BSO = Business Services Organisation
RQIA = Regulation and Quality Improvement Authority
PCC = Patient and Client Council
Agencies = Special Agencies (Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency)

Department of Health, Social Services & Public Safety

2.2. Section 2 of the Reform Act places on the Department a general duty to promote an integrated system of:

i health care designed to secure improvement:
- in the physical and mental health of people in Northern Ireland, and
- in the prevention, diagnosis and treatment of illness; and

ii social care designed to secure improvement in the social well-being of people in Northern Ireland.

2.3. In terms of service commissioning and provision, the Department discharges this duty primarily by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and to a number of other HSC bodies created to exercise specific functions on its behalf. All these HSC bodies are accountable to the Department which in turn is accountable, through the Minister, to the Assembly for the manner in which this duty is performed.

2.4. In addition, the Department retains the normal authority and responsibilities of a parent Department as regards direction and control of an arm's length body. The main principles, procedures etc are set out in the DFP guidance *Managing Public Money Northern Ireland* and are reflected in each body's management statement/financial memorandum (MSFM), in the letter appointing its chief executive as accounting officer for the body, and in the letters appointing its chair and other non-executive board members. The functioning of the bodies covered by this Framework Document is to be viewed in the context of, and without prejudice to, the Department's overriding authority and overall accountability.

Health & Social Care Board

2.5. The HSCB, which is established as the Regional Health & Social Care Board, under Section 7(1) of the Health & Social Care (Reform) Act

(Northern Ireland) 2009, has a range of functions that can be summarised under three broad headings.

2.6. **Commissioning** – this is the process of securing the provision of health and social care and other related interventions that is organised around a "commissioning cycle" from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need by agreeing with providers the delivery of appropriate services, monitoring delivery to ensure that it meets established safety and quality standards, and evaluating the impact and feeding back into a new baseline position in terms of how needs have changed. The discharge of this function and the HSCB's relationship with the PHA are set out in sections three and four.

2.7. **Performance management and service improvement** – this is a process of developing a culture of continuous improvement in the interests of patients, clients and carers by monitoring health and social care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance through appropriate interventions, service development and, where necessary, the application of sanctions and identifying and promulgating best practice. Working with the PHA, the HSCB has an important role to play in providing professional leadership to the HSC.

2.8. **Resource management** – this is a process of ensuring the best possible use of the resources of the health and social care system, both in terms of quality accessible services for users and value for money for the taxpayer.

2.9. The HSCB is required by the Reform Act to establish five committees, known as Local Commissioning Groups (LCGs), each focusing on the planning and resourcing of health and social care services to meet the needs of its local population. LCGs are co-terminus with the five HSC Trusts.

Public Health Agency

2.10. The PHA, which is 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 incorporates and builds on the work previously carried out by the Health Promotion Agency, the former Health and Social Services Boards and the Research and Development Office of the former Central Services Agency. Its primary functions can be summarised under three broad headings.

2.11. **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 of, and reduce health inequalities between, people in Northern Ireland;

2.12. **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 on environmental or public health grounds or arising out of emergencies;

2.13. **Service development** – working with the HSCB 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 the HSCB, the PHA has an important role to play in providing professional leadership to the HSC.

2.14. In exercise of 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.

Health and Social Care Trusts

2.15. HSC Trusts, which are established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991, are the main providers of health and social care services to the public, as commissioned by the HSCB. There are now six HSC Trusts operating in Northern Ireland:

- Belfast Health and Social Care Trust (covering local council areas of Belfast and Castlereagh);
- South Eastern Health and Social Care Trust (covering local council areas of Newtownards, Down, North Down and Lisburn);
- Northern Health and Social Care Trust (covering local council areas of Coleraine, Moyle, Larne, Antrim, Carrickfergus, Newtownabbey, Ballymoney, Ballymena, Magherafelt and Cookstown);
- Southern Health and Social Care Trust (covering local council areas of Dungannon, Armagh, Craigavon, Banbridge and Newry and Mourne);
- Western Health and Social Care Trust (covering local council areas of Derry, Limavady, Strabane, Omagh, and Fermanagh)
- Northern Ireland Ambulance Service Trust (covering all of Northern Ireland)

2.16. The six HSC Trusts are established to provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, are also responsible for exercising on behalf of the HSCB certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003).

2.17. Section 21 of the Reform Act places a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

Business Services Organisation

2.18. The BSO, which is established as the Regional Business Services Organisation under Section 14 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, contributes to health and social care in Northern Ireland by taking responsibility for the provision of a range of business support and specialist professional services to other health and social care bodies, as directed by the Department in accordance with Section 15 of the Reform Act.

2.19. The BSO incorporates the majority of services previously provided by Central Services Agency. The BSO, however, provides a broader range of support functions for the health and social care service, bringing together services which are common to bodies or persons engaged in providing health or social care. These include: administrative support, advice and assistance; financial services; human resource, personnel and corporate services; training; estates; information technology and

information management; procurement of goods and services; legal services; internal audit and fraud prevention. Such support services may be provided directly by the BSO or through a third party.

Patient and Client Council

2.20. The PCC, which is established under Section 16 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, is a regional body supported by five local offices operating within the same geographical areas covered by the five HSC Trusts and LCGs. The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers, and communities on health and social care issues through the exercise of the following functions:

- to represent the interests of the public by engaging with the public to obtain their views on services and engaging with Health and Social Care (HSC) organisations to ensure that the needs and expectations of the public are addressed in the planning, commissioning and delivery of health and social care services;
- to promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
- to provide assistance to individuals making or intending to make a complaint relating to health and social care; and
- to promote the provision of advice and information to the public by the HSC about the design, commissioning and delivery of health and social care services.

Regulation and Quality Improvement Authority (RQIA)

2.21. The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Although accountable to the Department, it is an independent health and social care regulatory body, whose functions

include:

i Keeping the Department informed about the provision, availability and quality of health and social care services;

ii Promoting improvement in the quality of health and social care services by, for example, disseminating advice on good practice and standards;

iii Reviewing and reporting on clinical and social care governance in the HSC - the RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, reporting to the Department and the Health and Social Care and making recommendations to take account of good practice and service improvements. Such reviews may be instigated by RQIA or commissioned by the Department;

iv Regulating (registering and inspecting) a wide range of health and social care services. Inspections are based on a new set of minimum care standards which ensures that both the public and service providers know what quality of services is expected. Establishments and agencies regulated by the RQIA include nursing and residential care homes; children's homes; independent hospitals; clinics; nursing agencies; day care settings for adults; residential family centres; adult placement agencies and voluntary adoption agencies. The Reform Act also transferred the functions of the former Mental Health Commission to the RQIA with effect from 1 April 2009. The RQIA now has a specific responsibility for keeping under review the care and treatment of patients and clients with a mental disorder or learning disability.

2.22. The RQIA is also the enforcement authority under the Ionising Radiation and Medical Exposure (Amendment) Regulations (N.I.) 2010 [IRMER] and is one of the four designated National Preventive Mechanisms under the United Nations Optional Protocol for the Convention against Torture [OPCAT] with a responsibility to visit individuals in places of detention and to prevent inhumane or degrading treatment. RQIA also conducts a rolling programme of hygiene inspections in HSC hospitals.

2.23. The Department can ask the RQIA to provide advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. The RQIA may also advise the Department about any changes which it considers should be made in the standards set by the Department.

Special Agencies

2.24. Special Agencies are established under the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 to provide specific functions on behalf of the Department.

2.26. **Northern Ireland Blood Transfusion Service (NIBTS)** - The NIBTS is responsible for the collection, testing and distribution of blood donations each year. The main aim of the NIBTS is to fully supply the needs of all hospitals and clinical units in Northern Ireland with safe and effective blood, blood products and other related services. The discharge of this function includes a commitment to the care and welfare of blood donors.

2.27. **Northern Ireland Medical and Dental Training Agency (NIMDTA)** – The NIMDTA was established to ensure that doctors and dentists are effectively trained to provide the highest standards of patient care. The NIMDTA is responsible for funding, managing and supporting postgraduate medical and dental education. It provides a wide range of functions in the organisation, development and quality assurance of postgraduate medical and dental education and in the delivery and quality assurance of continuing professional development for general, medical and dental practitioners.

2.28. **Northern Ireland Guardian ad Litem Agency (NIGALA)** – The NIGALA is responsible for maintaining a register of Guardians ad Litem who are independent officers of the court experienced in working with

children and families. Under the Children (NI) Order 1995, a Guardian ad Litem is appointed to safeguard the interests of children who are subject to family and adoption court proceedings and to ensure that their feelings and wishes are made clear to the court. The NIGALA also has a pivotal role in ensuring that the Children (Northern Ireland) Order is implemented as intended. The provision of an effective and efficient Guardian ad Litem Service is vital if the Children Order is to operate satisfactorily. It occupies a similar role under the Adoption (Northern Ireland) Order 1987 in that it brings an independence and objectivity to the task of safeguarding the interests of the child.

Non Departmental Public Bodies (NDPBs)

2.29. **The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) -** The NIPEC was established under the Health and Personal Social Services Act (Northern Ireland) 2002 as a non-departmental public body to support the development of nurses and midwives by promoting high standards of practice, education and professional development. The NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.

2.30. **The Northern Ireland Social Care Council (NISCC)** - The NISCC was established under the Health and Personal Social Services Act (Northern Ireland) 2001 as a non-departmental public body to protect the public, specifically those who use social care services, and to promote confidence and competence in the social care workforce. It achieves this aim by registering and regulating the social care workforce, setting and monitoring the standards for professional social work training and promoting training within the broader social care workforce.

Summary of working relationships

2.31. In common with all Arms Length Bodies (ALBs), on issues of

governance and assurance, all the HSC bodies are directly accountable to the Department. Detailed accountability arrangements are set out in section 6 of this Framework Document.

2.32. Article 67 of the Health and Personal Social Services (Northern Ireland) Order 1972 as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009 provides that "In exercising their respective functions, health and social care bodies, district councils, Education and Library Boards and the Northern Ireland Housing Executive shall co-operate with one another in order to secure and advance the health and social welfare of Northern Ireland."

2.33. Under the Reform Act, the Department has an overall duty to promote an integrated system of health and social care designed to improve the health and social well-being of the people in Northern Ireland. All health and social care bodies must work closely and co-operatively with the Department, with each other and with organisations outside the Department, in the manner best calculated to further that overall duty. Whilst this general duty of co-operation is paramount, there are a number of specific areas where co-operative working needs to be highlighted and these are dealt with in the following paragraphs.

2.34. The Department sets the strategic context for the commissioning of health and social care services through a Commissioning Direction to the HSCB. It may also direct the HSCB as to the performance indicators it should employ in improving the performance of HSC Trusts.

The Health and Social Care Board and the Public Health Agency

2.35. Under Section 8 of the Reform Act, the HSCB is required to produce an annual commissioning plan in response to the Commissioning Direction, in full consultation and agreement with the PHA. The form and content of the commissioning plan is directed by the Department in accordance with Section 8 of the Reform Act. This requirement is at the core of the

key working relationship that translates the strategic objectives, priorities and standards set by the Department into a range of high quality, accessible health and social care services and general improvement in public health and wellbeing. In practice, the employees of the HSCB and PHA work in fully integrated teams to support the commissioning process at local and regional levels.

2.36. Developing, securing approval for and implementing the annual commissioning plan and associated Service and Budget Agreements with providers is the responsibility of the HSCB. The HSCB is, however, statutorily required to have regard to advice and information provided by the PHA and cannot publish the plan unless it has been approved by the PHA. In the unlikely event that the HSCB and the PHA cannot agree on the commissioning plan, the matter is referred to the Department for resolution. The HSCB and the PHA must also work together in a fully integrated way to support providers to improve performance and deliver desired outcomes.

2.37. Given the Department's retained responsibilities in areas such as human resources and estate management, strategic planning for health and social services must take place in a spirit of co-operation between the Department, the HSCB, the PHA and other HSC stakeholders, notwithstanding the formal accountability arrangements described elsewhere in this Framework Document.

Health and Social Care Board and HSC Trusts

2.38. Trusts must provide services in response to the commissioning plan, and must meet the standards and targets set by the Minister. Service and Budget Agreements (SBAs) are the administrative vehicle for demonstrating that these obligations will be met. SBAs are established between the HSCB and Trusts setting out the services to be provided and linking volumes and outcomes to cost.

2.39. Working with the PHA as appropriate, the HSCB is responsible for managing and monitoring the achievement by Trusts of agreed objectives and targets, including financial breakeven. At the same time, the HSCB and PHA also work together closely in supporting Trusts to improve performance and achieve the desired outcomes.

2.40. Section 10 of the Reform Act gives the HSCB power, subject to the approval of the Department, to give guidance or direction to a Trust on carrying out a Trust function. Before giving direction, the HSCB is required to consult with the Trust concerned except when the urgency of the matter may preclude consultation. The HSCB must not however give any direction or guidance to a Trust that is inconsistent with this Framework Document or inconsistent with any other direction or guidance already given to the Trust by the Department.

Health and Social Care Board and Family Practitioner Services

2.41. Primary care in general and family practitioner services (FPS) in particular are central to the health and social care system. Family practitioners and those who work with them in extended primary care teams act as the first point of contact and as a gateway to a wider variety of services across the HSC. The HSCB has a key role to play in managing contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy. The HSCB is accountable to the Department for the proper management of FPS budgets.

Business Services Organisation and the Wider HSC

2.42. The role of BSO is to provide support services on behalf of HSC bodies as directed by the Department. The relationships between the BSO and HSC bodies are governed by the development of SLAs between the BSO and the relevant organisation setting out the range, quantity, quality

and costs of the services to be provided. These SLAs will develop in accordance with the phased expansion of the range of services provided by the BSO.

Patient and Client Council and Wider HSC

2.43. In addition to the overall requirement on HSC bodies to co-operate with each other to secure and advance the health and social welfare of Northern Ireland, Section 18 of the Reform Act places a specific duty on certain HSC bodies, as defined in the Act, to co-operate with the PCC in the exercise of its functions. This means that HSC bodies must consult the PCC on matters relevant to the latter's functions and must furnish the PCC with the information necessary for the discharge of its functions. Furthermore, HSC bodies must have regard to advice provided by the PCC about best methods and practices for consulting and involving the public in health and social care matters.

2.44. The PCC's relationship with the other HSC bodies is therefore characterised by, on the one hand, its independence from these bodies in representing the interests and promoting the involvement of the public in health and social care and, on the other, the need to engage with the wider HSC in a positive and constructive manner to ensure that it is able to efficiently and effectively discharge its statutory functions on behalf of patients, clients and carers. It also has considerable influence over the manner in which consultations are conducted by the HSC.

2.45. The PCC's functions do not include a duty to consult on behalf of the HSC. Each HSC body is required to put in place its own arrangements for engagement and consultation.

Regulation and Quality Improvement Authority, the Department and Wider HSC

2.46. The RQIA's relationship with the Department and other HSC bodies is

driven by its independent role in keeping the Department informed about the availability and quality of services, drawing on its regulatory functions, and its wider statutory responsibility to encourage improvement in the quality of services. HSC bodies look to the RQIA for independent validation of their internal arrangements for clinical and social care governance. Examples of RQIA's work in this respect can be seen within its rolling programme of special and thematic reviews within the HSC. The RQIA must also work closely with HSC Trusts in the discharge of its functions relating to regulation of independent sector providers, particularly in terms of safeguarding the interests of vulnerable people.

Special Agencies and the Department

2.47. Special Agencies carry out a range of discrete functions as set out above. Their primary relationship is with the Department, on behalf of which they discharge their functions. The services they deliver are largely in support of the wider health and social care system and they must therefore develop appropriate working relationships with other health and social care bodies.

The Northern Ireland Practice and Education Council, the Department and the HSC

2.48. The NIPEC's primary relationship is with the Department on behalf of which it discharges its functions. NIPEC also works closely with key stakeholders in the HSC system to support registered nurses, midwives and specialist community public health nurses to provide a safe and effective nursing and midwifery service to the population of Northern Ireland.

The Northern Ireland Social Care Council (NISCC), the Department and the Wider HSC

2.49. The NISCC's primary relationship is with the Department, on behalf of which it discharges its functions. The NISCC provides a framework for commissioners and providers to promote consistency in standards of conduct and practice throughout the social care system. The NISCC also works closely with its registrants and other key stakeholders to achieve its aims of raising the quality of social care practice.

3. SETTING THE AGENDA

Establishing the Priorities

3.1. In terms of setting the strategic agenda for the Health and Social Care system, Section 2 of the Reform Act requires the Department to:

i develop policies to secure the improvement of the health and social wellbeing of, and to reduce health inequalities between, people in Northern Ireland;

ii determine priorities and objectives for the provision of health and social care;

iii allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

iv set standards for the provision of health and social care;

v formulate the general policy and principles by reference to which particular functions are to be exercised.

3.2. The Department sets the strategic vision and priorities for Health and Social Care. The strategic vision provides an overarching direction of travel for the HSC that reflects already well-established policies and strategies. The strategic vision underpins the Department's contribution to budget process and Programme for Government (PfG) and, flowing from this, provides the context for the development of an annual Commissioning Direction, Priorities for Action (PfA), Commissioning Plan and Trust Delivery Plans (TDPs).

3.3. The Programme for Government (PfG) and a framework of Public Service Agreements (PSAs) express the Executive's strategic aims and

policies in measurable objectives and targets.

3.4. The Department publishes annually Priorities for Action (PfA), which translates the PfG and other ministerial priorities into an achievable and challenging agenda for Health and Social Care.

3.5. The Department sets out the Minister's instructions to the commissioners in the annual Commissioning Direction under Section 8 (3) of the Reform Act. This reflects the priorities in the PfA as revised annually, and the relevant standards and obligations that apply every year. Hence this makes clear the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

3.6. Every year the HSCB is responsible for producing a commissioning plan in full consultation and with the approval of the PHA. The plan must outline how they plan to deliver on the key priorities standards or targets set in PfA. This plan provides the framework for each HSC Trust to develop its annual Trust Delivery Plan (TDP) detailing the Trust's response to the annual commissioning priorities and targets set out in the commissioning plan.

Allocating the resources

3.7. Section 2 of the Reform Act requires the Department to allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way.

3.8. Resources available to the Northern Ireland Block are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. This sets the overall Departmental Expenditure Limit (DEL) for Northern Ireland. The funding levels are normally set for three or more financial years and may be reviewed every two years or so. Within the constraints of the NI DEL, gross spending power available to the Executive can be increased, currently

through revenue generated from the Regional Rate and borrowing power within the Reinvestment and Reform Initiative. Within the overall Block limits set by Treasury (i.e the NI DEL), the NI Executive establishes, in the light of local priorities, the three or four year resource allocations for all NI Departments, which cover both current expenditure and capital investment. The PfG specifies the Executive's plans and priorities for the years covered by the relevant budget period, while a separate Investment Strategy establishes capital priorities over a 10-year period.

3.9. It is the Department's responsibility to secure, as part of the Budget process, resources that enable the health and social care system to satisfy the population's need for high quality, accessible services.

3.10. In allocating current expenditure to HSC bodies, the Department must strike a balance between facilitating full and timely deployment of resources to the frontline and the need to ensure that appropriate control of funds is retained centrally by the Department. The aim is to channel the maximum resources to the point of service delivery at the earliest possible stage, with appropriate controls in place to ensure that they are deployed in accordance with Government priorities.

3.11. A Capitation Formula informs the Department (and, in turn, the HSCB) as to the most fair and equitable allocation of revenue funding for LCG areas. It does this by taking into account the number of people living within an area, with suitable adjustments relating to the age, sex and additional needs (largely due to deprivation) of the populations in question. The HSCB is required annually to provide the Department with an assessment of equity gaps, including the potential for re-distribution of resources across LCG populations and to demonstrate that resources have in fact benefited the populations for which they were intended. Allocation of capital expenditure to HSC Trusts is managed by the Department, with input from commissioners on the associated current expenditure funding required. The capital allocation and reporting process in described in more detail later in this section.

Funding the Health and Social Care Board and the Public Health Agency

3.12. The HSCB is responsible and accountable for commissioning of services, resource allocation and performance management, whilst the primary objective of PHA is to protect and improve the health and social well-being of the Northern Ireland population.

3.13. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. Each organisation holds the administrative and programme resources appropriate to their respective roles and responsibilities. Where such resources are deployed outside the context of the commissioning plan, the HSCB and the PHA submit, for Departmental approval, separate business plans in respect of those resources.

3.14. The following principles apply in relation to the funding arrangements for the HSCB and the PHA:

i Each of the bodies receives the bulk of its funding directly from the Department and each organisation remains separately accountable for all of the funds allocated to it;

ii In accordance with the detailed commissioning arrangements set out in section four, the funds allocated to the HSCB are:

- Committed to secure the provision of health and social care services for local populations from the six HSC Trusts, Family Health Services and other providers, consistent with the approved Commissioning Plan; and
- used for staffing, goods and services associated with the discharge of its functions;

iii The PHA directly funds initiatives related to its core roles of health improvement, screening or health protection activity, partnership working with local government, staffing and goods and services. Plans for use of the PHA's funding are incorporated within the Commissioning Plan, developed by the HSCB in consultation with and the agreement of the PHA. Similarly, services commissioned by the PHA from HSC Trusts and independent practitioners are reflected the Commissioning Plan as appropriate. Whilst the payment of funds for these services is administered by the HSCB on behalf of the PHA through the Service and Budget Agreements with HSC Trusts, the PHA remains accountable to the Department for the deployment of the resources. In the case of services commissioned from Family Health Service contractors, such as GPs, the HSCB takes primary responsibility for contract management, taking input from the PHA as appropriate.

Funding the Patient and Client Council

3.15. The Department directly meets the operating costs of the Patient and Client Council (PCC) to ensure that it operates independently from the service. The PCC produces, for Departmental approval, an annual business plan demonstrating how these resources will be used.

Funding the Business Services Organisation

3.16. Funding for the Business Services Organisation's (BSO) operating costs will flow through Service and Budget Agreements (SBAs) with its customers, the other HSC bodies. The SBAs determine the range, quality and costs of services to be provided. Movement towards the position of the BSO as an organisation fully financed from its service agreements with customers is being staged over a transitional period from April 2009.

3.17. The Health and Social Care (Reform) Act requires BSO to ensure that the arrangements which it puts in place for securing support services for its customers are the most economic, efficient and effective way of providing such services. It is required to have these arrangements approved by the Department before they are put in place. The Department approves the BSO's annual corporate business plan.

Funding Health and Social Care Trusts

3.18. HSC Trusts access funds by means of Service and Budget Agreements (SBAs) with their commissioners. Trusts are required to submit annual delivery plans (TDPs) to the HSCB for approval. TDPs must address both the content of the agreed SBAs with commissioners and the wider range of other corporate responsibilities. The HSCB provides assurance to the Department about the service and financial viability of TDPs.

Funding the Regulation and Quality Improvement Authority

3.19. The RQIA is funded directly by the Department on the basis of the priorities and objectives set out in its annual business plan and 3- year corporate strategy, which are approved by the Department. RQIA generates the balance of income through statutory fee charges for regulation of establishments and agencies.

Funding the Northern Ireland Guardian ad Litem Agency

3.20. NIGALA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Medical and Dental Training Agency

3.21. NIMDTA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is

approved by the Department.

Funding the Northern Ireland Blood Transfusion Service

3.22. Resources are allocated initially to the HSCB and are then channelled to Trusts through their Service and Budget Agreements (SBAs). NIBTS accesses the funds through the SBAs it has with Trusts for its services.

Funding the Northern Ireland Practice and Education Council

3.23. The NIPEC is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Social Care Council

3.24. The NISCC is funded substantially by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department. It also receives income from registration fees, Skills for Care and Development and in respect of student placements in the criminal justice sector (funded by the Department of Justice).

The Capital Allocation and Reporting Process

3.25. The strategic capital planning function, together with responsibility for overseeing procurement and performance management of capital programme delivery, rests with the Department. The Investment Strategy for Northern Ireland (ISNI), managed by the Strategic Investment Board (SIB) in conjunction with OFMDFM provides an indicative 10-year funding envelope for the Department. The Department contributes to the development of the ISNI, which is approved by the NI Executive.

3.26. Resources available to the Northern Ireland are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. The NI Executive establishes, on the basis of its own priorities, the spending plans for all NI departments. In parallel, the Executive's infrastructure plans are set out in a separate 10-year Investment Strategy for Northern Ireland. The current Strategy covers the period 2008-2018.

3.27. To inform ministerial decisions on capital allocation, the Department conducts a biennial Capital Priorities Review, with input from a Policy Infrastructure Forum comprising representatives from the Department, the HSCB and the PHA. A 10-year rolling capital plan is produced as the output of these regular reviews.

3.28. The HSCB and the PHA are responsible for identifying and quantifying the services required to meet assessed needs and for commissioner endorsement of the associated current expenditure costs subject to considerations of affordability.

3.29. The Trusts and the HSCB (for ICT), are responsible for preparing and obtaining approval for business cases for the capital requirements needed to deliver the service. These business cases must have commissioner support before approval.

3.30. The Department has overall responsibility for the capital investment programme and also acts as a Centre of Specialist Expertise (COSE) and a Centre of Procurement Expertise (COPE) for capital infrastructure and undertakes a performance management role in relation to the estate.

3.31. The HSCB, taking account of professional advice from the PHA, is responsible for confirming the appropriate models of care to deliver health and social care across Northern Ireland and the associated indicative infrastructure requirements.

3.32. BSO is the responsible Centre of Procurement Expertise for the procurement of services, supplies and IT equipment.

4. COMMISSIONING

Introduction

4.1. The purpose of HSC commissioning is to improve and protect the health and social well-being of the people of Northern Ireland and reduce differences in access to good health and quality of life. Commissioning aims to achieve a progressive improvement in services through investment based on evidence of effectiveness, compliance with quality and efficiency standards and a focus on addressing the determinants of poor health and wellbeing. The involvement of patients, clients, carers and communities and engagement with other partners has a central role in the commissioning process.

4.2. The Department sets the policy and legislative context for health and social care in Northern Ireland. It also determines the standards and targets by which quality, access and outcomes should be measured and provides the strategic direction for the health and social care professions. The commissioning process, which includes resource and performance management and is led by the HSCB, translates the agenda set by the Department into a comprehensive, integrated commissioning plan for health and social care services. Commissioning must maintain a strong focus on identifying and prioritising the needs of patients, clients, carers and communities. In doing so, it is the driver for continuous service improvement and provides assurance that resources are delivering the maximum benefits for users and taxpayers alike. In management terms, the separation of commissioners and providers is designed to promote a patient and client-centred system.

The Commissioning Cycle

4.3. Commissioning includes the following activities:

i Assessing the health and social well-being needs of groups,

populations and communities of interest;

ii Prioritising needs within available resources;

iii Building the capacity of the population to improve their own health and social well-being by partnership working on the determinants of health and social well-being in local areas;

iv Engag ing with patients/clients/carers/families and other key stakeholders and service providers at local level in planning health and social care services to meet current and emerging needs;

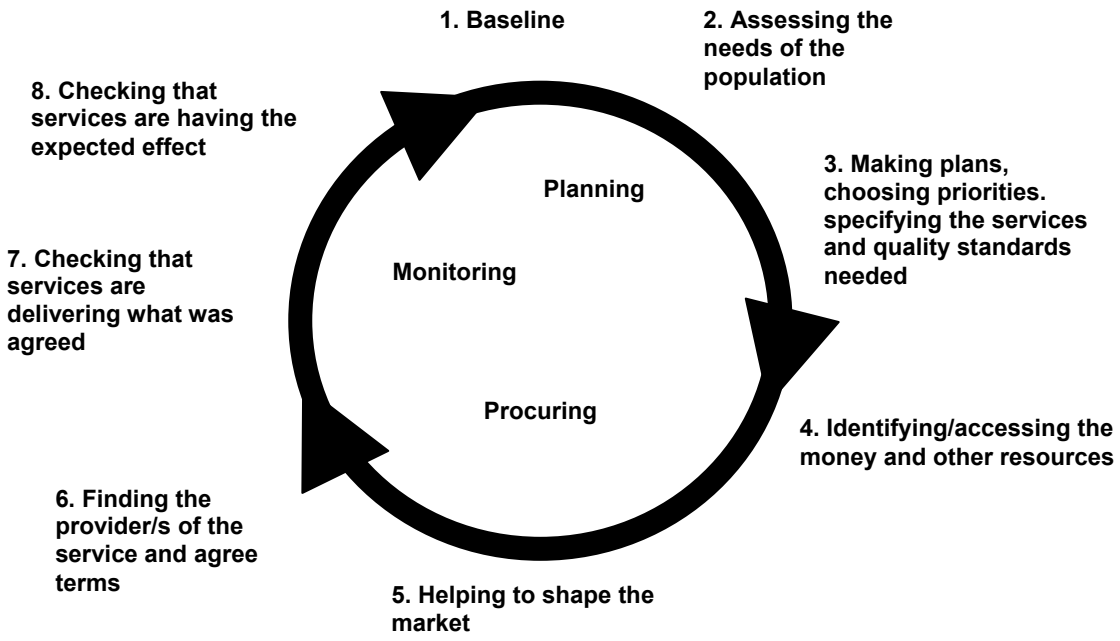
v Securing, through Service and Budget Agreements, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;

vi Safeguarding the vulnerable; and

vii Using investment, performance management and other initiatives to develop and reform services.

4.4. In the context of the integrated health and social care system in Northern Ireland, commissioning should be seen as an 'end to end' process. It organises activities around a commissioning cycle that moves through from assessing needs, strategic planning, priority setting, securing resources to address needs, agreeing with providers the delivery of appropriate services, monitoring that delivery, evaluating impact and feeding back that assessment into the new baseline position in terms of how needs have changed. Throughout the cycle, the HSCB and its LCGs engage with stakeholders, including service providers, at regional and local level.

4.5. Commissioners will facilitate a more integrated provider system by managing the interfaces between providers (statutory, independent and voluntary), developing provider networks and acting as 'guardians' of the care pathway.



The Commissioning Plan Direction

4.6. In exercising the powers conferred on it by Section 8 (3) of the Reform Act, the Department sets out the Minister's instructions to commissioners in an annual commissioning plan direction. The commissioning plan direction sets the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

The Commissioning Plan

4.7. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. The commissioning direction specifies the form and content of the commissioning plan in terms of the services to be commissioned and the resources to be deployed. The plan may not be published unless approved by the PHA. In the unlikely event of failure to agree the commissioning plan, the matter is referred to the Department for resolution.

Local Commissioning

4.8. The reformed system of commissioning introduced from 1 April 2009 established five geographically based Local Commissioning Groups (LCGs) that are co-terminus with the boundaries of the five Health and Social Care Trusts. The status of LCGs as committees of the HSCB is established in primary legislation.

4.9. LCGs have a lead role in the strategic commissioning process, in particular, having helped to shape strategic thinking, to apply it locally on behalf of their populations. They have responsibility for assessing health and social care needs in their areas, planning to meet current and emerging needs and securing the delivery of a comprehensive range of services to meet the needs of their populations. They have full delegated authority to discharge these responsibilities, including a significant ability to direct resources. The capitation formula identifies funds for the populations of each LCG area, and the HSCB is accountable for ensuring that they are used for that purpose. LCGs identify local priorities taking account of the views of patients, clients, carers, wider communities and service providers. They forge partnerships and involve a range of stakeholders in designing and reshaping services to better meet the needs of their local communities. The resources for each LCG population may be used to secure services for that population from any appropriate provider.

4.10. For the most part, the HSCB's Commissioning Plan reflects the decisions and recommendations of the LCGs in relation to the use of the capitation-based shares of the budget for their populations at local level. However, it is recognised that some services, by virtue of their specialist nature, restricted volume or statutory accountability, must be commissioned collaboratively on a regional basis, and hence the LCGs' decisions and recommendation will include contributions to the commissioning of regional services. The HSCB is responsible for establishing appropriate mechanisms for this process, which will ensure

that fair shares from the capitation-based budgets are committed to regionally commissioned services.

4.11. As committees of the HSCB, LCGs work within strategic priorities set by the Department, the HSCB, regional policy frameworks, available resources and performance targets. Section 9 (4) of the Reform Act requires LCGs to work in collaboration with the PHA and have due regard to any advice or information provided by it. To ensure a joint approach to commissioning, LCGs are supported by fully integrated, locally based, multi-disciplinary commissioning support teams made up of staff from the PHA and HSCB. Professional staff from both the HSCB and PHA are included in the membership of LCGs.

4.12. Each year the HSCB determines, in consultation with LCGs, the range of services to be commissioned locally and regionally and identifies the budgets from which such services are to be commissioned. LCGs prepare local commissioning plans, in keeping with the priorities and objectives of the HSCB. LCG commissioning plans are incorporated within the overall commissioning plan, which must be approved by the HSCB and the PHA.

Link between Commissioning and Performance Management

4.13. Monitoring performance of providers against the agreements they make in relation to service delivery is a key part of the commissioning cycle, and commissioners continue to ensure that this role remains core to how they work with providers. The HSCB and PHA must maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes.

4.14. The HSCB incorporating its LCGs must have appropriate monitoring arrangements to confirm that commissioned services are delivered, to benchmark comparative performance, and to ensure that quality outcomes, including positive user experience, are delivered.

4.15. Providers must have appropriate monitoring arrangements to ensure that they are meeting the requirements of commissioners and performing efficiently, effectively and economically.

4.16. The Department maintains appropriate monitoring arrangements in relation to the HSCB and the PHA to ensure that resources are used to best effect in the achievement of agreed strategic objectives and targets.

4.17. The HSCB and PHA also work together closely in supporting providers, through professional leadership and management collaboration, to improve performance and achieve desired outcomes. The HSCB is the lead organisation for supporting providers in relation to the delivery of a wide range of health and social care services and outcomes, with support provided by PHA professional staff. PHA is the lead organisation for supporting providers in the areas of health improvement, screening and health protection, with support provided by the performance, commissioning, finance, primary and social care staff of the HSCB.

Procurement by HSC Trusts

4.18. At the present time, it is not practical or desirable for the HSCB to contract directly with the full range of providers involved in the HSC system. The services involved are numerous, diverse, need to be provided flexibly and often need to be arranged at short notice, to meet the needs of individuals. Therefore a wide range of services commissioned by the HSCB are sub-contracted by Trusts to independent sector providers.

5 PERSONAL AND PUBLIC INVOLVEMENT

5.1 Patients, clients, carers and communities must be put at the centre of decision making in health and social care. This means that they must be properly involved in the planning, delivery and evaluation of their services. HSC bodies are accountable to people and communities for the quality, accessibility and responsiveness of the services they plan and provide.

5.2 Section 19 of the Reform Act places a statutory requirement on each organisation involved in the commissioning and delivery of health and social care to provide information about the services for which it is responsible; to gather information about care needs and the efficacy of care; and to support people in accessing that care and maintaining their own health and wellbeing.

5.3 This statutory requirement extends to the development of a consultation scheme, which must set out how the organisation involves and consults with patients, clients, carers and the Patient Client Council (PCC) about the health and social care for which it is responsible. Consultation schemes must be submitted to the Department for approval. The Department may approve a consultation scheme, with or without amendments, after consulting with the PCC.

5.4 Section 20 of the Reform Act specifies the form that consultation schemes should take, but this is supplemented by detailed policy guidelines for the HSC on personal and public involvement and the development and approval of consultation schemes.

Roles in Personal and Public Involvement (PPI)

5.5 In respect of Personal and Public Involvement (PPI), the Reform Act places a specific responsibility on the PCC to promote best practice in

involvement and in the provision of information about health and social care services. HSC bodies are required by the Reform Act to co-operate fully with the PCC in the discharge of these statutory responsibilities. The Department may consult the PCC in respect of specific consultation schemes before approving them.

5.6 The Department sets the policy and standards for Personal and Public Involvement (PPI). Working through the HSCB, the PHA has responsibility for ensuring that Trusts meet their PPI statutory and policy responsibilities and leading the implementation of policy on PPI across the HSC. A PPI Forum, chaired by the PHA and involving representatives from all HSC organisations, has been established for that purpose. This in no way detracts from the individual statutory responsibilities of organisations with regard to PPI.

5.7 The HSCB is responsible for ensuring that its LCGs establish arrangements for effective PPI which will allow the views of stakeholders to inform the development of commissioning plans. The HSCB should also ensure that Family Practitioner Services are meeting the requirements laid down in Departmental guidance on PPI.

5.8 HSC Trusts are responsible for establishing individual organisational governance arrangements, and for implementing their PPI consultation schemes, to meet their statutory duty of involvement, as well as any requirements laid down in Departmental guidance on PPI.

5.9 Special agencies also have responsibilities in respect of PPI. The NI Blood Transfusion Service (NIBTS), the NI Guardian Ad Litem Agency (NIGALA) and the NI Medical and Dental Training Agency (NIMDTA) should establish arrangements to ensure they meet their statutory duty of involvement and any requirements laid down in Departmental guidance. Each of these three special agencies will be accountable directly to the Department for the discharge of these functions.

5.10 The PCC will undertake research and conduct investigations into the most effective methods and practices for involving the public and provide advice on these to HSC organisations. The PCC also has an important challenge role for those HSC bodies prescribed in the Reform Act in respect of PPI, and will accordingly be expected to comment upon and scrutinise the actions and decisions of these bodies as they relate to PPI.

5.11 RQIA will continue to provide independent assurance to the Minister, via the Department, of the effectiveness of PPI structures in HSC organisations by continuing to monitor these as part of its programme of review of clinical and social care governance arrangements against the Quality Standards.

6 HOLDING THE SYSTEM TO ACCOUNT

Introduction

6.1. Ultimate accountability for the exercise of proper control of financial, corporate and clinical and social care governance in the HSC system rests with the Department and the Minister. Within a system of such magnitude and complexity, assurance about the rigour of control mechanisms can only be derived from the development and operation of robust systems and processes at all levels of decision making.

Performance and Assurance Dimensions

6.2. This section of the Framework Document describes the various lines of accountability and how they are exercised at different levels within the HSC system. The key performance and assurance roles and responsibilities are encompassed in the four dimensions of:

i Corporate Control – the arrangements by which the individual HSC bodies direct and control their functions and relate to stakeholders;

ii Safety and Quality – the arrangements for ensuring that health and social care services are safe and effective and meet patients' and clients' needs, including appropriate involvement;

iii Finance – the arrangements for ensuring the financial stability of the HSC system, for ensuring value for money and for ensuring that allocated resources are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework;

iv Operational Performance and Service Improvement – the arrangements for ensuring the delivery of Departmental targets and required service improvements.

Key Principles

6.3. The requirements in relation to performance and assurance roles may differ from body to body but some key principles underpin the overall approach to holding the HSC system to account:

i the Department has ultimate accountability for the effective functioning of the HSC across the four dimensions;

ii the Department will provide clear guidance across each of the four dimensions, specifying outputs and outcomes that are appropriate, affordable and achievable. This guidance will be developed with the involvement of the HSC bodies, consistent with their roles and responsibilities;

iii each HSC body is locally accountable for its organisational performance across the four dimensions and for ensuring that appropriate assurance arrangements are in place. This obligation rests wholly with the body's board of directors. It is the responsibility of boards to manage local performance and to manage emerging issues in the first instance;

iv the standard assurance arrangements and associated information streams within individual HSC organisations will, as far as possible, be used to meet the assurance requirements of the HSCB and PHA, and those of the Department, subject to such additional independent verification as may be deemed necessary;

v the Department, and in turn the HSCB and PHA (where they have a performance and assurance role in relation to one or more of the other bodies), will maintain a relationship with other HSC bodies based on openness and the sharing of information, adopting an informal, supportive approach to clarify and resolve issues as they

arise, and thereby minimising the need for formal intervention.

Corporate Control Dimension

6.4. Corporate control encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the HSC body is fulfilling its essential obligations as a public body. Most of the requirements reflect those in place across the public sector, but a few have been instituted for reasons peculiar to the field of health and social care – notably the statutory duty of quality created by Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003. In addition to that obligation, the controls relate to: the existence of appropriate board roles, structures and capacity; corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance of those processes.

6.5. All HSC bodies shall:

i adhere to the terms of the Accounting Officer appointment letter issued by the Department. This letter specifies the governance responsibilities and duties which the body owes to the Departmental Accounting Officer;

ii comply, in full, with the control framework requirements set out in the Management Statement/Financial Memorandum issued by the Department, in a form agreed by the Department of Finance and Personnel;

iii submit to the Department an annual Statement on Internal Control, signed by the Accounting Officer of the body, covering the range of issues in the standard form prescribed by the Department of Finance and Personnel, augmented by the additional health and social care-specific requirements set by the Department;

iv submit to the Department a mid-year assurance statement on control issues covering the same areas as the annual Statement on Internal Control;

v report as required on compliance with controls assurance and quality standards set by the Department including compliance with the Department's requirements for implementation of a risk management strategy and evidence that guidance on an assurance framework is being followed;

vi ensure that the appointment processes carried out by the body are demonstrably independent and free from external conflicts of interest;

vii adopt an Assurance Framework to strengthen board-level control and assurance in general, the Statement on Internal Control, and the mid-year assurance statement;

viii operate a board-approved scheme of delegated decision-making within the body based on systems of good practice updated by the Department;

ix ensure compliance with accepted or prescribed standards of public administration set by the Department – for example, in relation to equality of opportunity, equality legislation, complaints, etc;

x ensure compliance with the checklist of actions required of sponsor branches in the Department in obtaining assurance from their respective body's covering: roles and responsibilities; business planning and risk management; governance; and internal audit;

xi ensure compliance with procurement policy securing value for money, economically advantageous outcomes, equality of opportunity, sustainable development, etc., in accordance with the

policy framework set by the Executive and the Department of Finance and Personnel, key performance indicators set by the Department, the procurement strategy led by Regional Procurement Group (supported by BSO) and procurement under the Department's Infrastructure Strategy;

xii ensure that an Internal Audit function within each body operates to HM Treasury standards, including the requirement for external assessments, adhering to the professional qualifications, conduct and remit set out by the Department, and giving a comprehensive professional opinion from the chief internal auditor on the adequacy and effectiveness of the body's system of internal control;

xiii ensure implementation of agreed Northern Ireland Audit Office and Public Accounts Committee recommendations; and

xiv comply with the NI Executive's pay policy for the HSC e.g. arrangements for senior executive pay.

6.6. Compliance with the requirements at (i) – (x) are the subject of ongoing monitoring by the Department, and issues for resolution are resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

6.7. In relation to the requirement at (xi) the Regional Procurement Group, supported by BSO, as a centre of procurement expertise, promotes and oversees implementation of the overall procurement strategy and monitors compliance with procurement policy, while the Department secures assurance on adherence to policy rules and achievement of key performance indicators. All capital infrastructure is procured in conjunction with the centre of procurement expertise within the Department.

6.8. Adherence to the requirement at with (xii) is subject to ad hoc scrutiny by

the Department's Head of Internal Audit, with issues resolved at bi-annual accountability reviews or through ad hoc action if deemed appropriate by the Department.

6.9. Compliance with (xiii) is the subject of ongoing monitoring by the Department (or HSCB or PHA as determined by the Department), with issues for resolution will be resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department. Progress in relation to the recommendations is reported by the Department to the Northern Ireland Audit Office, Public Accounts Committee and the Department of Finance and Personnel.

6.10. Compliance at (xiv) is monitored by the Department, with issues for resolution addressed at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

Safety and Quality Dimension

6.11. Safety and quality covers a broad agenda, overlapping with many areas of operational performance and, to some extent, with financial performance and corporate control. It also applies to all programmes of care, including health improvement and health protection, and to infrastructure. This section describes assurance arrangements for specified elements of safety and quality, in particular, the arrangements for ensuring that HSC services are:

i safe - doing no harm to patients or clients and provided in an environment that is safe and clean;

ii effective - achieving agreed clinical and social care outcomes, which reflect high quality care and treatment and have a proven impact on health and wellbeing, especially prevention of poor health and wellbeing;

iii personalised - centred on the needs of individual patients clients and carers through their involvement in planning, delivery and evaluation.

6.12. Assurance to the Department and the Minister about the safety and quality of services is provided from a number of different sources. Each health and social body has clearly defined roles and responsibilities in this regard, which are summarised below.

6.13. The HSCB, working with the PHA on (i) to (viii) and (xii) below, is responsible for monitoring and reporting to the Department on:

i Compliance with Priorities for Action safety and quality requirements at least quarterly e.g. quality improvement plans;

ii Implementation of the RQIA and other independent safety and quality review recommendations in accordance with agreed plans;

iii Implementation of National Institute for Health and Clinical Excellence (NICE) technology appraisals endorsed by the Department;

iv Application by Trusts of lessons from adverse incidents and near misses (including those to be recorded on the PHA-managed RAIL system) and communicating, acting upon and reporting action taken in relation to safety information issued through the Northern Ireland Adverse Incident Centre Safety Alert Broadcast System (SABS);

v Evidence of provider-initiated action to improve safety and quality;

vi Family Practitioner Services' compliance with accepted standards e.g. clinical and social care governance arrangements, evidence of quality improvement, professional regulation and training and

development etc;

vii Trusts' compliance with accepted standards e.g. professional regulation and training and development (excluding those covered in para 6.14 (i) below);

viii Independent sector contracts related to waiting lists initiatives regarding for example conformity with clinical and social care governance arrangements and their performance on specified quality measures;

ix Independent sector contracts related to the provision of social care, regarding compliance with clinical and social care governance arrangements and specific quality standards;

x Implementation of statutory functions under agreed Schemes of Delegation;

xi Trust compliance with accepted standards for social care professionals e.g. professional regulation and training and development; and

xii Safety and quality aspects of HSCB contracts with independent sector providers.

6.14. The PHA is responsible for monitoring and reporting to the Department on:

i Trust compliance with accepted standards for medical, nursing and allied health professionals e.g. professional regulation and training and development; and

ii Compliance with statutory midwifery supervision requirements;

iii The identification and effective promulgation of learning from investigation of adverse incidents through the Regional Adverse Incident and Learning (RAIL) system and support for the development of quality improvement plans; and

iv Safety and quality aspects of PHA contracts with independent sector providers.

6.15. Joint Commissioning Teams led by the HSCB or PHA, as appropriate, are responsible for monitoring:

i Implementation of Service Frameworks;

ii Implementation of mandatory policy or guidance issued by the Department, which are not subject to formal performance arrangements, e.g. pandemic 'flu plans, quality of screening programmes, etc

iii Compliance with safety and quality and clinical and social care governance requirements specified by the commissioners of HSC services.

6.16. Trusts are responsible for monitoring independent sector contracts for health and social care to ensure compliance with relevant Departmental, HSCB or Trust guidance, including clinical and social care governance, relevant quality standards and arrangements to duly safeguard children and vulnerable adults.

6.17. The HSCB, working with the PHA, is responsible for monitoring Trust compliance with policies, standards and specific targets for the patient and client environment and support services including laundry and linen, catering, cleaning, portering and car parking.

6.18. The Department is responsible for monitoring:

i Compliance with policy, legislation and standards in respect of reusable medical devices;

ii Compliance with policy, legislation, standards and guidance in respect of the safe operation of life-critical healthcare-specific systems and processes.

6.19. In addition to assurance processes outlined above, the RQIA has an overall responsibility to encourage continuous improvement in the quality of health and social care across the public and independent health and social care sectors, against standards set by the Department, and to provide independent assurance on the quality of that care. When asked to do so by the Department it provides advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. It may also, at any time, advise the Department on any changes which it thinks should be made in the minimum standards set by the Department. RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, examining services provided, and highlighting areas of good practice, and making recommendations for improvement and reporting lessons learned to the Department and the wider HSC. Such reviews may be conducted as part of RQIA's ongoing independent assessment of quality, safety and availability of HSC services or may be commissioned by the Department.

Finance Dimension

6.20. Appropriate financial accountability mechanisms are necessary to:

i Ensure that the optimum resources are secured from the Executive for health and social care;

ii Ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money;

iii Deliver and maintain financial stability, through effective operation of the financial accountability of Trusts via the HSCB to the Department;

iv Ensure that the commissioners can be assured that financing of services is managed on the agreed and approved basis set by the HSCB, its LCGs and the PHA;

v Facilitate the delivery of economic, effective and efficient services by rewarding planned activity that maximises effectiveness and quality and minimises cost; and

vi Facilitate the development of innovative and effective models of care.

6.21. All financial resources delegated by the Department to HSC bodies remain subject to the same standards of probity and accountability irrespective of where day-to-day management and control is vested.

6.22. All organisations are ultimately accountable to the Department for the achievement of overall financial balance. The Department monitors on a monthly basis the break-even performance of each organisation and, exceptionally, bids for unanticipated and inescapable in-year pressures. The HSCB monitors the performance and financial breakeven of Trusts, measuring against Service and Budget Agreements and delivery of service targets, reporting on its monitoring to the Department;

6.23. To guard against over-spending and minimise under-spending, the Department undertakes monthly monitoring of the overall HSC (and Departmental) financial position, reporting the evolving position to the Department of Finance and Personnel. The Department is also responsible for the strategic capital planning process and oversight of procurement and programme management, taking action where slippage or potential overspends become apparent. HSC Trusts are required to report on capital expenditure on a monthly basis and detailed liaison on projects is undertaken through quarterly Strategic Investment Group meetings.

6.24. The Department undertakes monitoring of the efficiency savings obligations contained in the Executive's Budget settlement. Each HSC body is required to provide such information in order to satisfy itself, and the Executive, that the conditions attached to the efficiencies are being met.

6.25. Trust Financial Returns and Strategic Resource Framework-related data, which provide essential information on expenditure on HSC services and contain cost comparisons across providers, continue to be produced under Departmental guidance. Responsibility for collation, analysis etc lies with HSCB.

6.26. The Department is responsible for keeping the counter-fraud strategy under review, and for the development and issuing of related guidance. It also approves publication of the annual fraud report and addresses performance issues relating to the counter-fraud assurance arrangements in each HSC body. It is for the BSO to maintain and provide to the Department all monitoring information that it, DFP or the NIAO may require. Each HSC body is required to comply with prescribed fraud prevention, fraud reporting, fraud investigation and other operational counter-fraud processes, availing itself of BSO support as appropriate.

6.27. The Department, informed by Department of Finance and Personnel, is the focal point for developing and cascading financial guidance, circulars and memoranda. This includes the specification of statutory and other reporting requirements.

Operational Performance and Service Improvement

6.28. Performance management and service improvement arrangements are those that are necessary to ensure the achievement of Government and ministerial objectives, standards and targets.

6.29. Section 8 of the Reform Act requires that the HSCB exercise its functions with the aim of improving the performance of HSC Trusts, by reference to such indicators as the Department may direct. In determining responsibilities for performance management and service improvement, the overriding principle is that, unless there is good reason to the contrary, as in the case of capital expenditure, estate management and Human Resources, all such functions should be undertaken by the HSCB because: this is a core function of the HSCB; it minimises the lines of accountability for providers; it maximises the 'breadth of sight' for the HSCB, allowing it to adopt a holistic view of performance taking account of all relevant factors.

6.30. Possible exceptions to this principle are areas for which the HSCB does not have lead responsibility, or where there is likely to be significant formal interaction with other Government departments, e.g. joint responsibility for the delivery of Public Service Agreement (PSA) targets (in which case the Department would take the lead on behalf of the HSC sector).

6.31. The HSCB is in the lead for monitoring and supporting providers in relation to the delivery of a wide range of HSC services and outcomes, with support from PHA professional staff. The PHA is in the lead for monitoring and supporting providers in the areas of health improvement, screening and health protection, with relevant support provided by the HSCB. The organisations are, therefore to establish and maintain a number of joint programme teams, consisting of relevant staff from each organisation.

6.32. In relation to the monitoring of provider performance, the resolution of any performance issues is a matter for the HSCB, in close co-operation with the PHA, escalating to the Department only if required.

6.33. With the approval of the Department, the HSCB and the PHA (where

appropriate) produce detailed practical definitions for the application of targets. They also put in place arrangements to: monitor progress against targets, assess risks to achievement; hold regular performance meetings with providers; and escalate risks as appropriate. The HSCB reports on this process to the Department to enable it to maintain an overview of performance in these areas. The HSCB also resolves performance issues, escalating to the Department only where such resolution cannot be achieved. Capital, estate management and human resource targets are performance managed by Department.

6.34. The HSCB is responsible for the collection of all routine information from HSC Trusts for performance monitoring or statistical publication purposes at agreed intervals and to agreed standards, and for providing this to the Department. This will minimise the potential for duplication and establish a clear, single channel for submission and validation of information

6.35. In pursuit of service improvements in their respective areas of responsibility, the HSCB and the PHA must:

i identify evidenced-based good practice and develop an annual programme of action;

ii take account of patient, client and carer experience, including lessons learnt from complaints;

iii lead regional reform programmes, issuing guidance and specifying required actions;

iv provide training and support;

v review Trust action plans;

vi provide support to individual providers to address specific issues

and manage provider-provider interfaces;

vii review implementation of reforms and make available any reports on progress;

viii make regular reports to the Department, as required, on their activities in this field.

6.36. Regarding Public Service Agreement targets, the Department is responsible for their development and agreement, and for reporting progress against them to the Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel.

6.37. The Department sets HSC productivity and other HR-related targets and reports to Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel on progress towards their achievement. The HSCB is responsible for the regular ongoing monitoring of progress by providers, addressing issues of under-performance where they arise, escalating to the Department only where necessary;

6.38. The European Working Time Directive has put in place compliance arrangements, for which the Department sets targets for the medical workforce. The HSCB monitors progress, addresses issues of under-performance and reports to Department on compliance and progress. It is for the HSCB to resolve any compliance etc issues, escalating matters to the Department's attention only where necessary.

6.39. The Department is responsible for setting targets and monitoring HSC Trust performance in relation to the level of compliance with policy, legislation, standards and guidance in respect of the management of the HSC estate. HSC Trusts are accountable for the practical application of such guidance etc, for the effective management of the associated operational risks, and for providing appropriate assurance as to the

discharge of these responsibilities. The Department has in place an appropriate review process to allow Trusts to report to the Department on a regular basis as to their overall management of the HSC estate.

Independent Challenge

6.40. In considering how the HSC system is held to account, special mention should be made of the Regulation and Quality Improvement Authority and the Patient and Client Council, both of which have a particular role to play. They each provide an independent perspective on the performance of the HSC system, one which validates and challenges the system's own performance management arrangements.

6.41. The RQIA focuses on the quality and safety of services, using statutory and other standards agreed by the Department to benchmark not only the services but also the governance frameworks within which they are provided. PCC focuses on the interests of patients, clients and carers in HSC services. This goes beyond a straightforward information or advocacy role; it includes working with HSC bodies to promote the active involvement of patients, clients, carers and communities in the design, delivery and evaluation of services. The RQIA and the PCC also have the power to look into specific aspects of health and social care and report their findings publicly to the Department.

6.42. Both of these organisations provide important independent assurance to the wider public about the quality, efficacy and accessibility of health and social care services and the extent to which they are focused on user needs.

7 Conclusio n

7.1 This Framework Document is a summary of the structures, functions and processes that underpin the planning, delivery and evaluation of health and social care services in Northern Ireland. It will be kept under continuous review in the light of emerging policy and legislation.

7.2 If you have any enquiries about the content of the Framework Document, please contact:

Office of Permanent Secretary
DHSSPS
Permanent.Secretary@dhsspsni.gov.uk

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC Health and Social Care

HSC Collective Leadership Strategy




Health and Wellbeing 2026: Delivering Together

Foreword from Transformation Implementation Group

Evidence has shown that where a culture of Collective Leadership thrives it yields benefits for staff, leads to improved quality of care, results in a better experience for those who use our services and brings greater sustainability of those services. At no time has the need for Collective Leadership been more important.

Within our Health and Social Care system, we face considerable challenges and there is no doubt that our services and staff are under extreme pressure. Redressing this position will not be easy but over time we are determined to make it better for those who use our services and those who work in the HSC. *Delivering Together* has provided us with the roadmap for transformation but we recognise that leadership is key to achieving success.

In implementing this HSC Collective Leadership strategy, together we can improve the health and wellbeing of the people of Northern Ireland by harnessing our strengths and working collaboratively and effectively across traditional boundaries as one system.

Our vision is for a culture which values leaders, regardless of hierarchy or experience, location or discipline. It is one in which people strive for continuous improvement, are enabled to be innovative and take some risks along the way. We want to see staff flourish and take pride and joy in their work. This strategy provides a framework to achieve that ambition and we give our personal commitment to creating the conditions to make that happen.

We want to thank the many staff members across the HSC who helped to develop this strategy. They have set the bar high and it is for all of us to live up to their expectations.

Members of the Transformation Implementation Group

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Context

The NI Executive have endorsed the need to transform how we design and deliver health and social care services to meet the increasing demands and changing external pressures. *Health and Wellbeing 2026: Delivering Together* sets out the direction for transformation and how services can deliver better outcomes for our population. It identifies 18 key actions, one of which is to:

'Develop an HSC-wide leadership strategy, to consider a five year approach and plan for development of collective leadership behaviours across our system' **Health and Wellbeing 2026: Delivering Together, (Oct 2016)**

The case for change is not in itself new and has been made repeatedly by experts, our people who work across health and social care, our patients, clients and carers. The political summit hosted by the Expert Panel in February 2016 secured a political mandate for the need for change and the principles to underpin it. The advent of a new outcomes based approach in the draft Programme for Government puts an onus on us all to work together, across traditional boundaries, to deliver the best outcomes for the people of Northern Ireland.

Whilst there are many leadership frameworks, the collective leadership model has been adopted as it is informed by considerable research and, in particular, by two major programmes of study conducted within the National Health Service. The first is a study of cultures of quality and safety in the English National Health Service (Dixon-Woods et al., 2013). The second involved analysis of NHS national staff survey data from 350+ organizations surveyed each year from 2004 to 2011 (Dawson et al., 2011). The data from these surveys were linked to national patient satisfaction surveys, mortality data, data on quality of care, financial performance, staff absenteeism and staff turnover.

The research suggests that all leaders (from the front line to the top) in the best performing health care organisations prioritised a vision and developed a strategic narrative focused on high quality, compassionate care and support (Dixon-Woods et al., 2013). The research evidence suggests that high performing health care systems around the world are characterised by a culture of collective leadership as opposed to command and control. It also shows that it is compassionate leadership behaviours combined with a strong focus on quality improvement that create cultures where people who work across health and social care are able to deliver high quality, continually improving, compassionate care and support.

Widespread engagement locally with people at all levels who work in health and social care organisations and those who use our services has endorsed the use of the collective leadership model. These stakeholders have influenced the development and contributed to the final content of this strategy.

Collective leadership consists of four key components:

- Leadership being the responsibility of all
- Shared leadership in and across teams
- Interdependent and collaborative system leadership
- Compassionate leadership

This strategy sets out how we will achieve a collective leadership culture across the wider health and social care system.

Figure 1: Four components of Collective Leadership

Our Challenge

We recognise that now is the time for us to work more collaboratively and collectively across the system to deliver world class health and social care services to the population as a whole. This will require harnessing and integrating the strengths of different parts of the system across organisations and sectors as well as working beyond what is traditionally considered to be the health and social care sector.

Our health and social care system faces a number of challenges which will require us to have a consistent approach to leadership across all organisations.

Increasing Demand

We are working in a complex, rapidly changing environment with increasing demands on our health and social care services which we know will continue into the future. We require leaders who have the knowledge, skills and abilities to promote the collective leadership that will deliver and sustain the changes required to deliver a world class service.

Working across boundaries

We need to work across traditional boundaries to address the ever increasing complexity and demands on our services. For this transformation to be effective we need to increase the prevalence of collective leadership and reduce or eliminate any silo based leadership approaches, both within our organisations and across the wider health and social care system. Our success will be measured by our ability to recognise the interdependence of our collective efforts and the need for our leadership community, which will include service users and carers, to work collaboratively to build the health and social care system for the future.

Pressure on our people

Our people have told us that the pressure on our system from increasing demand and challenging targets is impacting on their ability to deliver the quality of services they wish to provide for our population. One of the most significant challenges is for us to create a consistent approach to leadership, building an environment where our people are supported, engaged, enabled and empowered to offer the quality of the care they aspire to deliver.

Leadership culture

We have a workforce of highly capable, committed and enthusiastic people, including skilled and dedicated leaders. Because our system is changing we will require a shift towards a new leadership culture, a culture that recognises service users and carers also as leaders and moves away from command and control to collective leadership responsibility which:

- Values both formal and informal leadership
- Takes risks and learns from mistakes
- Supports continuous improvement
- Recognises that leadership comes from all levels, as referenced in Delivering Together *"Rather than concentrating power at the top, I want all those working in health and social care to feel able to effect change and improvement in care. This means developing leadership at all levels, a truly collective leadership model"*
- Enables effective and meaningful personal and public involvement, leading to co-production and a commitment to 'no decision about me, without me'

Collective leadership offers us a real opportunity for creating a culture of high quality, continually improving, compassionate care and support. There is consistent evidence that collective leadership in health and social care is necessary for overcoming the challenges we face and we recognise that it will require us as leaders, both formal and informal, to have courage, commitment and determination.

Our Ambition

Our ambition is to create a health and social care leadership community in which all take responsibility for nurturing cultures of high quality, continually improving, compassionate care and support. Our leadership culture will be the outcome of the collective actions of formal and informal leaders working collaboratively to deliver our common purpose of world class health and social care services.

The delivery of our strategy will require commitment from everyone who works in health and social care, service users and carers working with us, as well as our political leaders. Our commitments at a local and regional level will be that:

- We use our strategy as a guide when we are undertaking all things concerning leadership, improvement and collaborative working so that we engage across the system with one voice
- We take responsibility and hold each other accountable for the values and behaviours required to create our collective leadership culture
- We model in all our interactions the compassionate leadership and attention to people development that establish continuous improvement cultures
- We will share learning and spread best practice to support a continuous improvement culture

Realising our ambition will require a change in both behaviour and mindsets, our strategy will provide a framework for developing the capabilities and desired culture of collective leadership

Our Change

"It is people not strategies that bring about change and it is relationships not systems which make it work" Systems, Not Structures - Changing Health and Social Care, Expert Panel Report (Oct 2016)

There are many good examples already within health and social care of collective leadership and this strategy will ensure that it spreads to become the consistent approach across our system. To deliver the transformation that is set out in Delivering Together 2026, we need everyone to be prepared to lead - not just in their own work area but to lead with others in order to fulfil the core purpose of health and social care - high quality, continually improving, compassionate care and support for all in Northern Ireland.

Now is the time to create a consistent approach to leadership, working collectively to deliver a world class health and social care service.

We must:

- Develop collective leadership capabilities at all levels
- Create the desired collective leadership culture

Collective leadership capabilities at all levels

We must continue to invest in our people including service users and carers working with us, and provide the environment to enable them to do what they do best – provide excellent, high quality, continually improving care and support. This means providing opportunities for them to develop their collective leadership capabilities so that leadership at all levels becomes a reality.

To enable the growth of collective leadership across our system we need to:

- Recognise that leadership is the responsibility of us all and we all need to develop our leadership skills, behaviours and capabilities
- Develop shared leadership within and across teams
- Develop system leadership by working collaboratively and effectively across boundaries to problem solve and co-create the future
- Create a consistent approach of compassionate leadership

Such collective approaches must be deployed effectively at the right time and place. Collective leadership does not replace the necessity for strong governance arrangements to ensure clear accountability and decisive leadership but overall, the shift in culture must be away from command and control to collective responsibility. Underpinning such collective leadership must also be the core values of health and social care.

Our leaders at all levels need to develop strong networks, supportive alliances and trusting relationships within and across organisational, professional and geographical boundaries.

Desired Collective Leadership Culture

Organisational culture can be defined as the values lived by its employees every day, 'the way we do things around here' – and we know at times this may not be the same as our stated values. We must recognise that if we want to provide users of our service with respect, care and compassion, all our leaders and people must afford all their colleagues the same respect, care and compassion.

A collective leadership culture is the product of our collective actions and our formal and informal leaders must act together to achieve organisational goals. This will require new levels of awareness of self and others, new mind-sets as well as new skills and may require personal changes in our individual behaviours.

The cultural characteristics of collective leadership that we need to embrace and integrate into everyday ways of working are:

- Prioritising an inspirational vision and narrative – focused on quality of care and support

- Commitment to effective, efficient performance and accountability - clear aligned goals, objectives and outcomes with helpful feedback
- Supportive people management and employee engagement - compassionate leadership
- Continuous learning and quality improvement
- Genuine team working and collaboration across boundaries
- Modelling in our everyday behaviour the values of the organisation

Collective leadership creates the foundation of a strong, supportive organisational culture.

Our Approach

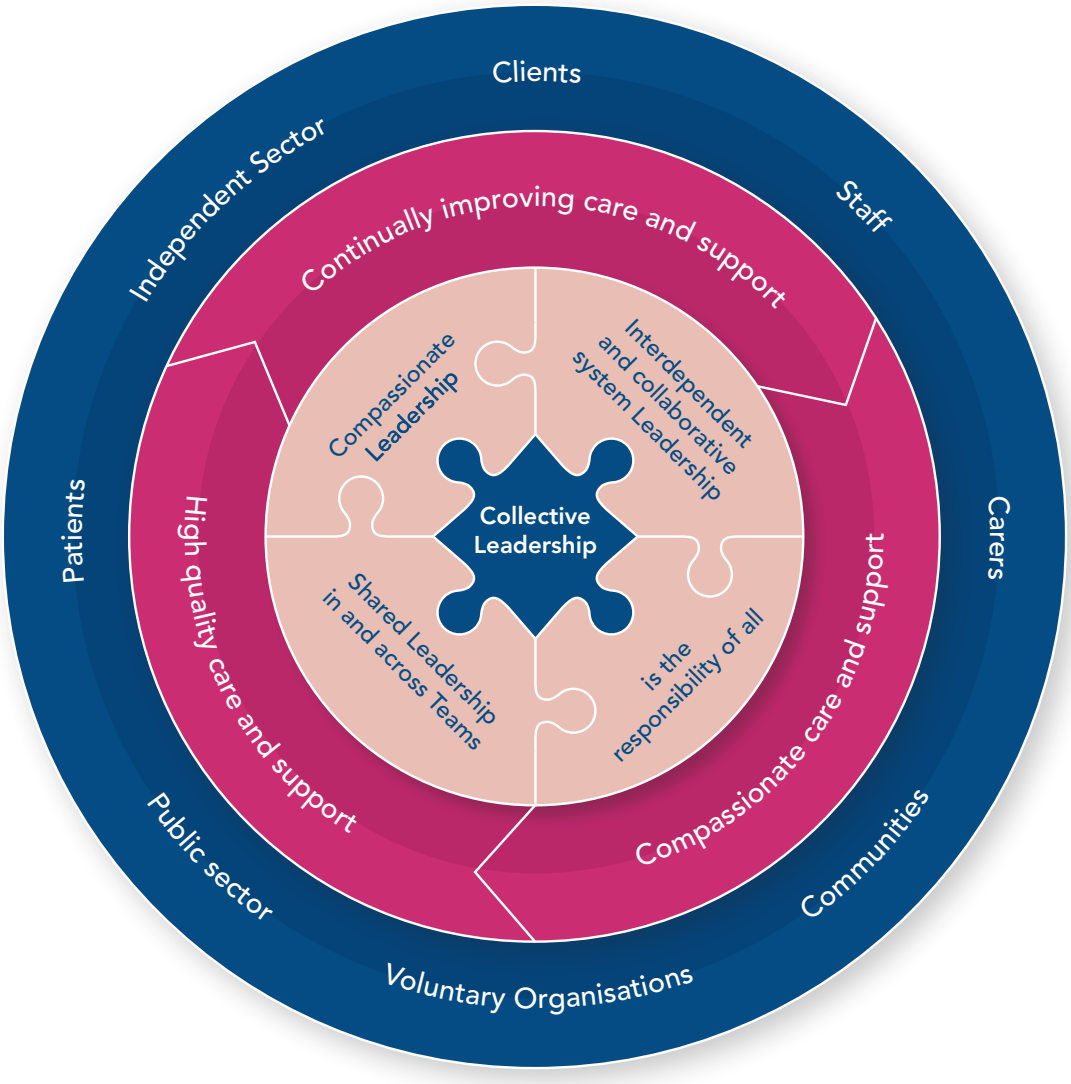
Our collective leadership strategy will be critical to ensuring that our health and social care organisations have the leadership they need to nurture cultures that:

- Deliver high quality, continuously improving, compassionate care and support, now and for the future of our population
- Equip and encourage those working in health and social care roles to deliver continuous improvement in local health and care systems
- Support those who work within our organisations to flourish, gain satisfaction, take pride and experience joy in their work

To enable this change in our culture the four components of effective and sustainable collective leadership are:

- Leadership is the responsibility of all
- Shared leadership in and across teams
- Interdependent and collaborative system leadership
- Compassionate leadership

Figure 2: HSC Collective Leadership



Whilst the model of collective leadership is new we have many excellent examples of this occurring across our health and social care system. These are illustrated by the following case studies.

Leadership is the responsibility of all

Collective leadership requires us to share leadership responsibility across all levels. It is a fluid approach enabling anyone with expertise for a particular task or situation to take responsibility when there is a need. Leaders in formal roles must create the conditions in which power, authority and decision making are distributed to all levels within and across our organisations. In developing leadership at all levels we need our people to be informed, enabled and empowered to deliver high quality, continually improving, compassionate care and support.

South Eastern HSC Trust

My name is Andrew Patterson, I am a Band 3 working in the Phlebotomy Team based in the Ulster Hospital. I was given the opportunity to take part in the Trust's Leading in Safety, Quality and Experience programme. This is where my leadership story began. Although banding plays a part in leadership, I realised that we are all leaders, we all have expertise in our own fields and we all have the potential to take on responsibility no matter how small when the need arises. Through the training I received I was able to take on responsibility for the service that I was providing and improve it to deliver the best possible results for those accessing our service, whether patient or staff. This led to a 43% reduction in the amount of blood sampling being carried out, freed up capacity in labs, a reduction in phlebitis and antibiotics prescription, results back in time to facilitate discharge and decision making and a reduction in the work load being handed onto JHO's out of hours. Alongside this we managed to save £4,367 in a three week period.

Since stepping up to the mark I have further developed myself not just in the area of leadership and education but also as a person. When someone invests in you, develops you, informs you, enables and empowers you to lead in this way it just doesn't benefit them.... It benefits you as a person. You become happier in your work, you feel a sense of ownership in your work, your passion is reignited, you feel proud of what you do and you know that your work really does matter.

Northern Ireland Ambulance Service

Over the past two years the Northern Ireland Ambulance Service has developed 12 new care pathways for patients which provide safe alternatives to ED and which mean patients with a chronic condition or a specific need – like palliative care support - can access that help more appropriately than being conveyed to the Emergency Department. Referrals can now be made to Falls teams, Minor Injury Units, Frail/Elderly Services, Palliative Care services, Respiratory services. A modernisation team drawn from Operations and Ambulance Control meant leadership came from within these services. The programme started with staff focus groups to ask front-line staff what services they thought their patients would benefit from. A feedback model of 'you said, we did' was used to show how this influenced conversations with hospital and community services to develop new pathways. This collaborative approach, coupled with a commitment from the modernisation team to spend time working in Ambulance Control, on the front-line, or shadowing front-line staff, meant that there was consistent attention paid to the observations and insights from those working in front-line ambulance services. There has been a lessons learned process carried out to ensure deep learning from how this process was led well and how to build and develop this in the future. Frontline staff commented:

- "Cross directorate working has been strong"
- "I like how much engagement there was with front-line staff"
- "When I sent in emails with ideas these were responded to and I got feedback."

Patients engaged through surveys and structured telephone calls to continue to help us learn and improve the pathways: Patient stated:

- "They couldn't have gotten a better service. Very happy with contact/treatment and referral pathway."
- "Very grateful for the referral and immediate action. The staff were lovely."

Northern Ireland Medical and Dental Training Agency

My name is Dr Anna O'Kane and I am a GP Trainee and ADEPT Clinical Leadership Fellow for 2016/17. ADEPT is the 'Achieve, Develop, Explore Programme for senior Trainees' established by the Northern Ireland Medical and Dental Training Agency in 2015. It enables senior doctors and dentists in training to take a year out of their training programme to work in an apprenticeship model with senior clinical leaders in host organisations across HSCNI.

As a GP trainee the fellowship has given me insight into the strategic and organisational aspects of General Practice as well as the wider HSC, the challenges that it faces and the value of true integration of care and meaningful co-production. I believe that this leadership training will offer real system benefits in connecting services, understanding how different people, teams and organisations interconnect and interact. By taking a collaborative leadership approach, I hope to use my skills by influencing for results, developing capability within the system, and enabling teams to deliver care across traditional boundaries.

I have gained immensely from the practical experience of being involved in a range of strategic projects focused on improving General Practice, and have particularly enjoyed and benefited from the opportunity to learn from inspirational leaders across our system. ADEPT has made me appreciate that whilst there are some inherent qualities suited to leadership roles, effective clinical leadership requires continual personal reflection, learning and growth in response to challenges and experience; and that it is essential all HSC staff feel encouraged and empowered to develop and use their leadership skills to the best of their ability and for the wider benefit of the system. I feel very privileged to have had this opportunity and believe it will enable me as a future GP to better influence and affect change to improve patient care and experience. I now feel a much greater connection to the HSC as a wider system as opposed to being a member of an individual specialty or trust area, as well as a greater sense of personal responsibility and confidence in my ability to actively contribute to improving our system.

Shared leadership in and across teams

Collective leadership requires us to develop shared leadership within teams and across teams based on open and supportive communication, candid and mutual feedback and agreed, shared and challenging goals. This will build communities of teams and create a culture that values differences and enables decision making at the closest point of contact to our users by teams rather than individuals. In our teams, we need to create a cohesive, optimistic and effective environment that stimulates and supports innovation, continuous learning and quality improvement. Every team must include among its objectives a commitment to improving the effectiveness with which they work with other teams and organisations to ensure the delivery of the best possible care and support for the population.

Northern HSC Trust

The Northern Trust focused on the design, implementation and evaluation of a virtual renal review clinic model for patients with Chronic Kidney Disease (CKD).

The Virtual Renal Clinic Project was led by a consultant nephrologist and included specialist nursing, community nursing, booking office and service management. This team worked together to agree a protocol for identifying CKD patients who would be suitable for telephone review with a renal nurse specialist rather than a face to face consultant review appointment. A pilot was established whereby suitable patients were offered a transfer to nurse telephone review, and a total of 60 patients were moved across. The feedback from patients was strongly positive, with a particular focus on avoiding a stressful and time-consuming trip to hospital. The evaluation showed a safe and effective service, less resource-intensive than a consultant review clinic, delivering excellent patient experience and a reduction in the renal outpatient review backlog.

The success of this initiative was largely due to the collaborative approach taken from the outset: clinical leadership from the consultant nephrology team, a willingness from the nurse specialist to try new ways of working, support and flexibility from community and admin services, and project and QI support from divisional management. The result is a safe and robust model for nurse-led virtual clinics which delivers good outcomes and excellent patient experience.

Western HSC Trust

The Western Trust developed an Infant Mental Health Strategy in 2011 that brought attention and focus to the importance of early intervention. As part of the natural development of the strategy it was important to grow leadership to promote and develop the culture of early intervention and also to lead and nurture innovation. There was a view that whilst important, the emphasis was only on very young children. The creation of a broader focus on Emotional Health and Wellbeing of all children and young people enabled a collective leadership approach to emerge. The collective leadership approach has generated broader interest and commitment across services thus enabling the strategy to permeate into the organisation at every level.

Bringing together a range of leaders from a range of professions and specialities was a challenge. Significant time was taken to agree the overarching vision and subsequently signing up to working together to ensure that there was quality and improvement across the whole system. The collective leadership challenge was significant and took time to embed. This was time well spent. The founding principle was that to succeed the contribution of everyone must be valued.

The leadership group has consolidated and grown in numbers and strength over the past 12 months. It has agreed a programme plan that is founded on the agreed vision and articulates what it hopes to achieve over the next 12 months. All of the leaders are leading by example and encouraging creativity and innovation. The secret has been collective ownership of the strategy and a commitment to work collaboratively to ensure there is positivity, energy and enthusiasm for every action undertaken. The group meet regularly and undertake work that spans all programmes and directorates ensuring key programmes are available to all.

Belfast HSC Trust

Delivering safe, high quality and compassionate care at all levels is the first order priority for the Belfast Health and Social Care Trust.

We are working to develop a culture of excellence in safety and quality; engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those who access care. By getting this right, we'll have collective leadership within and across our areas, and with other organisations in the wider HSC family; prioritising overall care outcomes rather than just the success of our part of it.

It is clear from the views of our staff, service users and research that a new way to think about leadership is required, one which enables local teams to take control and have the permission to drive improvement. This has shaped a broad programme of work focusing on creating the conditions – the structures, processes and behaviours – we need to deliver our first order priority. Our culture change programme covers all aspects of our corporate objectives and includes a relentless focus on safety and quality outcomes, supported by ways of working that nurture innovation and shared learning, and improved decision making and collaboration through a network of high performing teams.

Here's a snapshot of some of our work to date:

- Building the will and capability for safety and quality – delivery of a range of QI programmes, support materials and project based work involving staff from across all professions and levels. This is aligned to our Trust QI strategy and plan.
- Building the capability and confidence for collective leadership – including our Medical Leadership Development (consultant medical staff and above) and Leading with Care programmes (successful at tiers 3 and 4, and now being rolled out to all staff at Tier 5)
- Living our values – engaging staff in dialogue about our Trust values and objectives, and what these mean in our day to day working lives.
- Collective leadership in action – originally looking at improving the unscheduled care performance and experience of service users, IMPACT is a multi-disciplinary, collective leadership approach to service improvement which is now being rolled out in other service areas.
- Challenging our ways of working – looking at how our leadership structures can be enhanced to deliver more local accountability, partnership working, and better individual and collective decision making closer to the point of care.

The Trust is currently aligning and developing its enhanced leadership and decision-making structures, embedding collective leadership as a key enabler to the delivery of safe, high quality and compassionate care within teams and across teams. It is about continuously learning within teams, across teams, organisational boundaries and enabling better decision making, and the drive for quality improvement closer to the point of care.

Interdependent, collaborative system leadership

In our changing landscape of health and social care, our leaders must work effectively across boundaries. As system leaders we must create:

- A compelling shared vision for transforming the health and wellbeing of our population across Northern Ireland
- A shared commitment to work together for the medium and long term (not only the short term)
- Frequent contact between leaders who need to work together to build trust and make real progress in order to deliver a world class service
- A shared agreement to surface and resolve conflicts quickly, fairly, transparently and without blame, and a commitment to collaborative problem solving
- A commitment to establish shared learning for improvement rather than blaming for mistakes
- A clear commitment to support and value each other's organisations, mutually supporting system success in transforming the health and wellbeing of our population
- Equal partnerships between those who work in health and social care and the people they serve, through a co-production approach

Public Health Agency

Public Health Agency (PHA) worked in partnership with Age NI and local HSC Trusts to achieve a shared vision for improving nursing services in older peoples' settings using a co-design partnership approach with users. Peer educators from Age NI led on the co-design function of the initiative to identify what really matters to older people in care settings.

The production of a regional report 'What Matters' sets out the achievement of a number of products which have been very well received including a DVD and training resources which were co-produced in partnership through meaningful collaboration with HSC Trusts, PHA, users, Age NI and education providers. This successful collaboration has resulted in the PHA securing a significant nursing award from Burdett to undertake additional work with the organisations, based on the recommendations from the report.

A Lived Experience Perspective, Eileen Shevlin

I have been a member of the Service Delivery Board (SDB) within the Recovery College of the South Eastern Trust since its inception in 2014. Our college embraces a shared leadership approach with our vision built on the values of hope, control and opportunity. This means that the Board consists of an equal number of professionals, service users and partner organisations who are strategically responsible for the ongoing development of the college, monitoring quality and advising on how resources should be prioritised within the college.

The experience of working in this way, where all people are recognised for their unique skills and talents, has transformed relationships and the way we do things, as everyone is valued equally and everyone feels that they have a contribution to make. This is true co-production with our shared leadership approach recognising the equal importance of both learned experience and lived experience.

Personally, it has given me the opportunity to rediscover the skills that I thought I had lost forever due to my mental health. I could dip my toe in the water of a working environment again where Compassionate Leadership meant that I felt safe to be authentic, honest and open as well as demonstrate that I had leadership skills without being in a position of power. This co-productive way of working has given me great hope for my future and for the future of others, by recognising that everyone has their own skills and strengths from the strategic leaders, to the people at the front line and those who use the service.

The strength of the collective leadership approach adopted by our Recovery College means professionals and people with lived experience are proactively engaged, are empowered to make decisions and own the drive for better outcomes. At its heart is a culture of co-production and mutual learning with a commitment to 'no decision about me without me'.

Working together in this way has transformed the culture and relationships between managers, staff, people with lived experience and third sector organisations, with leadership seen as our shared responsibility.

For me it has opened many doors and created opportunities which I have grabbed with both hands. Wellness for me has always involved returning to the workplace using the skills that I had spent my life developing. Now, thanks to co-production and using a collective leadership approach I have a fabulous new CV and I feel ready to return to work and use those skills again.

Compassionate leadership

As leaders, whether formal or informal, we will create our desired culture of strong, visible collective leadership focused on high quality care and support which is continually improving and recognised through our behaviours. Creating a consistent approach to compassionate leadership in practice is:

- Attending: paying attention to our people – being present and listening with intent
- Understanding: finding a shared understanding of the situation
- Empathising: using emotional intelligence and engaging with our people
- Helping: taking intelligent action to help

Our leadership community will be characterised by authenticity, honesty and openness, curiosity, decisiveness and appreciation.

Department of Health and Public Health Agency

The Family Nurse Partnership (FNP) Programme is an intensive, preventive, one to one home visiting programme for young, first time mothers from early pregnancy until their child reaches two. Its main aims are to improve pregnancy outcomes, child health and development and the economic self-sufficiency of the family. FNP aims to introduce a new approach to nursing, working with the parents to help them build up their own skills and resources to parent their child well, but also to think about their own future aspirations.

The FNP programme is based on positive psychology and strengths based practice and collective leadership. At all levels of the organisation it is the responsibility of all to practise strengths based working, building on the client's and nurse's strengths and resilience to build a hopeful and positive future for the family and new baby. It is a shared leadership by all of the FNP team. Family nurses and clients manage incredible change and challenge in their lives. Every day, FNP teams support clients to navigate and overcome often unimaginable difficulties and uncertainty. They do this by drawing on past experience, skills and evidence, staying calm, being brave, and trusting their instincts – and each other. The FNP teams practise kindness compassion when working with young families and others. The building of respectful relationships between clients, nurses, stakeholders and supervisors is key to the success of the programme. The central team, supervisors and family nurses all role model compassion and self-awareness to enable and empower clients to develop their sense of self efficacy and confidence. This creates a parallel process between Supervisor and Nurse and Nurse and Client. Collaborative working with other professionals and agencies, building on a strengths based approach, remains central to the effectiveness of the programme.

The family nurses are supported by frequent restorative supervision by the supervisors, psychologists and safeguarding nurse. Supervision supports nurses to remain compassionate and strengths focused. Emotionally nourishing nurses through supervision processes, good leadership and an excellent learning programme will spread in a positive way to the young mothers, children and families. The FNP teams take time to be compassionate with each other and model this self-care to others.

The young clients and the family nurses are actively encouraged to help us develop and improve the programme. With leaders at all levels the FNP teams have a responsibility to listen to, be curious, understand, respect and value different views. The central team, supervisors and family nurses strive to find a shared understanding on how to improve the quality of the programme and ensure the high quality implementation and compassionate care.

Southern HSC Trust - Deirdre's story

Deirdre is a Health Visitor Team Manager in the Southern HSC Trust and took up post in 2012 having previously worked in the team for a number of years. This is Deirdre's story, as told by her team members.

"When our last Team Manager moved on to a new post in 2012, there was one team member that we all knew would be the right person for the job, and thankfully she succeeded in obtaining the post. Right from the start Deirdre was faced with many challenges. Our actual numbers of staff had been gravely depleted through general staff shortage, sick leave and maternity leave and even more stressfully – by a very dear and much-loved colleague who was diagnosed with a rapid terminal illness and died in November 2015.

Naturally our entire team was devastated but throughout all of this very challenging time, our Team Manager, Deirdre, was exceptional, continuing to motivate our small team with great compassion and professionalism. Deirdre ensured we all had time to visit our friend one last time, and had Carecall attend our team meeting to help us cope with our emotions and understand the way we may all face situations with different coping strategies, so we could better understand and support each other in our own ways. Despite her own personal grief at the loss of her dear friend and colleague of many years, Deirdre sought to help each one of us with great compassion and insight and offered each one of us, as individuals, her time.

Despite her own over-burdening managerial duties, Deirdre is not afraid to roll up her sleeves and help our team by practically carrying out home visits and hands-on duties. She keeps in touch with what's happening on the ground, yet excels in all her managerial duties leaving our team with the full knowledge and confidence in her ability and skills, to feel very well supported.

Deirdre is not a 'soft touch' but a quiet, very unassuming, yet inspiring role model in every way. She has the knack of helping us to feel special and valued in all that we do, aiding team cohesion and certainly staff morale. Deirdre has continued to work tirelessly and relentlessly to ensure that all of our team are mentally, emotionally and physically well. She always arrives in with a smile on her face, instantly inspiring and empowering us all to face the work challenges of each day. Her flexibility with the team and genuine compassion is often breath taking given the personal challenges of her own role on a day-to-day basis."

NHS England have already begun to put in place practical actions needed to develop and strengthen collective leadership across their system.

This case study provides an early illustration of the outcomes achievable through the implementation of a collective leadership approach.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

The Trust had already standardised its approach to QI and recognising the role leadership has in creating culture, believed the next step was to develop an aligned leadership strategy. This had huge support from the Board.

Our change team is one of the things we are most proud of. We developed a set of criteria in order to recruit to it. To apply, individuals had to:

- have the sponsorship and support of their line manager
- meet the criteria
- commit to attend 6 workshops
- undertake cultural audit work between the workshops

All of this was in addition to their "day jobs".

Applicants were shortlisted and assessed by a panel that consisted of execs, non-execs, heads of nursing and quality and directors of operations. The Board was also fully engaged in the process. We deliberately recruited a diverse section of people in terms of grades, roles, skills and experience. We tried to select a team that was representative of the workforce.

We originally planned to recruit 12 change champions but from a strong field we actually recruited 15 people from a pool of 30, one of the team is a patient/volunteer representative. Being in the change team is a development opportunity.

The impact has been huge. At the end of Phase 1, Discovery, the change team gave a presentation of their findings to the Board and received a standing ovation. The Board wanted to know how things really were, and the change champions felt they were doing something really valuable. We took the views of over 900 staff into account and, in itself, the cultural audit has proved to be a very positive engagement activity.

The change champions then worked with the Board to determine priorities and develop next steps. They gave further presentations and then sought feedback from the clinical directors and the council of governors. This work was then translated into an action plan which was agreed at the board meeting in July. The action plan set out our quick wins 'just do it' actions and things we need to take to the next phase: Phase 2: Design.

Our next steps are roadshows from our diagnostic phase – the 'cultural audit' - are now underway with a series of open meetings and attendance at existing team meetings being held. In these sessions, the findings of the cultural audit are being shared, staff are being invited to feed back on the findings and recommendations and shape the new culture. These sessions are being delivered by the change champions who are working in pairs and supported by a member of the executive team at each session.

We are now developing the design phase and looking to recruit more change champions alongside the current team.

Some of the outcomes that we are able to report are:

- following the CQC inspection, nearly 80% of our services received ratings of 'good' or better
- against a background of continued and sustained growth in emergency admission, our OPM length of stay reduced from 10.3 days to 6.2 days
- reduced spend of agency staff by £3.4m
- results from the National Staff Survey have improved:
  - 77% of staff recommend the Trust as a place to work (66% in 2016)
  - 89% of recommend the Trust as a place for treatment (83% in 2016)
  - Overall impression of Trust, mainly good 94% (88% in 2016)

The Actions

This strategy sets out our commitment to develop and implement a consistent collective leadership approach across our health and social care system in line with Health and Wellbeing 2026: Delivering Together. We recognise that this will not be easy and will require continuous effort. The outcome of implementing this strategy will be the development of collective leadership capabilities at all levels and the creation of a collective leadership culture that will deliver high quality, continually improving, compassionate care and support for our population.

To realise our ambition to deliver a world class health and social care system we must work together to deliver the following actions.

What are we going to do?	Date
Phase 1	
Establish and embed a core set of values and associated behaviours.	March 2018
Develop a framework that outlines the critical collective leadership capabilities needed by all our people who work in health and social care.	June 2018
Design and implement a system to monitor the outcomes and review the implementation of the collective leadership strategy.	June 2018
Embed the collective leadership framework into all leadership development activities consistently, including and ensuring talent management and succession planning.	March 2019
Develop a framework that will support and enhance team working in and across the system.	March 2019
Establish a programme of work that will modernise selection and recruitment arrangements within health and social care and is aligned to the Regional Workforce Strategy.	June 2019
Collaborate with education providers and professional bodies to introduce the principles of collective leadership into undergraduate and postgraduate training.	June 2020
Phase 2	
Embed the phase 1 actions across health and social care organisations	March 2024
Evaluate the outcomes identified in the strategy of - collective leadership capablities at all levels - a collective leadership culture within health and social care organisations.	2018-2026

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HSC Health and Social Care

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Health and Wellbeing 2026: Delivering Together

10/17

Nursing And Midwifery Task Group (NMTG)

Report and Recommendations

March 2020

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FOREWORD FROM SIR RICHARD BARNETT

It has been an absolute privilege to have chaired the Nursing and Midwifery Task Group (NMTG) over the last two years. I am completely humbled by the work of nurses and midwives and the amazing contribution they make to the lives of people across the life course every day in Northern Ireland (NI).

NI like the rest of the United Kingdom faces the challenges of rising demand which far exceeds the resources available. This reality as set out in 'System not Structures'[1] is putting enormous pressure on a system not designed to meet the changing needs of the population. There is growing consensus that for health and social care services to become sustainable, it cannot keep doing what it has always done. Without significant transformation, it is conceivable that the entire NI block grant would be needed to meet the demand being placed on health and social care. This is why I believe the transformation of nursing and midwifery services is essential to the stability and sustainability of the NI health and social care system.

During the course of the review I met with hundreds of nurses and midwives and their dedication, often in difficult circumstances, must be commended. Nursing and midwifery are the backbone of the NI health and social care system, and whilst those who lead nursing and midwifery are clearly committed to enhancing the professions contribution, it is crucial that nursing and midwifery are seen as an asset by all those involved in leading health and social care delivery. During the course of my review the Department of Health commitment to addressing the challenges facing nursing and midwifery is clearly evident through the provision of significant transformation funding of over £50million. This investment contributing to safe staffing, has enabled a significant growth in the numbers of undergraduate nursing and midwifery places and has enhanced a wider range of nursing specialisms and midwifery services. Clearly this level of investment needs to be sustained and the recommendations set out in this report will require the development of a costed implementation plan.

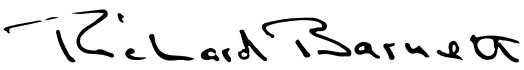
I believe an investment in nursing and midwifery is not only an investment in the lives of people who need care, but also in the NI economy. This report sets out an ambitious future agenda for nursing and midwifery which I believe will make a significant contribution to the transformation of health and social care, as set out in the *Health and Wellbeing 2026: Delivering Together* 2026 Vision. The recommendations in this report will facilitate the:-

1. Adoption of a population public health approach and put prevention and early intervention at the heart of nursing and midwifery practice.

2. Stabilisation of the nursing and midwifery workforce therefore ensuring safe and effective care.

3. Transformation of health and social care service through enhancing the roles that nurses and midwives play within and across multi-disciplinary teams (MDTs).

I want to thank all those who contributed to the formulation of the recommendations in this report. I believe if these recommendations are implemented, nurses and midwives can be confident that they will be able to deliver sound evidence based care, with the right numbers, at the right time, in the right place, by the right person with the right knowledge, and of course most importantly delivering the right experience for people, families and their communities.



Sir Richard Barnett
Chair of NMTG

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

1. NMTG Context

The previous Health Minister, Michelle O'Neill established a NMTG independently chaired by Sir Richard Barnett. The core aim of the group was to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured Health and Social Care (HSC) system over the next 10-15 years. The group were asked to consider this core aim within the context of developing a population/public health approach and to identify through evidence/innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes.

2. NMTG Review Methodology

The review team adopted an outcome based accountability and co-production approach and set up three major workstreams to provide focus and concentrate the work on how the contribution of nursing and midwifery could be maximised to improve outcomes. Almost 1,000 participants from all branches of nursing, midwifery, including representatives from independent sectors and from other professions took part in over 36 events. The findings from these events were compared with a wide range of evidenced based literature and were used in the formulation of the report's recommendations.

In line with the terms of reference of the NMTG, the recommendations set out in this report provide a 10—15 year road map which will deliver ***S.A.F.E*** care through:-

S

Stabilising the nursing and midwifery workforce, therefore ensuring safe and effective care.

A

Assuring the public, the Minister, the Department of Health (DoH) of the effectiveness and impact of person centred nursing and midwifery care.

F

Facilitating the adoption of a population health approach across nursing and midwifery practice resulting in improved outcomes for people across the lifespan.

E

Enabling the transformation of HSC service through enhancing the roles of midwives and nurses within and across a wide range of MDTs/services.

3. NMTG Overview of Work Streams

The Nursing and Midwifery Workforce

This workstream focused on four core areas: building and sustaining safe stable teams; the scale of the workforce focusing particularly on the numbers of pre and post registration nurses and midwives; exploration of evidenced based options for the further development and/or introduction of new nursing and midwifery roles in order to improve outcomes; and the depth and breadth of nursing and midwifery leadership.

Long Term Conditions (LTC)

This workstream focused on identifying the contribution of nursing and midwifery across primary, community, acute, specialist nursing and midwifery services. To do this a number of long term conditions (LTC) were chosen to explore how the contribution of nursing and midwifery could be maximised, which included frailty, diabetes and respiratory conditions. These conditions ranked in the top for admissions to acute care and their prevalence in primary care and effect on pregnancy and the baby. In addition, two further sources of information were included: the findings from a review into the role of mental health nursing commissioned by the Chief Nursing Officer (CNO); and the findings from a focus group discussion with learning disability nursing. The LTC chosen were indicative and were used to help model the recommendations for nursing and midwifery now and in the future.

Population Health Work Stream

Maximising the contribution of nursing and midwifery in terms of improving population health outcomes was a core objective of the review. This workstream analysed a range of public health data, particularly data relating to the impact of deprivation, adverse childhood experience, mental health and lifestyle choices on health and wellbeing. As a result the workstream focused on the actions needed to not only 'make every contact count' (MECC) but those required to build a strong public health agenda within and across nursing and midwifery services.

4. NMTG Key Findings

Workforce Planning

Unsurprisingly the issues surrounding workforce predominated discussions. The report emphasises that nursing and midwifery as the single largest group (representing 34% of the health care workforce) is fundamental to the delivery of a sustainable health and social care system. Therefore investment in nursing and midwifery needs to be

commensurate with its role in providing care across the lifespan. Workforce data indicates that 94% of the workforce are female and 6% male, and almost 60% of the nursing workforce hold posts at Band 5 and midwives mainly at Band 6. This is over double the amount, when compared with other professions categorised as Band 5. Indeed with the exception of Band 6, when compared with other professions at Band 7 and above, nursing and midwifery has significantly lower number of clinicians at senior grade. Alongside workforce shortage the report identifies the lack of specialist and advanced clinical posts as a major concern, particularly the impact on delivering the ambition outlined in Deliver Together (2026). The report also highlights the increasing number of nurse and midwife vacancies, which have grown to an average of 12% (2,500 posts).

In addition, agency spend has risen from £9,852,129 in 2010/2011 to £51M in 2018/2019. Bank costs have also doubled from £30M in 2010/11 to £61M 2018/19. Clearly this is very concerning, not only in cost terms, but also its impact on the stability of the workforce. Therefore the report recommends the need for a five – ten year sustainable plan to increase the number of undergraduate places. It should be noted that the increase in the number of undergraduate places made possible by transformation funding provides a foundation for growth. This however needs to be sustained in order to keep pace with both population and workforce demographics. There was also a significant call for the introduction of legislation for safe staffing in order to safeguard patient care.

Postgraduate Education

In terms of postgraduate education the report highlights that in order to both retain and develop our nurses and midwives there is a need to restore and incrementally grow postgraduate training budgets. Over the last ten years the core postgraduate education budget in nursing and midwifery has progressively decreased from £10.8 million to £7.3 million. This reduction has been further compounded over this time period by an increase in postgraduate education costs and the increased costs associated with backfill for some of the training places. It is important to note however over the last two years these reductions have been offset by non-recurrent transformation funding. In the absence of sustained recurrent transformation funding and/or a restoration of core funding commensurate with the size of nursing and midwifery workforce, this will have significant implications for nursing and midwifery practice, career pathways, and wider health and social care reform.

Morale and Collective Leadership

The report also emphasises the need to address the morale of the profession, reduce bureaucracy and the unwarranted variation in the roles, teams and the structures of nursing and midwifery, from point of care to the boardroom. One of the core recurring messages that emerged from all those who participated in the workshops was a perspective that nurses and midwives do not feel valued as equal members of the MDTs. This was strongly linked to the fact that the vast majority of nurses are Band 5. This was further compounded by the lack of a systematic approach to workforce development and therefore opportunities for career or grade progression have been limited. A review of the roles and functions of nursing and midwifery leadership also showed significant variation in managerial infrastructure. The lack of dedicated investment has highlighted the need for bespoke leadership development. Across all of the workshops the issue of pay divergence with other professions and the rest of the UK was a recurring concern.

Public Health and Population Health

In relation to population health, there was a strong message that promoting health and wellbeing for the population of NI should be every nurse and midwife's business. Nurses and midwives felt their public health contribution had been compromised largely because of competing demands in their roles. It was also determined that the lack of dedicated and recognised public health nursing roles was also a compounding factor. The epidemiological and demographical realities over the next 10 – 15 years create a strategic imperative to maximise the contribution of nursing and midwifery in improving population health and wellbeing outcomes across all ages, all settings and all communities. The development of primary care Multi-disciplinary Teams (MDTs) creates a real opportunity to enhance the public health nursing roles, particularly in health visiting, mental health nursing and district nursing.

Socio-economic Value of Nursing and Midwifery

Whilst more bespoke work is needed on the socio-economic value of nursing and midwifery, we compared our findings with a wide range of evidence based literature. The report draws on a plethora of emerging evidence that correlates improved patient experience, and outcomes (reducing morbidity and mortality) with increased graduate nurse patient ratio. In addition, there is clear evidence that public health and early years nursing (Midwifery, Health Visitor, School Nursing, Paediatric and Family Nurse Partnership) contributes significantly to enabling the best start in life and in particular reducing risks associated with poor lifestyle choices and in promoting developmental, psychological and social wellbeing. Further evidence now shows that Specialist and Advanced Nurse Practitioners (ANPs) improve clinical care outcomes and provide a cost effective solution in augmenting the role of doctors.

5. Department of Health Transformation Programme

Since the launch of *Health and Wellbeing 2026: Delivering Together* the Department of Health (DOH) has made significant investment in a wide range of nursing and midwifery services with over £50M invested in three key critical areas:-

Workforce Stabilisation

An additional investment of £7M undergraduate education has enabled the highest number (1025) of nursing and midwifery training places commissioned in NI 2019/20. This represents an increase of 45% from 2015/16 and demonstrates the Department of Healths commitment to addressing the current shortages and growing the local nursing and midwifery workforce.

In 2016 the Department embarked on a regional international nursing recruitment campaign with the aim of bringing 622 overseas nurses by November 2020 to strengthen the local HSC workforce. Transformation investment into the Clinical Education Centre (CEC) has supported overseas nurses to meet the essential registration requirements to practice as a nurse in the U.K.

The Department launched its Delivering Care Policy (safe staffing) and has commissioned to date nine discreet phases which have resulted in an investment of over £15.2M.

Workforce Development

The post registration transformation investment of over £7.7 million has delivered significant educational opportunities for the nursing and midwifery professions, benefiting 1,965 participants over the last two years. Investment has enabled a wide range of programmes to be funded to build the clinical expertise and leadership capacity within the workforce. The investment has supported the strategic direction with a focus on community specialist practice programmes such as District Nursing, Health Visiting and School Nursing. Investment in the development of ANP roles in Primary Care, Emergency Care and Children's Nursing has been a significant achievement with the first Masters level ANP programme delivered in NI.

A range of other programmes, including bespoke quality improvement and leadership initiatives have been funded across mental health, learning disability, adult, children services and midwifery. Furthermore, investment has facilitated an innovative post registration nursing Master's programme for NI, designed to develop leadership skills in new nurses and support workforce retention. Additionally, transformation investment in a regional nursing and midwifery data transformation project is assisting the professions with implementing electronic record keeping and digitalisation.

Service Developments and Reforms

The Department has also invested £18M in nursing service developments across the life span. This has resulted in additional Health Visitors (HV) enabling a new ratio of 1 HV to every 180 children. In addition, a District Nursing Framework 2018-2026 was launched that has been designed to enable the delivery of 24 hour district nursing care no matter where you live. This has also enabled a new ratio of 8-10 whole time equivalent (WTE) per 10,000 of the population. Through the establishment of MDTs there has been additional investment in Neighbourhood Nursing teams and in ANP within Primary Care Teams.

6. NMTG Ambition

The recommendations proposed reflect a new vision/ambition to maximise the contribution of nursing and midwifery. It is the ambition that nursing and midwifery deliver the right evidence based care, with the right numbers, at the right time, in right place, by the right person with the right knowledge, and of course most importantly delivering the right experience and outcomes for persons, families and communities.

7. Recommendations

Before moving onto the recommendations of the report it is worth highlighting the recommendations also take account of the new mandatory Nursing and Midwifery Council (NMC) Future Nurse Future Midwife (FNFM) proficiency standards launched in May 2018 (Nursing) and November 2019 (Midwifery). These standards are set to revolutionise and modernise nursing and midwifery practice, and they are strongly focused on evidence based care, delivering population health, and patient and women centred care which will improve outcomes for people. The review team analysed all of the data from the workshops and following a literature review themed the recommendations under three core headings. The recommendations have been framed to reflect a new vision/ambition designed to maximise the contribution of nursing and midwifery.

7.1 Theme 1: Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes: Clearly nurses and midwives have a critical and collective leadership role to play across the lifespan in promoting health and well-being. It is within this context that the report is recommending:

7.1.1 The development of a new population health management programme for nursing and midwifery.

7.1.2 The creation of dedicated population/public health advanced nurse and midwife consultant roles across all of our HSC bodies.

7.1.3 To increase the number of school nurses, health visitors and expand the family nurse partnership programme across all of NI.

7.1.4 Recognising the demographic shifts, nursing needs to have joint and collective responsibility for the development, planning and leadership of older people services, including all nursing care services provided in the independent sectors.

7.2 Theme 2: Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice: Addressing the workforce challenges is strategically essential for the stabilisation of the nursing and midwifery workforce and health and social care delivery, therefore under this theme it is recommended we:

7.2.1 Sustain a minimum of 1000 undergraduate nurse and midwife placements per year for at least the next five years until we have reached a position of oversupply.

7.2.2 Establish a ring-fenced post education budget commensurate with both the size of the workforce and the HSC transformation agenda and as a minimum re-establish the previous investment of £10M.

7.2.3 Build and resource a new career framework for nursing and midwifery to ensure that within ten years we have advanced nurse, specialist midwife and nurses roles, as well as nurse and midwife consultant roles across all branches of nursing and midwifery.

7.2.4 Increase the number of clinical academic careers roles across all branches of nursing and midwifery.

7.2.5 Put Delivering Care Policy (safe) staffing on a statutory footing.

7.2.6 Develop arrangements for accelerated pay progression Band 5 to Band 6 grades similar to other professions. This in particular recognises that many Band 5 nurses after several years of practice acquire additional specialist knowledge and skills and take on additional responsibilities commensurate with Band 6 role as a senior clinical decision maker. Midwives become Band 6 within a year post registration.

7.2.7 Develop a person-centred practice policy framework for all nursing services and continue to develop woman and family centred midwifery services.

7.3 Theme 3: Doing the right things in the most effective way and working in partnership: The recommendations under this theme recognise the need for collective leadership and the development of integrated practice models within and across MDTs. For this to be fully realised there is a need to:

7.3.1 Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse/midwife leadership framework and investment in leadership training for nurses and midwives.

7.3.2 Invest in improvement science training and increase role of nursing and midwifery leadership in quality improvement initiatives.

7.3.3 Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness.

7.3.4 Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) new digital nurse leadership role in all HSC bodies.

8. NMTG High level Implementation Plan

In order to take forward these recommendations, a new nursing and midwifery strategy will need to be developed that is in line with *Health and Wellbeing 2026: Delivering Together* priorities. Indeed the Bengoa Report (October 2016) makes clear that system transformation is dependent on the modernisation of practice. Nursing and midwifery in line with the recommendations of this report will undergo significant practice reforms and clearly with a multi-disciplinary approach which is central to the delivering of better outcomes. The recommendations in this report will inevitably require legislative and ministerial approval and the development of a dedicated action plan. Clearly the recommendations will require additional significant investment over a 10-15 year period and this will be dependent on resources being released through service reconfiguration and/or efficiencies as well as securing new investment.


Registered Nurse
Health and Social Care
Registered Nurse
Health and Social Care

1

THE TASK

SECTION 1: THE TASK

On 25 October 2016, the then Minister of Health, Michelle O'Neill launched an ambitious 10 year approach to transforming health and social care ***Health and Wellbeing 2026: Delivering Together***[2]. This vision document, based on the findings of the Expert Panel report, led by Professor Rafael Bengoa, ***'Systems, not Structures: Changing Health and Social Care***, recognised that our society is getting older and people are living longer with long term health conditions. The vision document set out the necessary 'change' to deliver the world class health and social care services the people of NI deserve, acknowledging that current health and social care services were designed to meet the needs of a 20th century population, with a requirement for a programme of transformation implemented in a safe and sustainable way that meets the challenges of a 21st century population.

It was within this context and the many challenges facing nursing and midwifery that the Health Minister established a NMTG in 2017. The core aim of the group was to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured HSC over the next 10-15 years. The group was asked to consider this core aim within the context of developing a population/public health approach and to identify through evidence/innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes.

The Task Group reflected the current strategic mandates set out in:-

Health and Wellbeing 2026: Delivering Together

Particularly ensuring that the nursing and midwifery strategic direction mirrors the quadruple aim ambition:-

- people are supported to stay well in the first place
- people have access to safe, high quality care when they need it
- staff are empowered and supported to perform their roles - recognising that they are the most valuable resource available to the HSC organisations
- services are efficient and sustainable for the future

As detailed in *Health and Wellbeing 2026: Delivering Together*, the Task Group also sought to reflect the nursing and midwifery contribution to the 'change needed' in:

1. **Building capacity in communities and prevention** particularity in reducing health and social inequalities.
2. **Providing more support in primary care** and at home.
3. **Reforming our community and hospital services** so that our population receive evidence based care in the right place.
4. **Organising health and social care** by ensuring systems are co-designed, and are delivered in the most efficient and effective way.

The group also reflected the strategic objective reflected in;-

- Systems not Structures; Changing Health and Social Care – the Expert Panel Report
- Programme for Government (PfG) Framework 2016 - 2021[3] particularly on creating the condition for the people of NI to 'enjoy healthy active lives'
- Making Life Better – A Whole System Strategic Framework for Public Health 2013 – 2023[4]

The work of the Task Group was to be underpinned by a public health approach that promoted health and wellbeing. It was also expected to identify best practice and innovations in nursing and midwifery practice, embracing and building on work already undertaken across the UK and Ireland and further afield. The Task Group membership was to examine the socioeconomic value of nursing and midwifery and identify potential opportunities for the future. The NMTG was chaired by Sir Richard Barnett, and full membership of the Group is included at **Annex A.**

The 10-15 Year Road Ahead

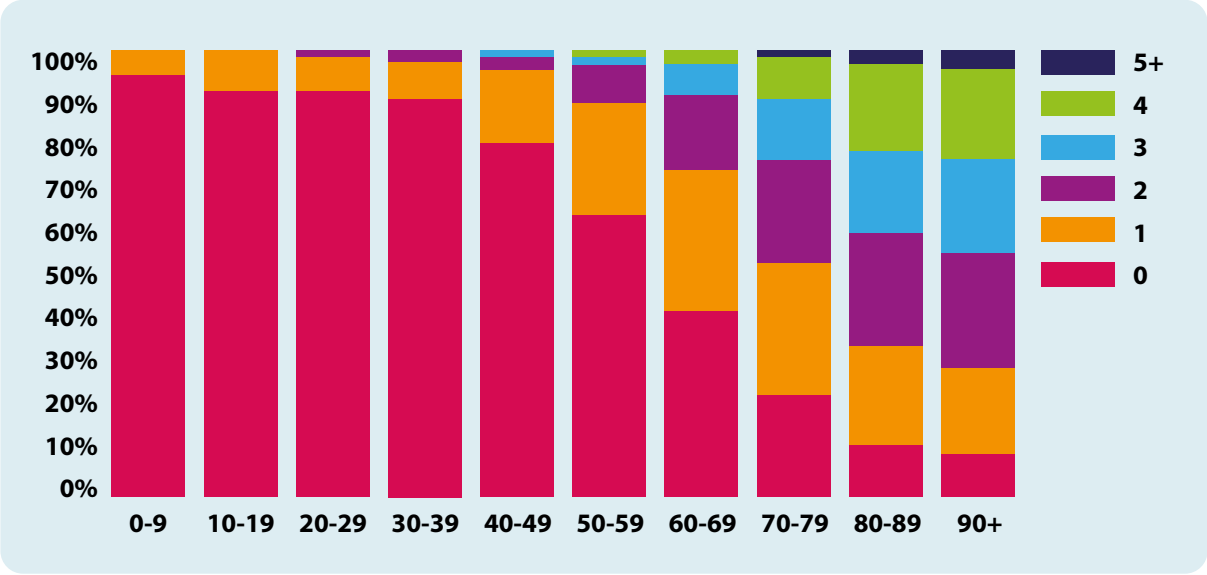
Looking forward over the next 10-15 years, NI like all the other countries of the UK and Ireland is facing a world where demographic realities and the pace of technological and social change will transform the relationship people have with health and social care.

The challenges outlined in **figure 1** will require a systemic, integrated and partnership approach across nursing and midwifery, the wider health and social care system and with the public.

Figure 1 - Reference NI NHS Conferdertion#NICON15

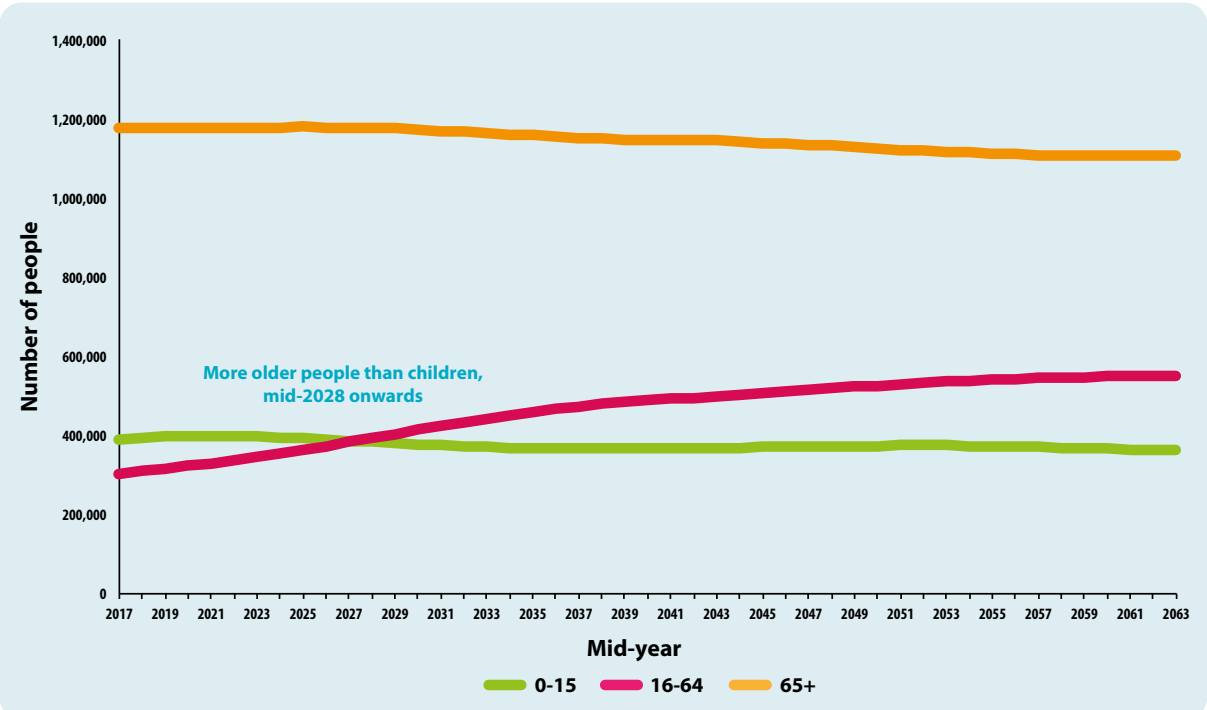
We know demand for services is arising largely as a result of an ageing population, many of who are living with complex needs and long-term conditions **(figure 2)**.

Figure 2 - Percentage of patients in each age band with the indicated number of morbidities



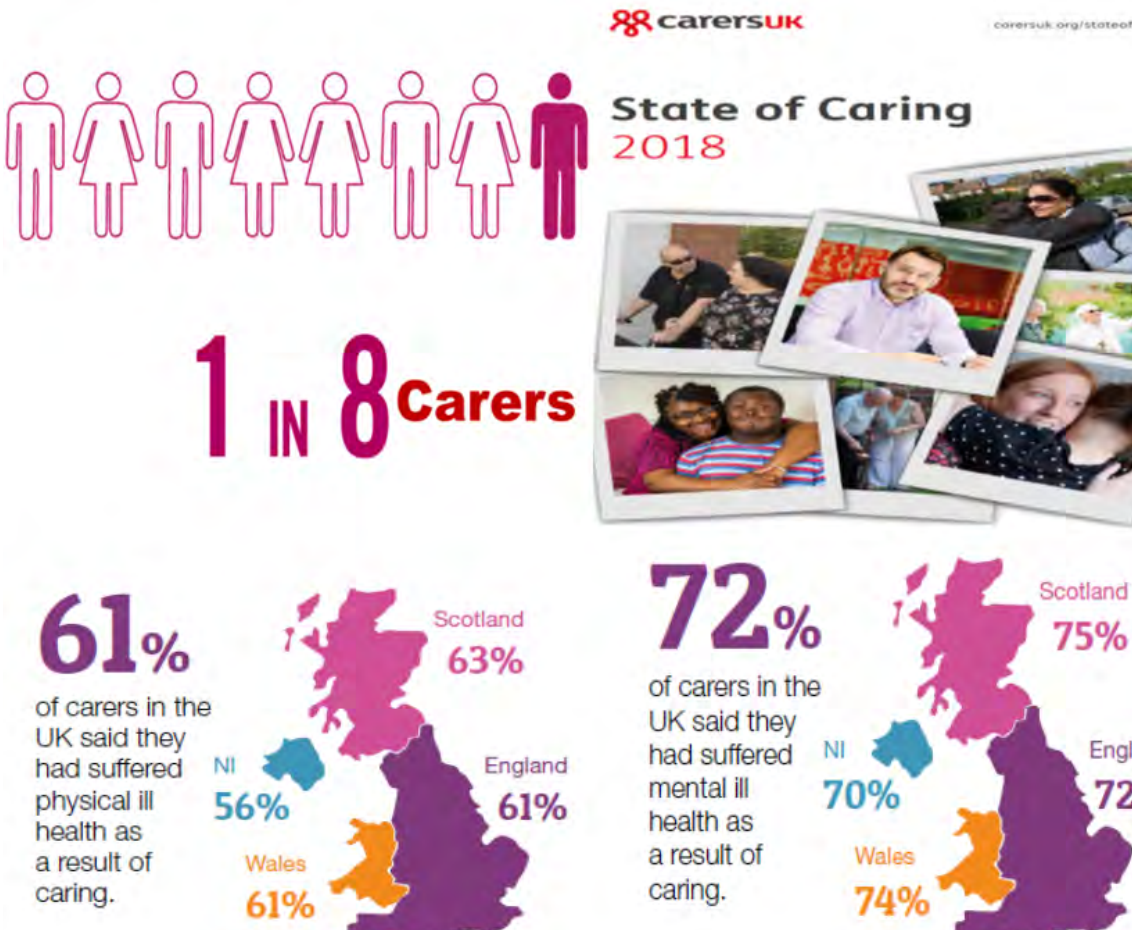
As set out in **figure 3** it is estimated by the year 2028 the population of older people in NI will be greater than the number of children. Indeed by 2023 the number of people over the age of 65 will make up 30% of the population and by 2061 it will grow to 50% of the population. The largest growth in the older person population will be those aged 85+. We also know this means there will be a commensurate rise in co-morbidities.

Figure 3 - Population by age group (mid-2017 to mid-2063)



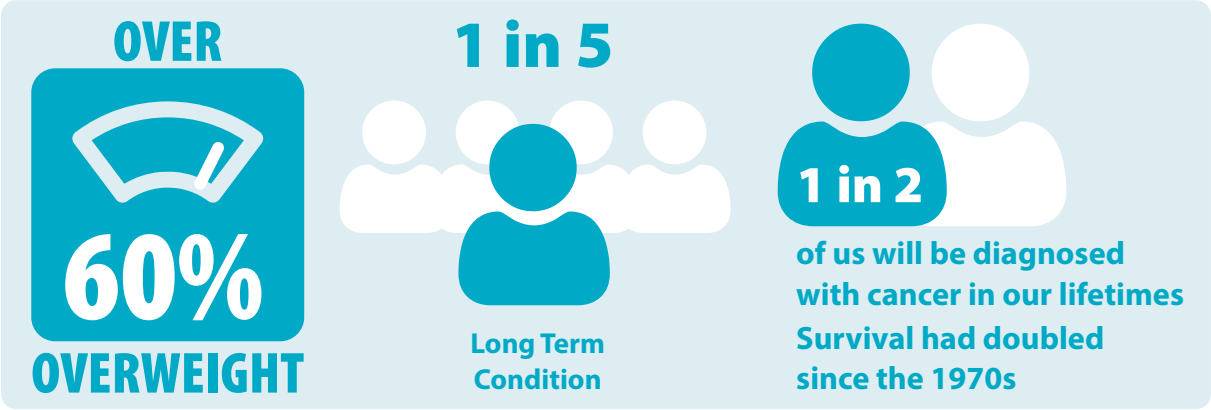
The reality behind these numbers also means that the numbers of people with dementia is estimated to increase from an average of 20,000 to 60,000 by 2051. It is also estimated that 1 in 8 adults are also carers. **(Figure 4)** It is anticipated the number of carers in NI is expected to rise from 220,000 to 400,000 by 2037, meaning that 1 in four adults in NI will be carers. Clearly we are increasingly becoming reliant on older people as informal carers, many who themselves will be vulnerable from poor health. Research by Carers UK (2018) found that in NI 61% of carers experienced poor physical health and 71% had experienced stress and depression as result of their caring role.

Figure 4 - State of Caring



We also know that 1 in 5 of our population now live with a long term condition, 1 in 2 of us will experience cancer and about 60% of us are overweight, this along with sedentary lifestyles and excessive drinking has created additional demand on the health and social care system. **(Figure 5)**

Figure 5 - Picture of Health Needs



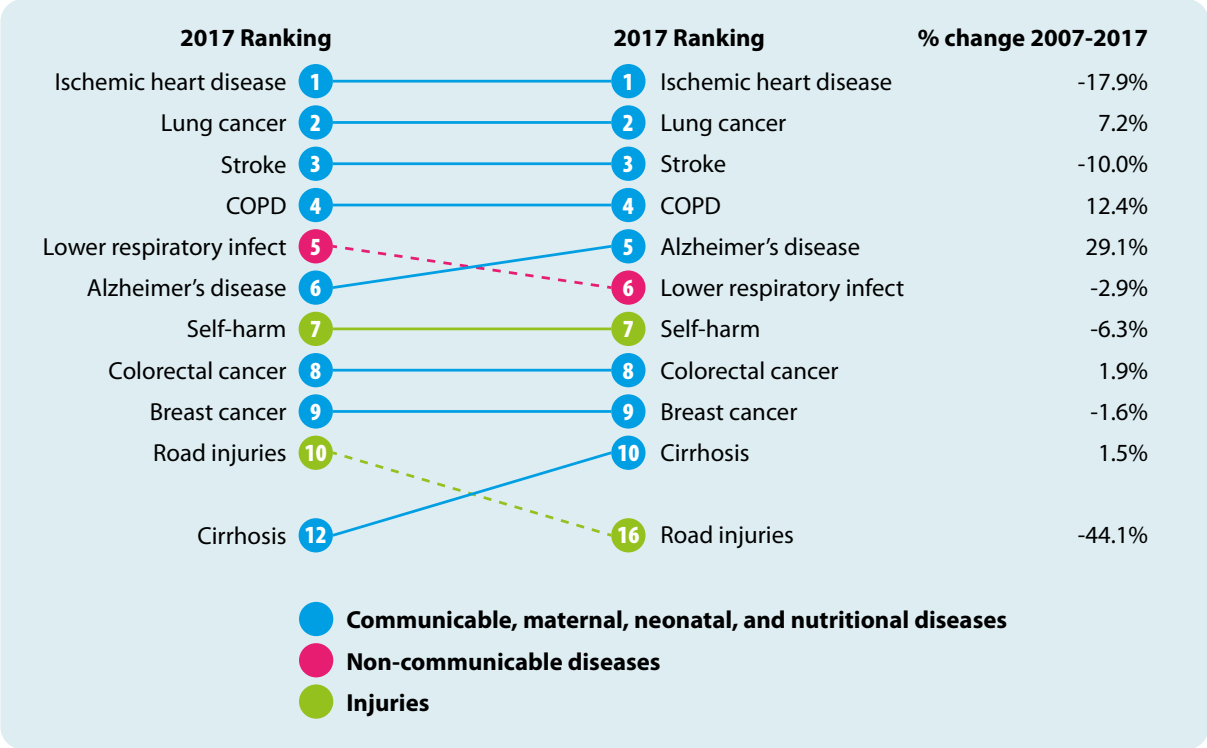
It is also regrettable as set out in **figure 6** that in NI life expectancy remains 7 years less for males and over 4 years less for females in the most deprived areas when compared with the least deprived areas of NI.

Figure 6 - Left Expectancy

Issue	Least Deprived	Most Deprived	Gap
Male Life Expectancy (2012-14)	81.1 years	74.1 years	7.0 Years
Female Life Expectancy (2012-14)	84.1 years	79.7 years	4.4 Years
Male Healthy Life Expectancy (2012-14)	63.4 years	51.2 years	12.2 Years
Female Healthy Life Expectancy (2012-14)	68.0 years	53.4 years	14.6 Years
Alcohol-related Deaths per 100,000 (2010-14)	7.9	33.0	318%
Alcohol-related Admissions per 100,000 (2012/13-2014/15)	318	1,600	403%
Smoking-related Deaths per 100,000 (2010-14)	111	255	129%
Self Harm Admissions to Hospital per 100,000 (2010/11-2014/15)	106	427	302%
Suicide Deaths per 100,000 (2010-14)	9.2	27.2	196%
Preventable Deaths per 100,000 (2010-14)	140	347	148%
Low Birth Weight (2015)	6.1%	7.8%	27%

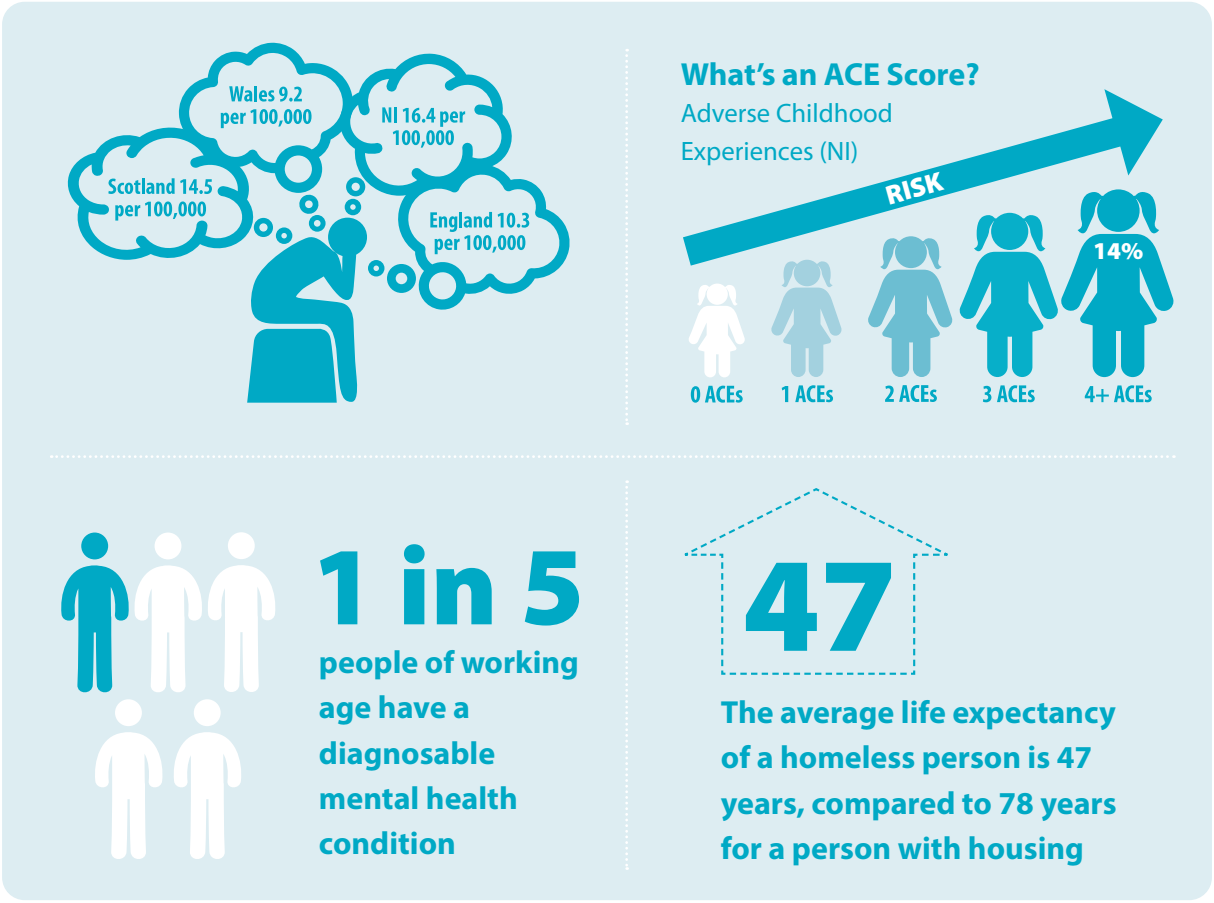
As set out in **figure 7** many of the causes of premature death are preventable through adopting healthier lifestyles.

Figure 7 - What causes the most premature death?



We also know that 1 in 5 **(figure 8)** people in NI will experience mental ill health. For people who experience serious mental ill health, research shows they live shorter lives by some 15- 20 years. Indeed research also shows if you experience homelessness your average life expectancy is 47 years. We know that around about 14% of Children and Young People (CYP) experience four or more Adverse Childhood Experience. Worryingly this means they are more likely to develop serious physical and mental health long term health conditions. This reality inevitably means the robust adoption of a population health approach and the fast tracking of innovation and implementation of evidence in order to prevent ill health, reduce the impact of health and social adversity, and enable people to live well and/or more independently with long term conditions. This means every nurse and midwife will have a critical role to play in promoting health and well-being and working in partnership with individuals, family, and their communities to address the wider social determinants of health.

Figure 8 - Profile of Mental Health Needs



Adopting a population health approach will enable nursing and midwifery to balance the intensive care needs of those in greatest need, with preventative health and social care intervention. This means health care will be driven by the utilisation of digital and data-driven technologies which will not only improve care outcomes but will enable the targeting of resources towards prevention and the early identification of risks.

Emerging and new personalised technologies (wearable devices) will change the way people will monitor and manage their health and will drive the personalisation of care and enable self-management/self-directed care. The expansion of remote care models, such as video consultations and symptom checkers, provided inside and outside the HSC system will also change the nature of the interaction with health care professionals. The advancement in genomics and precision medicine will improve the prevention, management and treatment of disease. Indeed the application of technologies, powered by health data will improve diagnostics, triage, reduce variation and increase efficiencies. Consequently new and emerging enabling technologies will radically change nursing and midwifery practice over the course of the next 10 -15 years. Such innovation unleashes the full potential of nurses and midwives to deliver more expert, personalised, and targeted health and social care in response to the changing demographic needs of the population of NI.

2

THE VALUE OF NURSING AND MIDWIFERY TO GLOBAL HEALTH

SECTION 2 – THE VALUE OF NURSING AND MIDWIFERY TO GLOBAL HEALTH

The value of nursing and midwifery is almost inestimable. Nurses and midwives make up nearly half of the global health workforce, with around 20 million nurses and 2 million midwives worldwide. Working in a wide variety of roles and in many different contexts, nurses are often the first and only health professionals people see for their health-care needs. Nursing and Midwifery is essential to meeting the challenges posed by demographic changes and rising health-care demands.[5] Also, nurses and midwives have a central role in universal health coverage (UHC). Nurse-led clinics could allow rapid and cost-effective expansion of services for non-communicable diseases, ANPs and Nurse Specialists could strengthen primary care, and nurses and midwives could be at the forefront of public health promotion and prevention campaigns and interventions.

It is within this context that nurses and midwives play a critical role in building communities that are resilient and capable of managing and responding to their own healthcare needs[6]. This is dependent upon a workforce which is both available and accessible to all. The professions of nursing and midwifery act as enablers to service delivery and many notable achievements have been made in this area. As the largest professional workforce they have the ability to transform how healthcare is both organised and delivered. It is important that nursing and midwifery is seen as a system asset and that policy makers and health and social care planners seek to optimise the potential that exists within the nursing and midwifery professions in order to improve the health of the population. This can be best achieved through evidence based policy development, effective collective leadership, strong professional governance and management.

In the United Kingdom, the nursing and midwifery workforce continues to develop practice and services, embracing new and emerging evidence to adapt to the changing environment and population needs. Change includes responding to an increasing complexity of care within differing models of service delivery, where safety, quality and service user experience are fundamental principles of professional practice[7]. As a result, significant gains have been made in increasing life expectancy and reducing many of the risk factors associated with mortality[8]. Crucially nursing and midwifery has a significant role particularly in the earlier years to address the wider social determinant of health.

In the words of Professor Marmot *"**Nurses are the most trusted group of people. Rightly so. Nurses and midwives treat individuals with compassion and care, and have great potential to improve the health of communities, through action on the social determinants of health."***

Recent inquiry has sought to define the economic value and impact of nursing and midwifery to society whilst recognising the challenges of providing such evidence, where value to the individual citizen is more often related to intangible psychological and emotional benefits that are difficult to measure quantitatively[9].

Studies globally from 2009 – 2011[10] have demonstrated that nurse staffing and missed care were significantly associated with increased mortality rates. A systematic review of these studies in 2016 asserted that the evidence points towards a higher proportion of registered nurses being associated with the most cost effective approach to provision of healthcare, when a wider consideration of societal benefits, such as averted lost productivity, could provide a substantial potential net economic benefit[11].

The World Health Organisation (WHO) Global Strategy on Human Resources for Health sets out an overwhelming case for robust workforce planning, investment in education and providing an environment conducive to the delivery of safe high quality health care. There is a clear alignment with *Health and Wellbeing 2026: Delivering Together* and the Health and Social Care (HSC) Workforce Strategy[12]. Whilst there are ongoing healthcare challenges presented by shortages of available workforces, addressing the health of a population should ensure healthcare resources are employed and deployed strategically. The report[13] argues for a "contemporary agenda with an unprecedented level of ambition. Better alignment to population needs, while improving cost-effectiveness depends on recognition that integrated and people-centred healthcare services can benefit from team-based care at the primary level". WHO asserts that a reshaped and transformative agenda through policy should provide a different type of healthcare worker with attention to expanded practice that enables appropriate utilisation of the workforce. The nursing scope of practice is highlighted as one which is flexible to populations and patient health needs, and has been particularly successful in delivering services to the most vulnerable and hard-to-reach populations[14].

Similarly, the midwifery scope of practice has the potential to provide 87% of the essential care needed for sexual, reproductive, maternal and newborn health services[15]. The 2014 Lancet series on the contribution of midwifery demonstrated the substantial health and wellbeing benefits for women, mothers and their infants when high-quality midwifery care was delivered[16]. The series recognised that the generation of further evidence of economic value was required; however that which existed established that midwifery care provided by educated and regulated practitioners was cost-effective, the return on investment similar to the cost per death averted for vaccination programmes.

Midwives make a critically important contribution to the quality and safety of maternity care providing skilled, knowledgeable, respectful and compassionate care for all women, newborn infants and their families. Their work is across the continuum from pre-pregnancy, pregnancy, labour and birth, postpartum and the early weeks of life including the woman's future reproductive health wellbeing and choices, as well as very early child development and the parent's transition to parenthood. The midwife is central to high quality maternity care, and the principle that 'all women need a midwife and some need a doctor too' is widely accepted.

Policies are in place with the aim of promoting woman centred care, continuity of care, greater choice of place and type of birth, reduction of unnecessary interventions, reduction of inequalities and improving safety. Recent policy on early years also underlines the importance of high quality maternity services.

Midwifery led settings are a cost-effective alternative to the prevailing model of obstetric led settings, increasing the agency of both women and midwives. A substantial body of evidence now exists to show that care provided by midwives in a continuity of care model, where the midwife is the lead professional in the planning, organisation and delivery of care throughout pregnancy, birth and postpartum period, contributes to high quality safe care. The recent Cochrane review (2016) has demonstrated that this model of care is associated with significant benefits for mothers and babies and has no identified adverse effects. Women experiencing this model of care are less likely to have an epidural, amniotomy or episiotomy; instrumental birth; have a premature birth; or experience fetal loss. They are more likely to have a spontaneous vaginal birth; to know the midwife who looks after them during labour and birth; express satisfaction with information, advice, explanation, preparation for childbirth and women who find services hard to access (due to social complexity), particularly value midwifery continuity of care.

A future leadership imperative is to continue to define and evidence the impact that the nursing and midwifery professions have on population health outcomes, developing and aligning service provision where the best use of registrant expertise is demonstrated.

3

THE AMBITION

SECTION 3 – THE AMBITION

Nurses and midwives already make a significant contribution across the lifespan in partnering and empowering the people of NI to:-

- Enjoy healthy active lives,
- Recover, from ill health and in promoting self-management for those with pre-existing /long term conditions.
- Make person centred choices through effective end of life care.

This provides a crucial foundation on which to maximise the future contribution of nurses and midwives over the next 15 years. **Figure 9**: **Maximising the Contribution of Nurses and Midwives** below presents a strategic map of the future direction that will maximise the positive contribution of nursing and midwifery across health and social care.

Figure 9: Maximising the Contribution of Nurses and Midwives

We Enjoy Long Healthy Active Lives

The health aspiration outlined in the Executive's Draft Programme for Government (PfG) was the outcome ***'we enjoy long, healthy, active lives'.*** *Health and Wellbeing 2026: Delivering Together* outlined an ambitious roadmap reflecting the quadruple aim. In order to maximise the contribution of nurses and midwives, a part of that ambition is to strengthen the development of the professions that leads to every nurse and midwife understanding the importance of, and contributing to, public health approaches across the life course. Across all services and levels nurses and midwives will lead and contribute to understanding the needs of the population they serve, proactively co-designing solutions that prevent avoidable illness and improve health and social well-being outcomes based on population profiling and needs stratification.

Right Number of Nurses and Midwives with Right Skills, Doing Right Thing, At Right Times, In Right Places working in partnership and across boundaries

This ambition requires the development of knowledge, skills and abilities, to equip nurses and midwives to improve population outcomes. Central to this is the reform of nursing and midwifery education at pre-registration and post-registration levels including the intent to strengthen apprenticeship approaches and development of graduate entry models. A further enabler is the establishment of core standards for staffing levels across all midwifery and nursing services to ensure the right number of nurses and midwives are doing the right thing, in the right place, at the right time. Furthermore, this ambition can only be realised through the development of significant nursing and midwifery leaders for the future.

Person centred practice that enables health and wellbeing, preventative and early intervention, recovery, self-management, and end of life care

Visible leadership which is person-centred in word and deed, is central to the ambition and requires a commitment to a core set of values reflected in the practice of nurses and midwives at all levels from frontline to boardroom positions and across a range of career pathways. This approach recognises the need for collective leadership across education, practice, research and policy careers to support the future provision of person-centred health and social care.

Enabling people to make healthy choices and live well

Through the development of the nursing and midwifery workforce, the people of NI, irrespective of their age, personal circumstances and health status, will be enabled to make healthy choices and live well:

across their life course

whilst managing chronic and long term conditions

through acute and episodic care and treatment

and at the end of life

Delivering population, person and family centred outcome focussed care in the most appropriate setting

The ambition takes account of the vision for health and social care within NI which is to deliver world class health and social care services that are a safe and sustainable way to meet the challenges of a 21st century population. It recognises the challenges of achieving person-centred outcomes in the context of shared decision making and complexity of care delivery across diverse care environments.

In summary, this ambition will enable us to deliver person centred outcomes for patients, people, families, carers and staff which are aligned to the quadruple aim: improving the health of our people, ensuring sustainability of services, improving the quality and experience of care and supporting and empowering our staff.

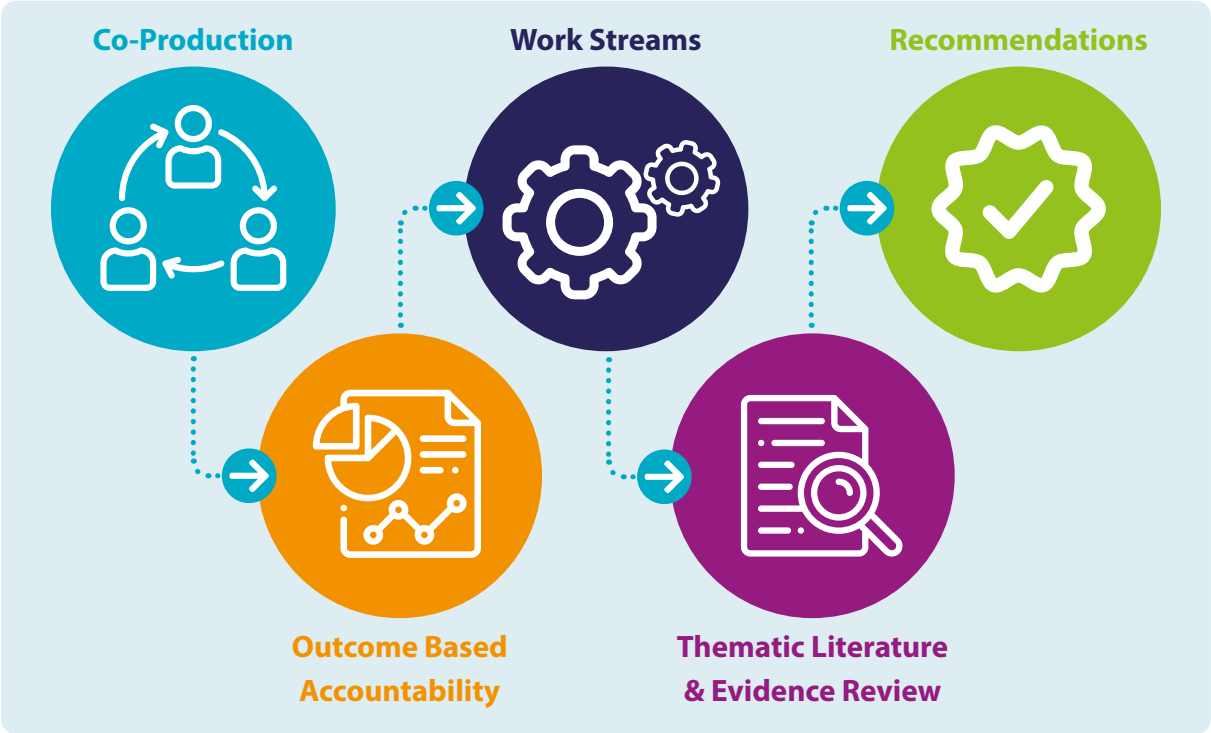
4

THE APPROACH

SECTION 4 – THE APPROACH

The core aim of the NMTG, as previously stated, was to develop a roadmap which would provide direction in achieving world class nursing and midwifery services in a reconfigured HSC over the next 10-15 years. The work of the Task Group was shaped by adopting a population health, evidenced based outcomes and life span approach. The approach has been shaped by the NMC Code of Conduct, NMC Future Nurse Proficiency Standards, NMC Education Standard's and UK CNO Enabling Professionalism. The work involved five key strands as outlined in **figure 10**, below.

Figure 10: Overview of the Approach



In order to create ownership across the midwifery and the nursing family a Co-Production model was adopted. This involved engaging midwives and nurses at all levels and across a wide range of services and settings, who through their engagement have contributed to the recommendations of this report.

In line with the Draft PfG, engagement events were modelled on the Outcomes Based Accountability (OBA) approach. This approach focuses on high level outcomes as the starting point of work rather than the end product, and works towards agreeing actions to achieve these outcomes. OBA supports a long term vision, allowing the Task Group to look ahead to the contribution of nursing and midwifery to population outcomes over the next 10-15 years.

As part of the OBA approach, three core workstreams were established to assist in the formulation of the recommendations in this report. These work streams were: nursing and midwifery workforce, long term conditions and population health presented in **figure 11**, below. This was achieved through group discussions that focused on:-

1. Lived and worked experience of staff.
2. Evidence of what works
3. What needs to change in order to deliver better outcomes?
4. How would we recognise success?

Across the three work-streams, the NMTG hosted over 36 events and had almost 1,000 participants from all branches of nursing and from midwifery, including independent sectors. Other professions also contributed to the work.

Figure 11: Overview of Nursing and Midwifery Group Attendee

	Worksteams	Number of Meetings	Ave Number of People Attending	Total
Stable Teams	3	8	25	200
Long Term Cond	3	9	25	225
Population Health	3	9	25	225
Learning Disability	1	1	25	25
Cancer Nurses Network	1	1	25	25
NIPEC Event	1	1	100	100
Practice Nurses	1	1	20	20
Mental Health Nurses	1	5	25	125
Leadership event	1	1	25	25
Total	15	36	32	970

- Estimated number of participants, calculated on basis on min 3 works streams 3 events per theme by average of 25 people attending)

Figure 12: Overview of Work Streams

Workforce

This workstream focused on four core areas: building and sustaining safe stable teams; the scale of the workforce focusing particularly on the numbers of pre and post registration nurses and midwives; exploration of evidence based options for the further development and/or introduction of new nursing and midwifery roles in order to improve outcomes; and the depth and breadth of nursing and midwifery leadership. Data in respect of workforce were drawn from the DoH Workforce Policy branch, and also from other work streams where workforce featured as part of discussion.

Long Term Conditions

This workstream focused on identifying the contribution of nursing across primary, community, acute and specialist nursing, and midwifery services. To do this a number of long term conditions were chosen to explore how the contribution of nursing and midwifery could be maximised, which included frailty, diabetes and respiratory conditions. These conditions ranked the top for admissions to acute care and their prevalence in primary care and for diabetes and respiratory conditions, their impact on pregnancy and the baby. In addition, two further sources of information were included: the findings from a review into the role of Mental Health Nursing commissioned by the CNO; and the findings from a focus group discussion with Learning Disability nursing.

Population Health

In light of the overall aim, population health was the third work stream. Having analysed data relating to key public health concerns, this workstream focused on healthy weight, mental health and emotional wellbeing and public health approaches in nursing and midwifery.

Data from the three work streams was collated and thematically analysed to draw out key areas that were further explored in the context of the existing evidence base. This resulted in nine themes which are presented in Section 7, page 81 and formed the foundation for the development of the recommendations outlined at page 85.

The final stage in the approach was the development and drafting of the report. This was an iterative process undertaken by a sub group of the NMTG and involved external expert review.

5

THE CURRENT PICTURE

SECTION 5: THE CURRENT PICTURE

Collectively the registered nurses, midwives and aligned support staff are the largest professional group in the HSC workforce, accounting for 34.4% of the total number of staff[17]. In this report we have presented evidence emphasising the value of nursing and midwifery. Within a challenging current context that often mitigates against the professions maximising their contribution. Nurses and midwives consistently demonstrate their contribution to the health and wellbeing of the population in NI, leading the way in delivering high quality, innovative person-centred care, contributing to the strategic objectives of transformation and co-production.

This section highlights some examples of nursing and midwifery practice excellence across NI, whilst contrasting some of the challenges for the current workforce.

Transformation of Nursing and Midwifery Service

Since the launch of *Health and Wellbeing 2026: Delivering Together* the Department has made significant investment in a wide range of nursing and midwifery services with over £50 million invested in three key critical areas:-

1. Workforce Stabilisation

An additional investment of £7 million undergraduate education has enabled the highest number (1025) of nursing and midwifery training places commissioned in NI 2019/20. This represents an increase of 45% from 2015/16 and demonstrated the Department's commitment to addressing the current shortages and growing our local nursing and midwifery workforce.

In 2016 the Department embarked on a regional International Nursing recruitment campaign with the aim of bringing 622 overseas nurses by November 2020 to strengthen the local HSC workforce. Transformation investment into the CEC has supported overseas nurses to meet the essential registration requirements to practice as a nurse in the U.K

The Department launched its Delivering Care Policy (safe staffing) and has commissioned to date nine discreet phases which has resulted in an investment of over £15.2M.

2. Workforce Development

The post registration transformation investment of over £7.7 Million has delivered significant educational opportunities for the nursing and midwifery professions, benefiting 1,965 participants over the last two years. Investment has enabled a wide range of programmes to be funded to build the clinical expertise and leadership capacity within the workforce. The investment has supported the strategic direction with a focus on community specialist practice programmes such as District Nursing, Health Visiting and School Nursing. Investment in the development of ANP roles in Primary Care, Emergency Care and Children's Nursing has been a significant achievement with the first Masters level ANP programme delivered in NI. A range of other programmes, including bespoke quality improvement and leadership initiatives have been funded across mental health, learning disability, adult, children services and midwifery. Furthermore, investment has facilitated an innovative post registration Nursing Masters programme for NI, designed to develop leadership skills in new nurses and support workforce retention. Additionally, transformation investment in a regional nursing and midwifery data transformation project is assisting the professions with implementing electronic record keeping and digitalisation.

3. Service Developments and Reforms

The Department has also invested £18M in nursing service developments across the life span. This has resulted in additional Health Visitors that has enabled a new ratio of 1 Health Visitor to every 180 children. In addition a District Nursing Framework 2018-2026 was launched that has been designed to enable the delivery of 24 hour district nursing care no matter where you live. This has also enabled a new ratio of 8-10 Whole Time Equivalent per 10,000 of the population. Through the establishment of Multi-Disciplinary Teams (MDTs) there has been additional investment in a Neighbourhood Nursing teams and in ANP within Primary Care Teams.

Examples of Nursing Improvement and Transformation

Across HSC Trusts nurses and midwives have been leading innovation and improvement across services. Examples include:

- A programme of work to prevent hospital admission for patients accommodated in a nursing home with a range of complex needs, including dementia, physical disability, and both chronic and terminal illness. A registered nurse worked with patients, relatives, staff, local GPs, allied health professionals, rapid response team and care managers to develop advanced care pathways. This initiative resulted in a significant reduction in decisions to admit patients from the nursing home to hospital.

- A donor transplant nurse having realised the number of kidneys transplanted from live donors was much lower in NI than the rest of the UK, embarked on a mission to streamline the process and worked with other colleagues to reduce the assessment time from two years to a one-day process. In doing so she has made it easier for people who wish to donate a kidney, improved the quality of life for patients, and ultimately saved lives.
- The first community-based fully integrated child and adolescent mental health service (CAMHS) for young people with intellectual disability established specialist teams within CAMHS, providing early intervention and holistic bio-psychosocial assessment through to high intensity intervention. This has improved referral pathways, the delivery of effective interventions, risk management, reduced the use of psychotropic medication and has demonstrated high levels of service user satisfaction.
- A telephone follow-up aftercare service for people who were being treated for head and neck cancer providing education and support for people and their families/ carers, empowered individuals to develop skills and confidence for self-surveillance and facilitated fast tracking to follow up services. This created a patient-led follow up service and reduced the requirement for a routine appointment follow up service.
- A pioneering nurse led initiative that provides treatment and care for patients who require intravenous therapies such as blood transfusions and intravenous antibiotics, now enables patients who would normally have been treated in an in-patient unit or out-patient department of major acute hospitals to be treated in their local communities.

Workforce Trends

The midwifery and nursing workforce make up approximately 34% of the health and social care workforce, making it the largest single professional group. Crucially midwifery and nursing are the backbone of health care and are therefore central to leading and delivering transformation across the entire life-course and across the health and social care system.

Currently the picture across health and social care is one of high vacancy and pressured work environments - registered nurse vacancy levels ranging from 8-10 %[18]. The shortfall of nurses and midwives in NI and across the UK, is reflective of the global position. The WHO predicts that by 2030 the global nursing deficit will be 7.6 million[19]**.** In a predominantly female profession, high levels of maternity leave is an ongoing workforce challenge, compounded by a shortage of available nurses and midwives to cover temporary posts. Consequently, heavy reliance on bank and agency support to maintain safe staffing levels has resulted in spiralling costs that could be invested more productively to benefit the workforce. High vacancy and pressured environments have consequently led to climbing sickness absence rates in the nursing and midwifery professions, **figure 13**.

Figure 13 - Health & Social Care Staff by Occupational Family (% WTE), March 2018

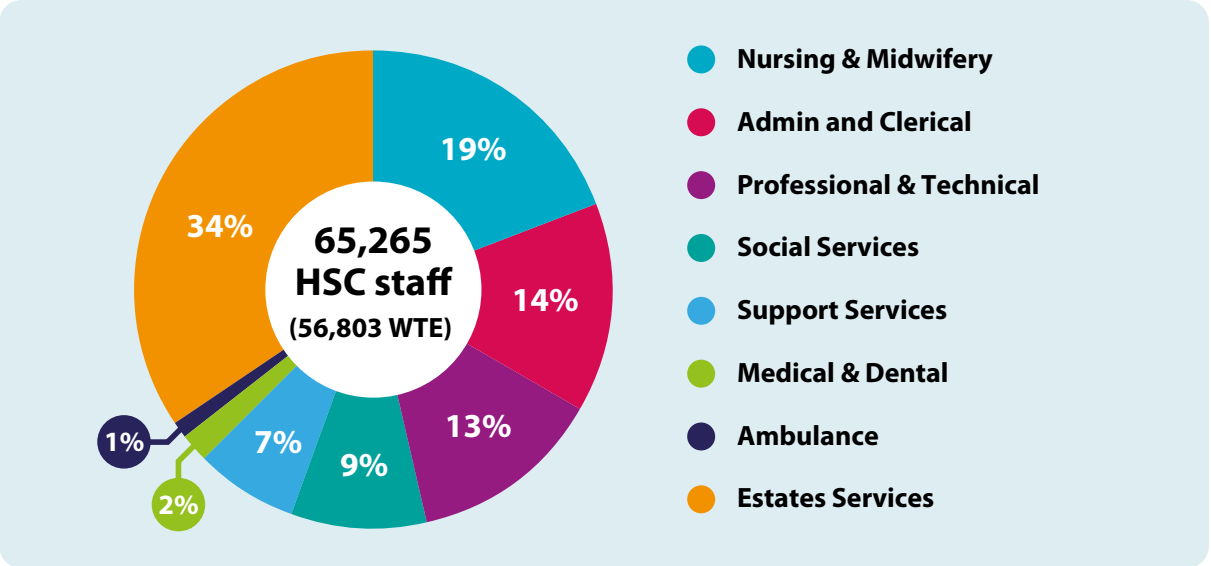
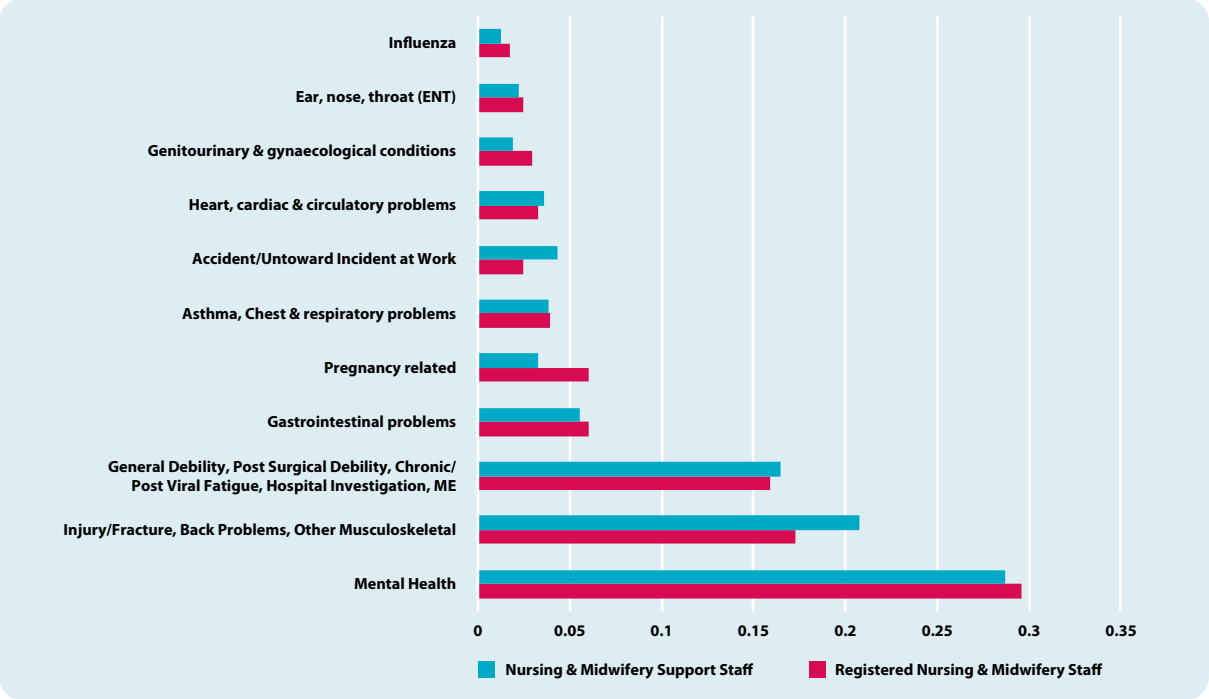


Figure 14 - Proportion of HSC Sickness Absence Hours Lost by Top 12 Absence Categories - 2018/19



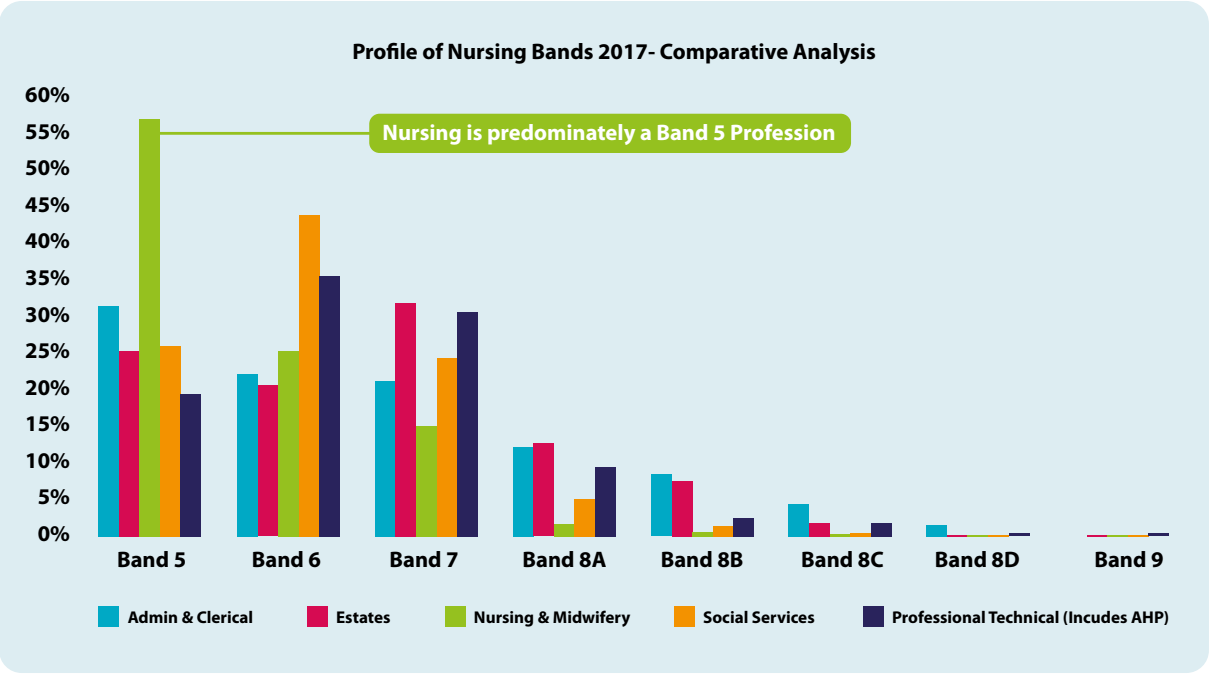
Between March 2016 and March 2017 the NMC reported a significant reduction in registrants[20]. The NMC surveyed those people who had left the register between June 2016 and May 2017. 4,544 former registrants responded citing working conditions as the top reason for leaving (44%). During the period 2008 to 2017 the nursing and midwifery workforce in NI increased by 7.8%. This has not kept pace with the increasing demand however, nor has it aligned with other professional groups.

Career Progression for Nurses and Midwives

The majority of health and social care professionals, with the exception of medicine, once graduated and registered with their regulatory body take up employment within the HSC enter the Agenda for Change (AfC) Pay Structure in Band 5 posts. Progression from the bottom of the pay band to the top of the pay band takes at least 7 years. HSC staff in NI have not received any pay uplift for 2017/2018. They are currently paid 1% less than National Health Service (NHS) staff in England and 2% less than Scotland. NHS staff in England have just accepted a pay deal that will see all staff at the top of each pay band receive a minimum of a 6.5% increase in pay over 3 years[21]. The pay structure is being simplified and the number of pay points are being reduced enabling staff to reach the top rate in each pay band sooner. NHS staff in Scotland are to receive 9% increase over three years and Wales are still in pay negotiations. The gap between NHS pay in NI and pay in the rest of UK is growing, making it difficult to recruit and retain an increasingly mobile workforce.

Furthermore, a higher percentage of roles carried out by registered nurses and midwives within the HSC are in lower pay bands than that of social services or professional technical. Over half of the qualified nursing workforce (56.8%) are in the lowest pay band (Band 5) and there are consistently lower percentages of registered nurse or midwife posts than social services or professional technical posts, across pay bands 6, 7, 8a. 8b, 8c and 8d as presented in **figure 15.** This pattern is also repeated in nursing and midwifery support posts across AfC Bands 1-4.

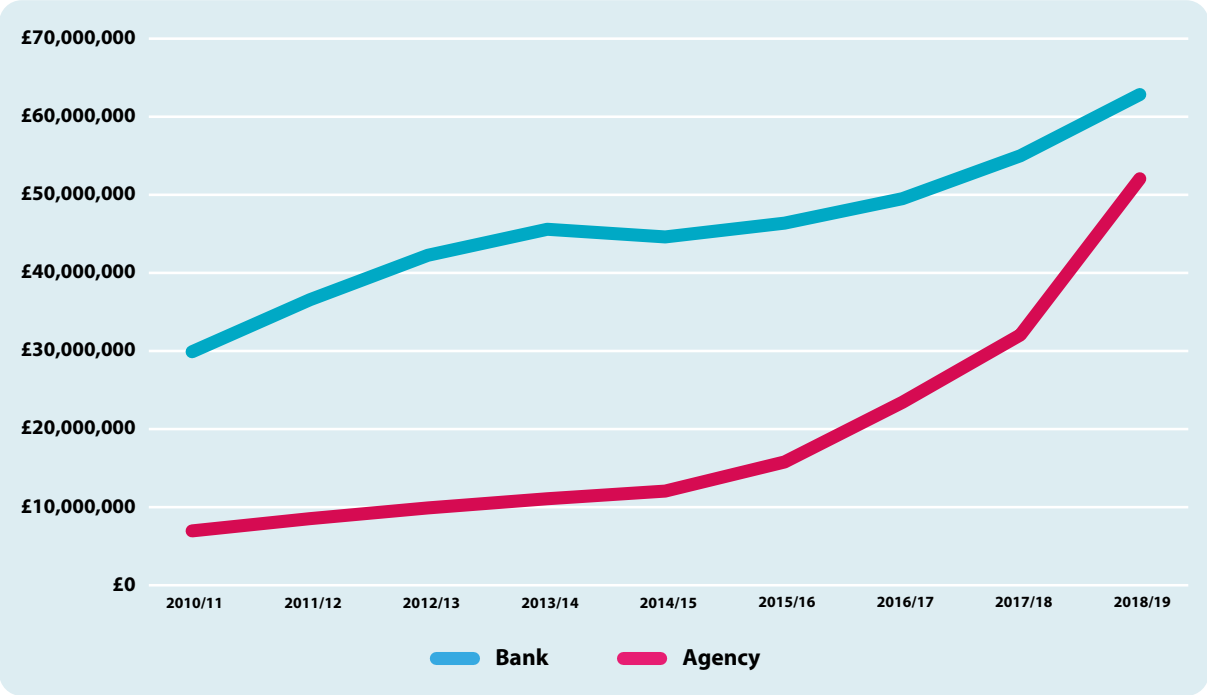
Figure 15 - Whole Time equivalent and % NI HSC Staff by Occupational Family & Pay Band 5-9 (March 17)



Impact on Nurses and Midwives

Within HSC organisations, the percentage of scheduled hours lost in the 2016/17 year due to sickness absence was around 6.6% and accounted for over £100 million[22] with mental ill health accounting for 30% of hours lost. HSC Staff surveys carried out in 2009[23], 2012[24] and 2015[25] report over 70% of nursing and midwifery staff working more than their contracted hours, with surveys consistently presenting increasing numbers of unpaid hours worked each week (59% working 1-5 hours, 13% 6-10 hours and 5% over 10 hours in 2015). The Royal College of Nursing (RCN)[26] reported that in 2017, shifts with one or more bank or agency nurse working was highest in NI cited at 50% compared with 45% in England, 40% in Wales and 38% in Scotland. A significant number of nursing staff respondents from NI (56%), also reported that they were unable to take sufficient breaks. **Figure 16** demonstrates a comparison between rising bank and agency costs across the nursing and midwifery workforce.

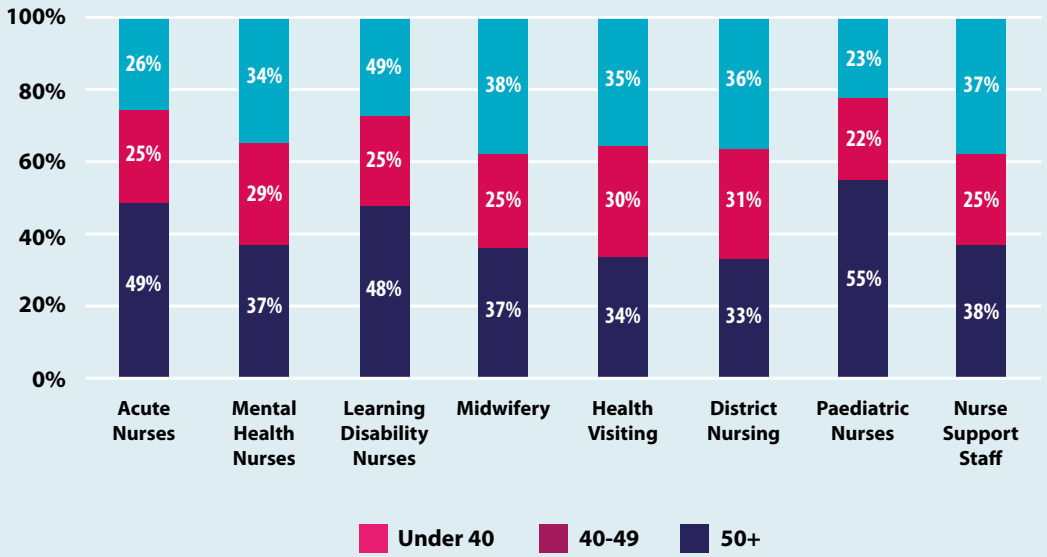
Figure 16 - Expenditure on Nursing & Midwifery bank and agency staff



In Source for **figure 16:** HRPTS. Figures exclude bank staff and staff on career breaks. 2010/2011 the HSC spent a total of £9,852,129 funding agency shifts across the service in NI. This has risen over the last 9 years to £51M in 2018/2019. Bank costs have also doubled from £30M in 2010/11 to £61M 2018/19. Clearly this is very concerning not only in cost terms but also its impact on the stability of the workforce.

The RCN reports that (across the 4 countries) that 65% of nursing staff are working on average almost one hour extra, of which 93% were not paid for. For nursing staff working outside the NHS across the UK this figure was 76%. This was highest in NI where 69% of respondents reported working additional unpaid time.

Figure 17 - Nursing and Midwifery Staff by Age Group (5 Head count) March 2018 Census



Furthermore as set out in **figure 17** over 32% of the Nursing and Midwifery workforce are over the age of 50, clearly this has significant implications for workforce planning and reinforces the need to raise the number of undergraduate places over the next five years to not only address current vacancies, but also to address potential retirements. There is therefore a need to develop a dynamic workforce model, which factors in need, demand, complexity, work-pattern flexibility, safe staffing, new ways of working, and staff leavers, in order to predict the number of nurses and midwifes in the next 5-10 years.

In summary, this paints a picture of a registered workforce under pressure and presents a compelling case for change in order to maximise the contribution of nursing and midwifery to improve the health of the population of NI.

Nursing and Midwifery in the Wider Context

Nurses and midwives are central to care and service provision for people with actual or potential health and social care problems across a range settings. As set out in **figure 17** nursing and midwifery has a long tradition of being an outward looking profession. Nurses and midwives have always proactively worked with other professionals (Doctors, Social Workers, AHPs) to deliver an integrated experience of care and improved outcomes. Within the context of *Health and Wellbeing 2026: Delivering Together* integrated working between professionals and across professional boundaries is an essential requirement for the transformation and the delivery of safe effective care.

As all professions examine, reform and transform their practice models, it is crucial as outlined in the Workforce Strategy that multi-professional and interdisciplinary practice adapts in response to our population needs. Whilst this means each profession must understand and respect the unique contribution of each other. It also creates opportunities to work together to develop new ways of working, for knowledge sharing and for the blending of skills (integrative practice models) across services and professions. Over the course of the next ten years nurses and midwives will play both core and enhanced roles in public health, primary care, acute, community and specialist care service. Therefore within the context of the HSC Collective Leadership Strategy (2017), nurses and midwives will take collective ownership for population health outcomes and in so doing will ensure that their distinct knowledge and skills complement the roles of other professions.

Promoting social justice is one of the foundational values of nursing and midwifery. Nurses and midwives are committed, therefore, at an individual, family and community level to work with others to address the health and social inequalities to improve outcomes among different population groups. This requires nurses and midwives to share responsibility for safeguarding, advocating and promoting the human rights for vulnerable people. Through strengthening community development approaches within nursing and midwifery, this will not only augment community planning approaches, but will create real opportunities for the development of assets, people and community based approaches to

health and social care reform. In so doing nurses and midwives make a positive partnership based contribution to creating the conditions for:-

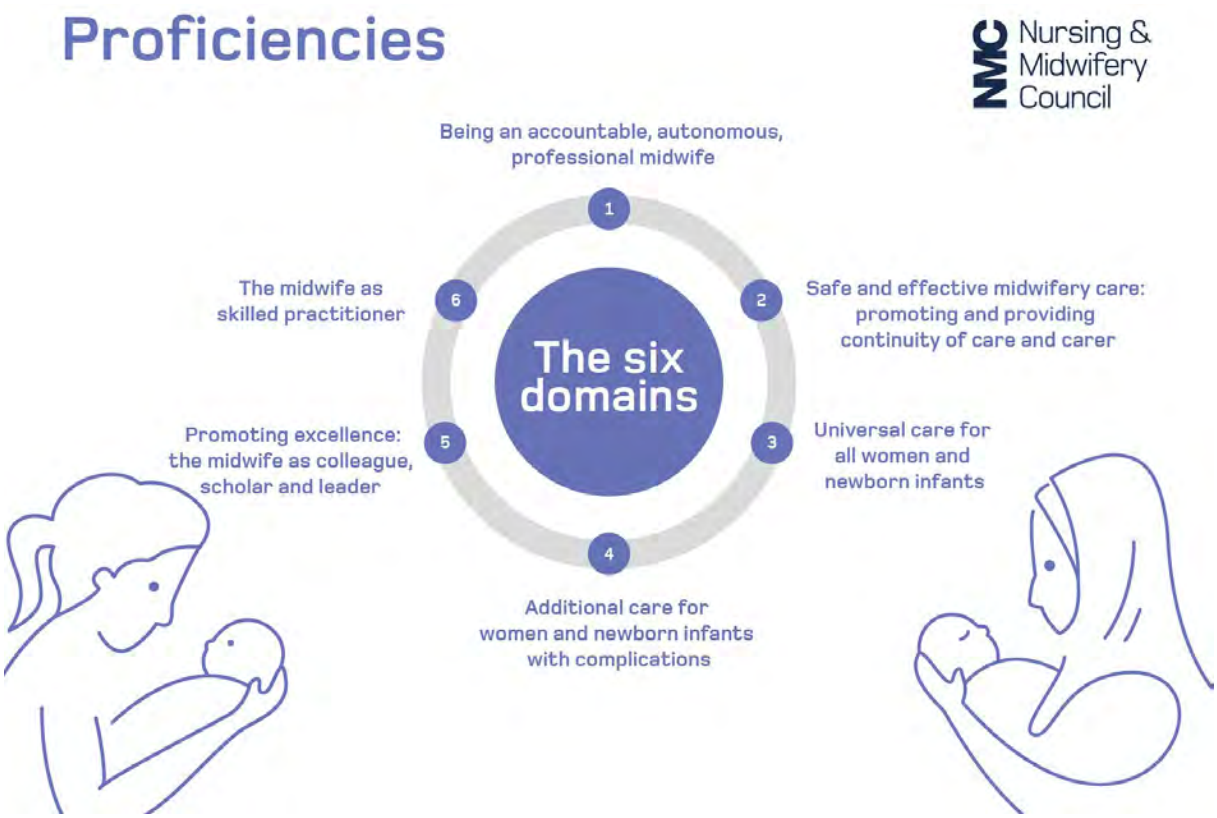
- a more equal society (PfG Outcome 3)
- people to *lead long, healthy and active lives* (PfG Outcome)
- a collaborative approach across sectors where we care for others and we help those in need (Progamme for Government Outcome 8)
- the delivery of high quality public services (PfG Outcome 11)
- Our children and young people the best start in life. (PfG Outcome 14)

Midwifery vignettes

In 2018 Lagan Valley Midwifery Led Unit (MLU) was named 'Best Maternity Unit' at the NI Positive Birth Conference. This is a Free Standing Midwife Led Unit (FMU) which promotes a positive childbirth philosophy and a calm and relaxing atmosphere. The midwives provide a fully integrated service caring for women in pregnancy, birth and beyond and the team is well established in the local community. In the previous year 92% of women who attended Lagan Valley MLU had a normal birth, 37% of these births were in water. The transfer rate to local Obstetric Units is 13%, subsequently 87% of women who start their labours in Lagan Valley MLU give birth there without the need for transfer. This reflects findings from the Birthplace UK study (2011).

The Belfast HSC Trust appointed a Specialist Midwife for Social Complexity and Perinatal Mental Health to increase the level of support and improve the coordination of care across the maternity and neonatal service. The role provides support to vulnerable mothers in pregnancy improving antenatal care services for these women, signposting and referring to appropriate agencies and services in order to enhance health, wellbeing and parenting preparation. This can reduce the associated risks including, the incidence of growth restricted babies; neonatal unit admissions due to drug/alcohol withdrawal symptoms; feeding problems; the associated increased incidence of intrauterine death and Sudden Infant Deaths amongst this group; adverse emotional behavioural and development outcomes associated with disturbed bonding processes with a vulnerable mother.

Future midwives in Northern Ireland will be educated to achieve the proficiencies illustrated below



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6

SHAPING THE FUTURE

SECTION 6: SHAPING THE FUTURE

Throughout the engagement process, a large amount of rich information was gathered from the perspective of nurses, midwives and support staff working at different levels from a wide range of sectors. Review of this information has generated nine themes that are presented in **figure 18**, below. This section will describe each theme and sub-themes within, highlighting the key messages and ideas articulated by workshop participants. The data gathered within the nine themes in a common structure are:

- ***Where We Are Now*** – providing a summary of strategic context and direction for the theme
- ***What We Heard*** – providing summary detail of the messages from staff and stakeholders who attended the workshops
- ***Where We Need to Be*** – providing a summary of the vision for the theme articulated by staff and stakeholders who attended the workshops

Each theme concludes with a summary of key messages that have informed the development of the recommendations for the Minister for Health, presented in Section 7.

Figure 18: Nine Themes from Engagement Events

Championing Person-centredness

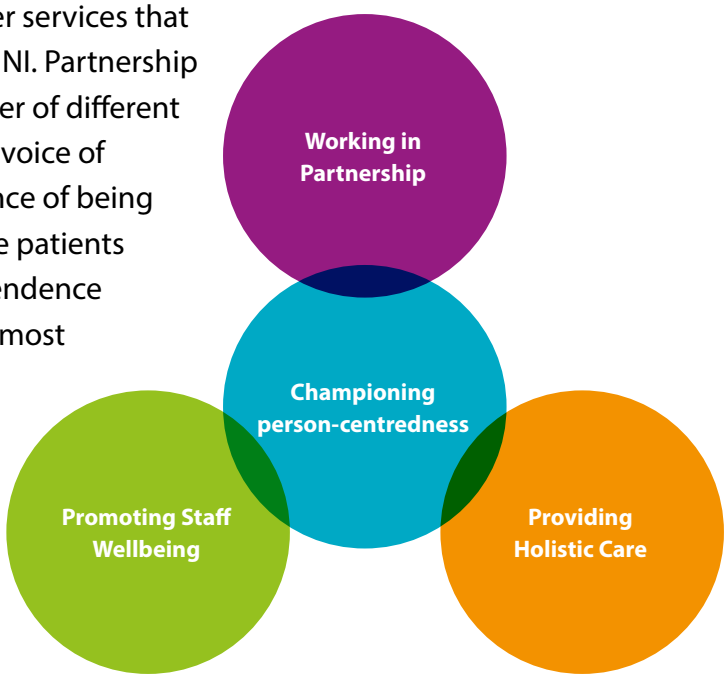
Create and promote a culture of appreciation in all directions.

Where we are now

The challenges in delivering quality care in practice, however, continue to be well recognised, and this debate has been fuelled by high profile inquiries and reviews suggesting that the experience of care is variable and often fails to meet the expected standard[27]. This has led to a commitment within the professions to reaffirm the importance of the fundamentals of care, emphasised in publications over the past 10 years[28], all of which highlight the challenges for nurses and midwives in providing sensitive and dignified care. There has, however, been consistent effort across the healthcare system within NI to develop person-centered practice in the nursing and midwifery professions, with a focus required for wider application and sustainability over time. This has been reflected in previous and current regional nursing and midwifery strategies and is now the clear policy direction as laid out in *Health and Wellbeing 2026: Delivering Together*.

What we heard

A consistent thread across many of the engagement events reflected person-centred care and its component parts. There was a strong emphasis on the desire to ***provide holistic care***, refocusing on the fundamentals of nursing and midwifery practice. This was in recognition of a perceived increasing shift towards a task orientated approach to care delivery that was being driven by workforce issues and demands to deliver services within highly pressurised environments. Closely aligned to this was a commitment to ***working in partnership*** to develop and deliver services that meet the needs of the population of NI. Partnership working was discussed from a number of different perspectives including: securing the voice of service users based on their experience of being in the system; and working alongside patients and their families to promote independence and develop pathways that ensured most appropriate place of care. Whilst effective partnerships within the multidisciplinary team to facilitate working across boundaries was referred to in the data, this was less evident in the context of delivering person-centred care.



There was also a focus on ***promoting staff well-being*** and creating workplace cultures that enabled people to flourish, which is an important aspect of person-centred practice.

Remove the blinkers, don't just focus on the immediate condition you are there to treat – look at the person as a whole.

Where we need to be

In NI we want nursing and midwifery to lead the way in creating the conditions that enable the development of person-centred cultures that will deliver on positive outcomes. In order to achieve this, there needs to be a shared understanding across the professions of person-centredness in its broadest sense and development of strategies that enable this to be operationalised across services and settings. The new Guide for Co-production in NI[29], will provide an impetus to move forward particularly working in partnership with the population of NI to achieve the best health and wellbeing outcomes.

Midwives have a long history of working in partnership with women, enabling their views and preferences and helping to strengthen their capabilities. Their focus on women centred care has long been central to the provision of safe, respectful, nurturing, empowering and equitable care, irrespective of social context and setting. Further development of midwife led models of care will continue to ensure that midwives are in a position to advocate for women within a complex system, coordinating care.

The benefits of championing person-centeredness for the nursing and midwifery workforce reach beyond impact to patients, clients and families. Emerging evidence indicates positive outcomes for staff well-being through proxy measures such as improved staff recruitment and retention. Furthermore, these outcomes are aligned to the quadruple aim with a particular focus on improving the quality and experience of care, supporting and empowering staff. Nurses and midwives are well placed to lead the development and implementation of approaches underpinned by co-production that will ensure a positive patient experience.

Key Messages:

- **A desire to refocus on the fundamentals of practice that enable a positive care experience for patients, families and staff**
- **The need to develop effective strategies that will deliver person-centred outcomes**
- **Co-production should be integral to working in partnership with people, families communities and within and across teams and services**

Providing Visible Leadership At All Levels

Where are we now

For some years, there has not been, a systematic or sustained approach to leadership and management training across the nursing and midwifery family in NI. The reality is that many staff stepping into their first leadership roles have not received any formal development or training.

Whilst the vast majority of HSC bodies have Executive Directors of Nursing, the scope of their strategic and operational responsibilities varies across the region. Inevitably this variation is reflected in the levels supporting the Executive Director of Nursing role, resulting in operational decisions about nursing being taken by other disciplines or professions. This includes decisions about adding or removing nursing and midwifery posts.

There are programmes currently focused on leadership development for Ward Sisters, Charge Nurses and Team Leaders and ad-hoc training in generic leadership programmes. From this positive starting position there are many opportunities to develop and grow leaders at levels through alternative approaches such as mentoring and coaching.

What we heard

Visible leadership was highlighted as essential to the delivery of safe and effective care. It is within this context that nurses and midwives stated they want to be 'well led' and 'empowered' by their leaders to influence the design and delivery of services. There was a strong sense that nurses and midwives had become increasingly 'micromanaged' and therefore nurses want existing leadership to create the conditions so that they can have more autonomy to act. Those attending the workshops were clear that they wanted this leadership to be more 'visible' and to 'take time' to appreciate and understand the realties for staff who were delivering direct care in clinical environments. The need for ***courageous leaders*** who would be ambassadors for the professions to challenge and remove the barriers to change was viewed as the enabler for nurses and midwives to do the 'job they trained to do'.

There was a sense that staff were often 'dropped' into senior roles without the necessary leadership training or support. Staff experience was often reliant on the leadership style and abilities of the person or people line managing their teams. Inevitably this led to variation in staff experience and the ability of team members to ***live out person-centred values***. As a result of decades of a general management approach to service delivery, staff perception was that nursing and midwifery leadership roles had become increasingly advisory with the consequences that a number of senior operational nursing leadership posts had been progressively disappearing. This was cited as having had a negative impact on the leadership capacity of the professions and the need to ***develop leadership skills for the future***.

Where do we need to be?

Within the context of the Collective Leadership Strategy[30] nurses and midwives are ready to be equal partners in policy, strategy, operational and professional leadership. Crucially within the collective leadership model, it will be important that the expertise of the nursing and midwifery professions is nurtured to ensure nurses and midwives are appropriately represented at all levels. Furthermore, it is imperative to ensure nurses and midwives at all levels are professionally led by senior nurse and midwife leaders, including staff working in social care and arm's length bodies. Furthermore, over the next decade the professions will be at the cutting edge of transformation, requiring nursing and midwifery to be equipped as current and future leaders from the front line to the boardroom, to maximise their contribution in improving peoples' experience of health and social care and the health and wellbeing of the population.

Key Messages:

- **Lack of a sustained approach to leadership development within nursing and midwifery**
- **Variation in HSC structures has resulted in other professions making operational decisions about nursing and midwifery care and resources.**
- **Nurses and midwives need to be equipped to lead the transformation of future services to enhance the health and well-being of the population.**

Improving Public Health

Public Health isn't just about children - our older population deserve support and help

Where we are now

Many of the previous reforms in health and social care have placed greater emphasis on development of services which impact on the present rather than investing in the future. Nurses and midwives have not yet had the capacity to influence more widely as the skills of population health assessment are not always recognised or valued by the professions and others[31]. Furthermore, the pressure and demands of work do little to promote good health and wellbeing in nurses and midwives. Improvements in this area are inextricably linked to capacity and support, along with remuneration and a stable workforce. *Health and Wellbeing 2026: Delivering Together* redresses that balance with a clear aim of investing in the future and in improving the health and wellbeing of the population.

Currently, the significant emphasis for public health nursing is on children and health visiting, with little or no recognition or investment in the role of public health nurses more widely across the life course.

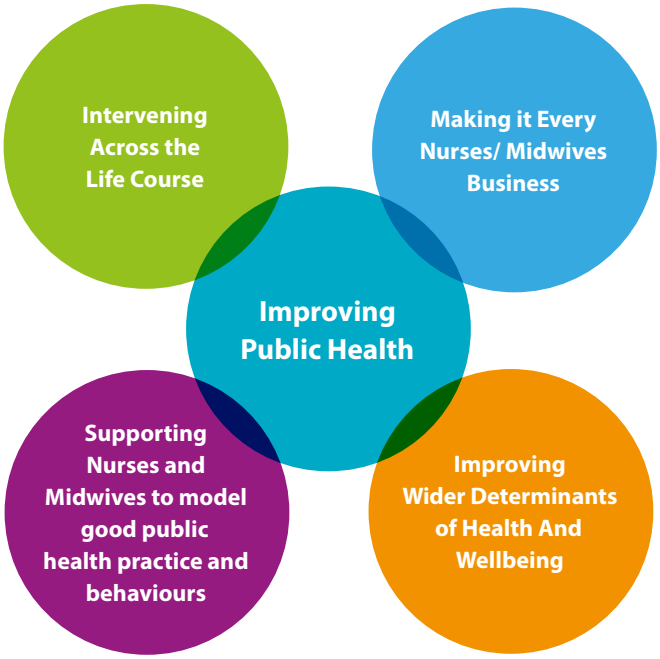
What nursing and midwifery brings to the future is a steadfast commitment to improving the health and wellbeing of individuals and communities at all ages and in all places. In response to increasing demands on nursing and midwifery services the focus on public health being everyone's business has weakened over the last decade, although the new NMC FNFM standards (2018 & 2019) emphasise public health. Whilst there are some small targeted public health nursing/midwifery initiatives in marginalised groups such as: MECC, Early Intervention Transformation Programme (EITP), and Family Nurse Partnerships and are starting to redress the balance in some small and focused areas of practice but they are not consistent across NI[32]. It is within this context that the pace of public health and population health nursing needs to be stepped up and maximised across the life course.

Recognise and promote the impact of every nurse / midwife from pre conception to older age and event moment between

We need to live the values we espouse and at times we will need help to do that

Who can make a difference to individual and population health through the social determinants of health

What we heard



Pregnancy and early years have a decisive impact on the health and well-being of mothers, children and families. The midwife has a vital part to play not only in helping to ensure the health of mother and baby, but in their future health and well-being and that of society as a whole. Pregnancy and early life lay the foundations for our individual health, well-being, cognitive development and emotional security – not just in childhood but also in adult life. What happens to children before they are born and in their early years profoundly affects their future health and well-being.

Midwives are crucial members of the public health workforce, well placed to help every child make the best start in life. Their health promotion and health protection activities improve maternity outcomes and long term health gains by addressing individual and social health determinants such as breastfeeding, smoking, drinking and their social and behavioural origins. The public health approach includes a commitment to the promotion of positive parenting and an acknowledgement of the importance of the parent's emotional well-being.

The promotion of health and wellbeing as ***every nurses' and midwives' business*** was a key message. It was recognised that the focus of public health and wellbeing practice early intervention; prevention and health promotion, promoting social inclusion and reducing inequalities in health and wellbeing. If nurses and midwives were to have the capacity and skills to maximise every contact they have with individuals and communities the impact on health and wellbeing could be significant. Furthermore, feedback reinforced that the influence of nurses and midwives to improve public health must be ***across the life course*** and in all places, including the young, those at working age and adults who are older, where we grow, where we work and where we live. Nurses and midwives recognised that they should ***model good public health practice and behaviours*** in maintaining their own health and wellbeing and promote a positive coaching approach. The data also reinforced the positioning of nurses and midwives as integral to where people work and live and as such can impact on every aspect of life. This is strengthened by the respect nurses and midwives are held in, yet they are often not afforded the time and capacity to influence beyond health and social care. There was a strongly held view that the relationship with communities has been lost in the pressure of service delivery reducing the ability of nurses and midwives to ***improve the wider determinants of health and wellbeing.***

Where do we need to be?

There is a significant role for the professions to impact on the health of the population. The main focus should be to facilitate the capability of nurses and midwives to avail of every opportunity to impact on individual and population health and wellbeing. The value and contribution of nurses and midwives to improving the health and wellbeing of the population of NI must therefore be supported and recognised. This will enable NI to rapidly move to the vision in *Health and Wellbeing 2026: Delivering Together* and nurses and midwives will be better prepared and supported to play their role in improving public health. Nurses and midwives should be facilitated to make the fullest contribution to public health across the life course and in all places working with other partners, such as local councils to improve the life changes for all.

To achieve this aim, the professions need to be appropriately prepared for their role in improving the health and wellbeing of the public at all levels within a public health career pathway. This will require roles for nurses and midwives that enable them to lead on population health approaches across the life span, including population health needs analysis, health and wellbeing improvement, health protection and providing public health practice within and across the system. One very important aspect of this vision is the need to support nurses and midwives to live the values of public health in both their professional and personal lives.

Key Messages:

- **Promoting health and wellbeing for the population of Northern Ireland should be every nurse and midwives' business**
- **Public health approaches should be normalised into nursing and midwifery practice to impact on all ages across settings and communities**
- **The need to develop population health management knowledge and skills to maximise the contribution of nursing and midwifery to health and wellbeing**

Staffing For Safe And Effective Care

Where we are now

It is timely and significant that the recent publication of the Health and Social Care Workforce Strategy by the DoH, takes a very detailed look at the workforce challenges facing health and social care in NI. The strategy sets out ambitious goals for a workforce that will match the requirements of a transformed system and which addresses the need to tackle the serious challenges with supply, recruitment and retention of staff. One of the key actions is to develop and sustainably fund an optimal workforce model for reconfigured health and social care services by 2026.

The implementation and progression of the Department's policy framework, *Delivering Care: Nurse Staffing in NI*, has served to highlight a stark disparity between actual staffing levels across a range of specialities and those staffing models identified for optimum delivery of safe and effective care.

The DoH has increased investment in pre-registration commissioning since 2016, following a five year downturn in training places between 2010-2015. In 2018/19 a further significant investment, supported by transformation funding, has financed a total of 1000 pre-registration places, which is at an all-time high.

International nurse recruitment is a current strategic short term measure to strengthen the existing workforce. A regional international campaign commenced in 2016 and is on track to deliver 622 nurses into NI by March 2020. Recruitment has yielded greater success in non-EU countries than in EU countries. The impact of the United Kingdom leaving the European Union in 2019, brings a further uncertain dimension to the current workforce challenges that could potentially exert a destabilising influence on the nursing and midwifery workforce, particularly on those workplaces in close proximity to the Republic of Ireland.

Evidence exists of enhancing contribution through role development, as nurses and midwives endeavour to embrace change and adapt their practice to meet service needs and demands. One such example is the development of ANP roles, the value of which is strategically endorsed in *Health and Wellbeing 2026: Delivering Together* and is gaining increasing recognition across primary and secondary care settings.

Within the unregistered nursing and midwifery workforce, roles have developed to provide additional support to the registered workforce, operating within the context of the delegation framework. In recognition of the valued contribution of this cohort of staff, the DoH, in 2018 mandated a suite of regional resources specifically to support nursing assistants and senior nursing assistants, including Standards and an Induction and Development Pathway.

What we heard

The urgent need to ***increase the numbers of registered nurses and midwives*** was a consistently strong and unanimous message. The presenting data painted a concerning picture of a pressurised, under resourced workforce, curtailing the capacity and capability of the nursing and midwifery professions to effectively deliver person-centred, safe and effective care. There was widespread recognition that sufficient resourcing of the workforce was a critical enabling success factor for safe staffing and improving outcomes for all. Increasing investment in pre-registration nursing and midwifery training was viewed as a key pivotal priority, for effective workforce planning in addressing the current workforce deficit.

It was clear from the evidence gathered that the ***providing support and reducing bureaucracy*** was highly valued and inextricably linked to the wellbeing and resilience of the nursing and midwifery workforce. Increased bureaucracy was cited as a significant barrier to enabling efficient functioning of the nursing and midwifery workforce, with frustrations expressed around data collection requirements, HRPTS and cumbersome electronic HR processes, which impede timely recruitment into vacant posts. Support was viewed as crucial for nurses and midwives in managerial and leadership roles, particularly with regard to recruitment processes, and managing sickness absence and also clinical support for newly registered staff.

There was a real desire and enthusiasm expressed to ***enhance nursing and midwifery contribution through the development of new roles*** within the professions. Opportunities to access, develop and resource new and innovative roles was viewed as essential for the preparedness of the future workforce, for example, the development of advanced nurse practitioner roles.

Furthermore, the value placed on the contribution of the non-registered workforce was also highlighted and viewed by registrants as a vitally important area for development, to maximise the impact of this group of staff, in supporting the delivery of safe and effective person-centred care.

Where do we need to be?

In order to achieve staffing for safe and effective care, we need to move to a desired position of having a sufficiently resourced and supported nursing and midwifery workforce in NI. This is crucial for maximising the contribution of the professions to deliver positive health and wellbeing outcomes for our population.

There is a lack of staff. We need to train more nurses and midwives to meet the demand

Reduce bureaucracy especially in recruitment to speed up the process as it is very cumbersome

We need to develop new and expanding roles in response to need and changes in nursing practice e.g. in Primary Care settings

Clinical support for newly qualified staff

A range of supportive measures is needed at all levels to enable the workforce to function effectively and focus on delivering high quality nursing and midwifery care. Supportive models should be developed for newly qualified registrants joining the workforce and also for experienced registrants in managerial and leadership roles, with HR and administrative support for recruitment processes, absence management and data collection requirements.

We need to promote, develop and sufficiently resource enhanced roles to optimise the nursing and midwifery contribution to population health, and ensure readiness of the professions to meet current and future challenges and demands.

Key Messages:

- **A fundamental and pressing priority is the need to address workforce shortages and to strengthening the capacity of the nursing and midwifery workforce to deliver safe and effective care.**
- **The workforce should be supported to function effectively by reducing unnecessary bureaucracy**
- **Enhancing the development of new roles should be nurtured and progressed to optimise the contribution made by the professions across the life course.**
- **There is a need to ensure safe staffing levels are mandatory and funded**

Educating For The Future

Where are we now

Education and lifelong learning is fundamental to supporting nurses and midwives to meet challenges now and into the future. An educated, competent and motivated nursing and midwifery workforce is crucial to support UHC as a key imperative for improvement[33].

From April 2016, revalidation is the process that all nurses and midwives in the UK follow to maintain their registration with the NMC which includes a requirement to undertake CPD. The process of revalidation is aligned to The Code[34] which outlines professional standards of practice to ensure the safeguarding and general well-being of people. As previously cited, NMC has radically overhauling pre-registration nursing and midwifery standards and implementing a new education framework for the delivery of nursing and midwifery education and training in the UK. The NMC next piece of work will be on reforming post-registration standards.

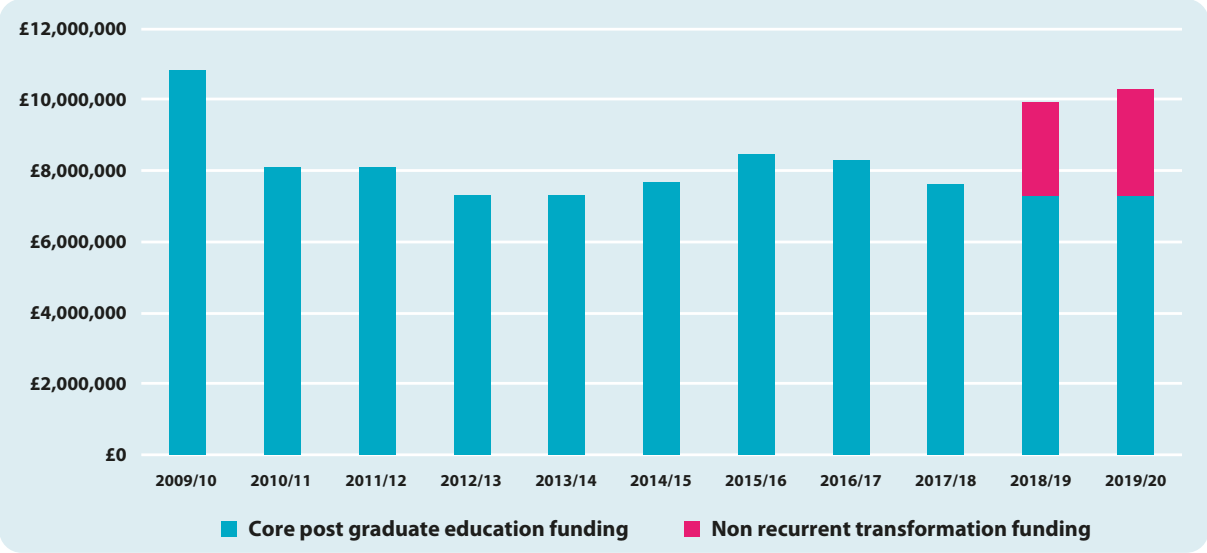
Within this context nurses continue to develop and expand their roles and responsibilities and exemplars of good practice are demonstrable across all settings in NI. Several programmes of work are already being taken forward at regional and national level to address a number of issues which have emerged regarding the current and future education of nurses and midwives. For example: development of Specialist midwife and Advance Nurse Practitioner (ANP) roles across a range of settings and consultant nurse and midwife roles. Much of this has been funded by redirecting resources from across the education budget and often resulted in deficits elsewhere. On occasions despite access to education there has also been lack of support for those wishing to pursue careers roles such as Clinical Academic Careers despite availability of PhD sponsorship.

Within the DoH, the CNO has responsibility for the post registration nursing and midwifery budget. On an annual basis a business case is developed to propose what is needed for the incoming year. This process is not sustainable as it is not possible to commission post registration programmes from universities and other education providers beyond the current annual and ad hoc basis. In terms of post-graduate education the report highlights that in order to both retain and develop our nurses and midwives there is a need to restore and incrementally grow postgraduate training budgets.

Over the last ten years **(figure 19)** the postgraduate education budget in nursing and midwifery has been progressively decreased from £10.8 million to £7.3 million. This reduction has been further compounded over this time period by an increase in post-graduate education costs and the increased costs associated with backfill for some of the training places. It is important to note however over the last two years these reductions have been

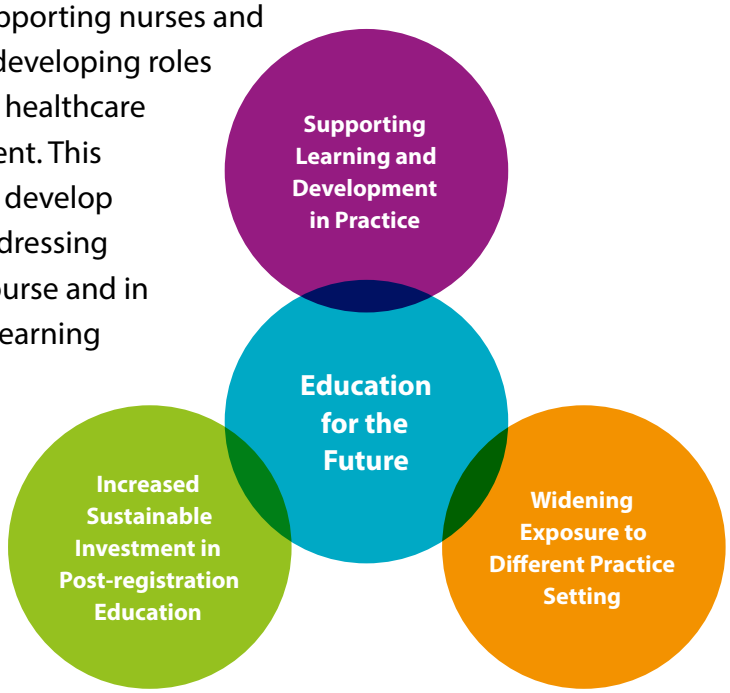
offset by non-recurrent transformation funding and an increase in both nurse and midwife student places. In the absence of sustained transformation funding and/or a restoration of recurrent funding commensurate with the size of nursing and midwifery workforce, this will have significant implications for nursing and midwifery practice career pathways and wider health and social care reform.

Figure 19 - Nursing & Midwifery Post Registration Education Investment Profile Source DOH



What we heard

Lifelong education and learning across a graduate workforce was highlighted as pivotal to maximising the potential for nurses and midwives to contribute to improving health and wellbeing of the population. Supporting nurses and midwives to take on innovative and developing roles was considered crucial for continued healthcare improvement and service development. This included the knowledge and skills to develop services outside hospital settings, addressing the needs of people across the life course and in particular those with comorbidities, learning disabilities, mental health needs and older people. Timely access to postgraduate education using blended learning approaches, where possible, delivered on a multi-professional flexible basis was identified as a fundamental driver for success.



Professional facilitation roles that support learning and development in practice such as preceptors, mentors and clinical educators, were viewed as enablers to learning and development in and outside of care environments. In particular, there was an expressed need to support new registrants in the immediate post qualifying period. Preceptors reported a feeling of being pressurised and found it difficult to spend time to focus on supporting newly qualified colleagues in the work place. Learning outside traditional boundaries through pre and post registration programmes within a multi-disciplinary context was considered a key component to ***widening exposure to difference practice settings***. Despite the current workforce challenges there was a real desire to ensure that the student nurse experiences in university and practice placements were positive and appropriate with a good level of support in a culture that encourages innovation and improvement.

A major concern was that qualified and experienced staff who were motivated to maintain and extend their skills and roles through Continuous Professional Development (CPD), were finding it difficult to access education. There was also widespread concern that postgraduate education was often inappropriate and inaccessible and that better outcomes could often be achieved through multidisciplinary training at a local level. There was a case made for ***increased and sustainable investment in post-registration education*** that would maximise the contribution of nurses and midwives into the future.

Where do we need to be?

The new proficiency standards for nursing and midwifery have been practice launched by the NMC. These standards are set to revolutionise and modernise nursing and midwifery practice, and they are strongly focused on delivering population health, and evidenced based interventions which will improve outcomes for people. The CNO has now established a Future Nurse Board to ensure NI becomes an exemplar of these standards. These standards will complement the direction of travel proposed in our report and indeed they have also been factored into the recommendations.

The recent Health and Social Care Committee, England, nursing workforce inquiry[35] has significant messages for all countries. It looked at the current and future scale of the shortfall of nursing staff and whether the Government and responsible bodies have effective plans to recruit, train and retain this vital workforce. The Committee heard a clear message that access to continuing professional development plays an important role in retention. Whilst it was noted that efforts are being made to retain staff, key recommendations included a reversal of cuts to nurses' CPD budgets; specific funding made available to support CPD for nurses working in the community; and access to continuing professional development needed to reflect skill shortages and patient needs. There is a need therefore, to ensure that the workforce is supported and developed to enable registrants and those contemplating a career in nursing or midwifery to lead service improvement and impact significantly on the delivery of person centred care.

Moving toward a future where nurses and midwives are at the forefront of service transformation requires a commitment to support the professions across their careers through progression and role expansion. There is a need to invest in post-registration education to ensure the right number nurses and midwives, with the right knowledge, skills and experience are working in the right place at the right time to improve the health and meet the needs of the population. Opportunities to undertake masters and doctoral programmes should be available, including the establishment of clinical academic careers. This should include establishing clinical academic posts for midwifery and each branch of nursing in all HSC organisations to strengthen the research and development capacity within nursing and midwifery teams. Cognisance should be taken of nurses working in lone roles, such as Practice Nurses. Furthermore there should be support for education in clinical practice available through a range of opportunities e.g. Clinical teaching, eLearning, Human Factors training, coupled with opportunities for Higher Education Institutions to plan for the development and delivery of programmes within a sustainable model which meets the emerging policy and strategy needs of the DoH.

Key Messages:

- **Continuous professional education and development is vital for safe effective practice and career development**
- **Within the current context and due to workforce constraints nurses and midwives are finding it increasingly difficult to access educational opportunities**
- **A sustainable funding and workforce model is required to support post-registration education to deliver on the transformational agenda**
- **Professional facilitation roles should be further enhanced to enable learning and development in a range of care environments.**

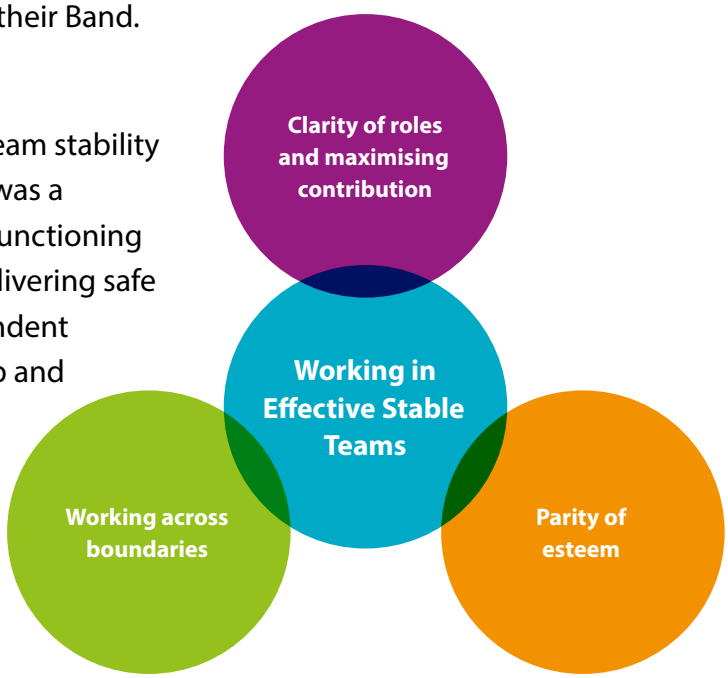
Working In Effective Stable Teams

Where we are now

Nurses and midwives are working across care settings in pressured environments which affects the stability of their teams. It is clear that working in teams that are short staffed has a negative impact on the professions, affecting their own safety and wellbeing, as well as eroding pride in their roles. Nurses and midwives serve as an around the clock surveillance system for early detection and prompt intervention when people's conditions deteriorate both in community practice and within hospitals. That surveillance system must be adequately resourced and communication systems must be excellent to ensure delivery of safe and effective care by stable teams. The context presented in section 5, reflects workforce trends including vacancy rates, recruitment and retention, and subsequent use of bank and agency staff that significantly challenge the establishment of effective teams.

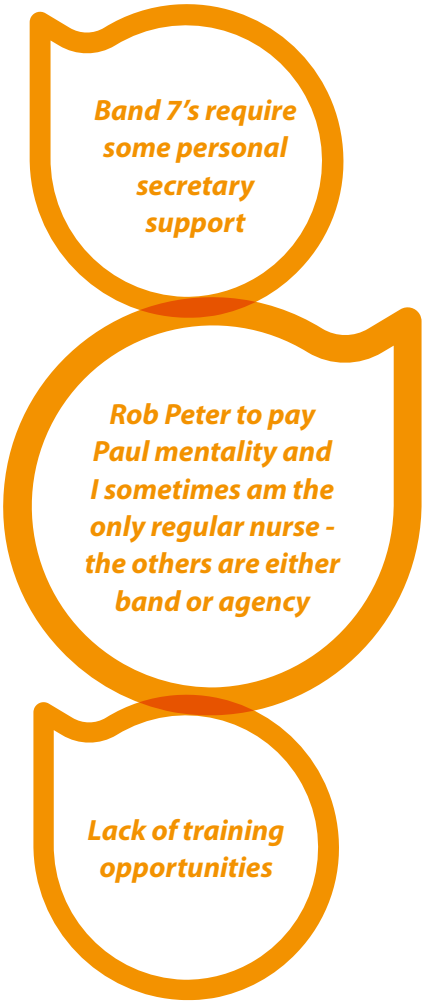
NI has much fewer opportunities for nurses and midwives above pay Band 5 than the rest of the United Kingdom. This lack of opportunity frustrates the professions in NI, as they feel there is very little opportunity for career progression, with no reward for midwives and those nurses who are working at the top of their Band.

What we heard



The need to strengthen and sustain team stability across all environments and settings was a resounding message. Effective team functioning was viewed as a crucial enabler to delivering safe and effective care with stability dependent on adequate staffing, good leadership and effective communication. Issues raised around this theme included the importance of regular team meetings, supervision and support, shift patterns and recruitment and retention. The reasons provided for this challenge were: frequent use of agency staff; delayed replacement of staff exiting the organisation; and a lack of opportunity for meaningful staff meetings. Staff identified that crisis management was the norm, where moving staff to areas under even more pressure was common practice. The reality was that nursing and midwifery staff were 'acting down' to plug gaps brought on by deficiencies in administrative support.

There was a need for ***clarity of roles that maximised the contribution*** of nursing and midwifery. Evidence was provided that nurses were expected to pick up on tasks and duties previously performed by other members of the multidisciplinary team. Staff also identified the lack of opportunity to experience different roles and regularly enquired about an internal transfer system for employees already in the HSC system enabling them to ***work across boundaries*** whilst avoiding a full application and recruitment process.



Nurses and midwives used the example of the advancement across AfC pay scales for other professions as an indicator of lack of ***parity of esteem***. This often played out in the effective functioning of teams; for example, AfC Band 5 nurses provided an example of mentoring new social workers who automatically progress to Band 6 pay scale after one year, whilst an experienced nurse remains at Band 5. This was counter-intuitive to an agenda that releases the potential of nurses and midwives and maximises their contribution within the system.

Where do we need to be?

Improving teamwork competency across nursing and midwifery could have enormous financial and quality care implications across the health and social care sector as a whole. Improving teamwork competency saves lives[36] and is marked as an international priority in discussions about restructuring nursing care provision[37]. Furthermore, in hospitals where nursing teamwork is rated as strong they report less missed patient care (Kalisch, Lee & Rochman 2010), fewer patient falls (Kalisch et al. 2007) and higher quality of work life impacting staff recruitment and retention (Brunetto et al. 2013)[38]. A direct correlation between teamwork, adequate staffing levels and job satisfaction has been evidenced[39]. Familiarity with team members, stability of the team, a shared common purpose among team members, as well as the right physical working environment that is conducive to staff engagement are all thought to characterise high performance teams.

The Department has invested in developing new roles in Advanced Nurse Practitioner (ANP) and it will be vital that employers ensure jobs are developed to match the skills of these very highly trained practitioners. In addition there needs to be encouragement and incentives for nurses to work at the top of their scope of practice. Nurses are the members of the inter-professional team which is available to the patient/client 7 days a week and 24 hours per day, so it makes sense to incentivise them to up-skill and work at the very top of their scope of practice. There is also a need for nurses especially out of hospital to operate in virtual, flexible and multiple teams, working across teams and agencies is a critical leadership skill.

Key Messages:

- **Workforce trends such as vacancy rate, use of bank and agency, and sickness absence rates are impacting on the establishment of effective stable teams**
- **There is a clear link between teamwork competency and the provision of safe and effective care**
- **There is a need to maximise the contribution of nurses and midwives within teams by incentivising them to work at the top of their scope of practice through appropriate career progression**

Maximising Digital Transformation

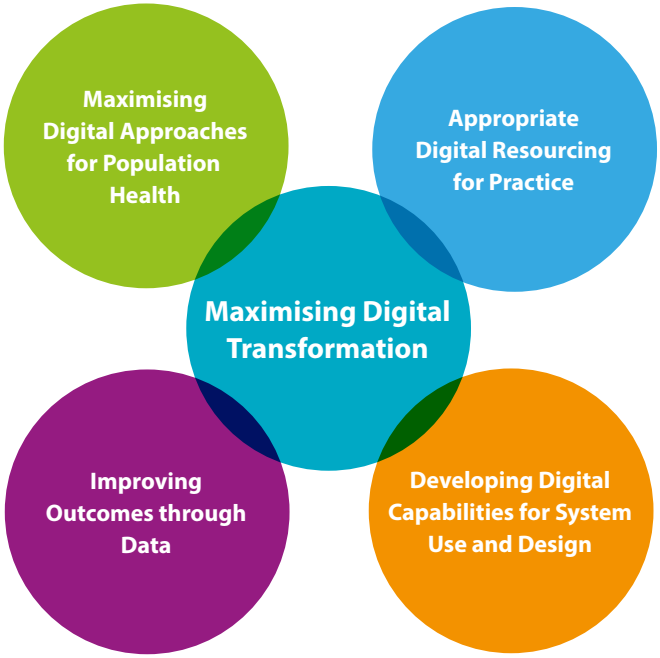
Where we are now

Technology systems in NI, with the notable exceptions of the Northern Ireland Electronic Care Record (NIECR) and the primary care system used by General Practitioners, are in the main unable to communicate with other technological systems between and across organisations. People in NI do not have electronic access to their health records; health records are mainly in paper format; innovation is slow to mainstream in practice and data requires more standardisation and structure. Where electronic records are operating, they tend to be in a form filing format, where there is limited ability to interrogate, report on or use the vast amount of information that nurses and midwives input to these systems every day.

Access to the internet and therefore infrastructure to support digital technologies can be difficult in some geographical localities of NI, particularly in rural areas. The abilities and skills to engage with, direct, develop and use digital technologies and data are not currently included in nursing and midwifery programmes across NI, neither at undergraduate or post-graduate levels.

Nurses and midwives often express the fact that they are not equipped with the necessary up-to-date hardware or software to do their jobs efficiently. They also often debate the utility of some of the systems currently deployed in NI citing that they are not intuitive to use, lack user-friendly interfaces (known as Application Programme Interfaces or APIs) and can be time consuming to complete, removing them from the opportunity to spend more time engaging with patients, women and their families.

This mirrors a recent UK-wide survey undertaken by the RCN, published in 2018[40] relating to the progress towards digital readiness for nursing to use health technologies in every day practice. This survey, whilst limited in the number that responded and therefore representative sampling, demonstrated messages about what nurses wanted in relation to technologies. Those nurses that responded sent a clear message that they wished to engage more in the development of health technologies, that current systems were not fit for purpose and that organisations needed to get the basics right in terms of provision of hardware and software to the registrant workforce, enabling them to do their job well.



What we heard

Necessary steps were identified by nurses and midwives for future digital maturity for health and social care services in NI. There was a repeated focus on ***appropriate digital resources to support practice*** through hardware and digital infrastructure for mobile and remote working across organisations. The ***development of digital capabilities for system use and design*** across all levels of the professions was also a strong theme that linked to ***understanding data*** from technological systems for the purposes of practice and ***outcome improvement***. From a future facing perspective, there was a clear message that systems design and opportunities to use technology to ***maximise digital approaches to population health*** should have nurses and midwives at the forefront, driving innovation. This included the use of digital approaches to support self-management of chronic conditions for the population of NI, both technologies currently available and those yet to be developed.

Where do we need to be?

NI has a strategy underpinning eHealth and technology[41] with a focus on developing both technologies to assist the public, health and social care service providers, and staff to use them. Real-time engagement about care and services with the public of NI through patient portals fostering the spirit of coproduction, a clear message from *Health and Wellbeing 2026: Delivering Together*; capture of data through remote monitoring systems; capture of data by the public themselves through fitness tracking equipment and health apps, could provide vital information about the health of our population and future opportunities to promote health and wellbeing. Nurses and midwives need to be appropriately equipped to track this data, understand utility for improvement and trend for bigger messages relating to population health and the impact of nursing interventions on health outcomes. In addition, a single system that communicates seamlessly across all sectors in NI is the ambition, through the Encompass programme of work currently being taken forward. Nurses and midwives understanding how to use this system and maximise the information flowing from it to improve outcomes for people should characterise the future.

Invest in technology infrastructure and training for nurses and midwives

The recent Wachter Review[42], commissioned to review and articulate the factors impacting the successful adoption of health information systems in care services in England, was tasked with providing a set of recommendations drawing on the key challenges, priorities and opportunities, messages resonating across all countries in the UK. In particular, there was a focus on the importance of developing digital leaders and clinician informaticians across organisations with appropriate resources and authority. Indeed recommendation 3 stated that efforts should be made to '*develop a workforce of trained clinician informaticians at the Trusts and give them appropriate resources and authority*'.

There is opportunity for nurses and midwives, therefore, to develop the required digital capabilities to enable quality improvement, appropriate data gathering – including decisions on that which should, and should not be gathered, data analysis, and engaging with technology driven healthcare to improve outcomes for populations[43]. Experienced nursing and midwifery roles are crucial to the implementation of interventions that are technology based[44], with significant opportunity to impact the implementation and design of digital health technologies because of their expert clinical workflow knowledge, decision making capacity and leadership role[45]. Nursing and midwifery leaders are also highly influential in the adoption of practice trends and should therefore seek to understand what digital providers offer including how these systems can assist or hinder nursing practice[46].

Key Messages:

- **Investment is needed for digital equipment and infrastructure to support its widespread use**
- **There is a need to build the skills and authority of nurses and midwives to lead the potential for future digital practice**
- **Digital systems need to be designed collaboratively with appropriately skilled registrants to ensure they are fit for nursing and midwifery practice**
- **Nurses and midwives need to be enabled to lead and engage with and influence the design of innovative digital health approaches for the population**

Recognising And Rewarding Excellence In Practice

Where we are now

In a UK-wide report, *Safe and Effective Staffing: The Real Picture*[47] four out of five Directors and Deputy Directors of Nursing indicated that their organisations ran on the good will of their staff to provide services. Nearly three in five (57%) of Directors and Deputy Directors of Nursing said that staff wellbeing declined over the past two years. In a similar report within HSC organisations in NI, 52% of nursing staff reported not having enough time to carry out all their tasks and duties and 28% reported that there were too few staff, feeling overwhelmed by workload[48].

In 2017, the Commissioner for Older People exercised his discretion to commence a statutory investigation into specific matters affecting older people, carrying out an investigation into the standards of care received by residents of Dunmurry Manor Nursing Home. His report of the findings of his investigation[49] set out 59 recommendations. These include a recommendation to ensure workforce plans are developed that take cognisance of nurse staffing requirements for the Independent Sector. He also recommended that a high level of staff turnover and use of agency should be considered a "red flag" issue for commissioners of care and the Regulation and Quality Improvement Authority (RQIA).

The DoH and the Northern Ireland Practice and Education Council (NIPEC)[50] have published a suite of documents to ensure a consistent approach across HSC Trusts regarding role, remit, function, training and education of Nursing Assistant and Senior Nursing Assistant roles undertaking delegated aspects of nursing care supervised by a registered nurse or midwife. This includes core elements of a job description for AfC Band 2 and 3 staff.

The DoH and NIPEC have also published an Interim Career Framework for Specialist Practice Roles[51], an Advanced Nursing Practice Framework[52] and Professional Guidance Supporting Consultant Nurse and Consultant Midwife Roles[53], distinguishing characteristics within components of practice between these roles. Alongside of these developments, nurses and midwives have consistently demonstrated their contribution to the health and wellbeing of the population in NI. There are cited examples, included in Section 5, of how they are leading the way in delivering high quality, innovative person-centred care, contributing to the strategic objectives of transformation and co-production.

Finally, NI has been collecting and demonstrating evidence on the contribution and impact of nursing and midwifery practice to person-centred health outcomes through the collection of Key Performance Indicators (KPIs) across a number of work programmes and

operational directorates. This initiative has been led collaboratively by the Public Health Agency and NIPEC since 2012 and is chaired by the CNO. Over the last 6 years since the work began, a wealth of data has been collected that has evidenced the positive impact of nurses and midwives on the health outcomes of people receiving health and social care services in NI. For further information on nursing and midwifery KPIS in NI please go to: http://www.nipec.hscni.net/work-and-projects/stds-of-pract-amg-nurs-mids/evidencing-care-kpi-for-nurs-mid-project/

What We Heard

Nurses and midwives across all care settings consistently reported feeling overstretched, resulting in patient care being compromised and care being left undone due to lack of time. Repeated concerns were raised about gaps in skill mix and a lack of corporate and professional infrastructure to support the professions. Participants at the workshops frequently reported that they felt the impact personally in terms of their own health and wellbeing and were concerned about work life balance, their own welfare and that of their colleagues. Morale was repeatedly described as "low", and regular statements were made relating to 'a simple thank you' from employers being appreciated by nurses and midwives. There was a clear message of the value of ***celebrating and rewarding success*** and promoting excellence in practice.

There was a consistent message about nurses and midwives being expected to take on the roles of other health and social care staff specifically administrative and domestic staff, Allied Healthcare Professionals, medical staff and social workers. The system was characterised by "too much bureaucracy", too much unnecessary paperwork and duplication of effort. This was further exacerbated by a lack of IT support and systems. There was strong consensus that these issues needed to be addressed in order to release time to ***maximising the value of nursing and midwifery*** care.

Many expressed concerns about the lower rates of pay earned by staff on AfC terms and conditions in NI. There was a generalised perception that the contribution of other health and social care professionals was being recognised in terms of AfC Banding, whilst the contribution made by nurses and midwives was not. There was a perceived lack of openness and transparency in relation to development opportunities and access to post-registration education and development programmes. Staff also cited occasions when they had been supported by their employer to complete specialist development programmes but were subsequently not employed, deployed, or in a position to utilise their specialist practice knowledge and skills in post following completion. There were also situations recounted of nurses utilising higher level skills beyond their AfC Job Band however were not remunerated at an appropriate level. This articulates a rationale for ***ensuring appropriate remuneration aligned to career progression for nurses and midwives***.

Issues relating to the ability of staff to provide appropriate levels of safety, quality and patient/ client experience were reinforced, such as: inadequate workforce planning, an increasing number of staff secured via agencies, and the stability of nursing and midwifery teams. These issues have been discussed in more detail in previous sections of this report. Shortages were more acutely felt in the Independent Sector and participants expressed dismay that workforce planning had consistently excluded the requirements of this sector.

Where do we need to be ?

Nurses and midwives need to feel valued and should be rewarded for advancing practice and being a significant contributor to the transformation agenda alongside other professions who are similarly acknowledged through career advancement and pay progression. Similarly, future services contracted out to be provided on behalf of the HSC by the Independent Sector HSC contracts must ensure that terms and conditions of employment for staff support a stable workforce.

A number of key policies and best practice documents from a professional and system perspective have painted a clear picture of the future in relation to recognition, enabling transformative leadership to achieve the overall aim within the current PfG aim of 'enjoying long, healthy and active lives'. Nurses and midwives are well placed to significantly contribute to improving the public health of the community, maximising transformation through person centred practice and improving quality and experience of care. The *Health and Social Care Workforce Strategy* identified two themes focused on actions in relation to promoting the health and wellbeing of the workforce and maintaining an effective work life balance.

Nurses and midwives should not suffer the unintended consequences of any service reform, particularly of administrative and support services that adversely impact on their ability to provide safe and effective care to patients and clients. Administrative processes that cause a duplication of effort placing an increasing burden on nurses and midwives need to be eradicated. Rather a system of streamlined information management and technology is required to support nurses and midwives to deliver person centred, safe and effective care. In shaping the future it is imperative for the professions to be able to evidence the impact of their practice which is key to maximising the contribution of nursing and midwifery to the population of NI.

Key Messages:

- **Action is required to improve the health and well-being and work-life balance of nursing and midwifery staff.**
- **In the interests of bringing stability to the nursing and midwifery workforce and reducing reliance temporary bank and agency staff, nurses and midwives pay in Northern Ireland should be commensurate with that in the other countries of the UK.**
- **The clinical infrastructure to support nursing and midwifery must be strengthened and critically involves reducing bureaucracy, streamlining information management and technology.**
- **HSC contracts for the independent and voluntary organisations must ensure that terms and conditions of employment for staff support a stable workforce in this sector.**
- **The future development of nursing and midwifery should be informed by the generation of evidence in practice and through the development of clinical academic careers.**

Leading Quality And Innovation

Where we are now

Health and Wellbeing 2026: Delivering Together sets out the road map for the development of a word class health and social care system. Any system that aspires to be world class must take a strong position on quality improvement. It is within this context that all health and social care professionals are required to fully integrate quality improvement into their work. This will mean improving our capacity to foster local innovation and to implement what works at scale. The NMC Code and Enabling Professionalism framework also articulates the requirement for nurses and midwives to continually learn and improve in practice. Through the Quality 2020 Strategy the IHI Improvement skills training suite, quality improvement capacity is being developed across nursing and midwifery services. There was also a deep recognition that QI training in nursing and midwifery is at an early stage of development and more needs to be done to build capacity across the nursing and midwifery workforce. In addition, the work of Regional Nursing Key Performance Indicator Advisory Group has increasingly introduced a culture of outcome measurement.
Again much more work is needed to ensure effective measurement of nursing and midwifery practice to become a systemic part of delivering routine care.

What we heard:

There was a recognition across all the workshops that to deliver care interventions based on evidence, nurses and midwives needed to be proactively supported to lead on quality and innovation.

Utilising and managing data to enable learning and improvement was linked to maximising the impact of nursing and midwifery practice across the life course.

This was clearly linked to the development of a supportive IT infrastructure to enable the capture and use of both experiential and clinical data and learn from and improve practice. Nurses and midwives expressed the need to ***engage in improvement and implementation science*** but there was recognition that nursing and midwifery as the largest professions still needed to build quality improvement capacity and capability, which would require sustained dedicated investment. There was an expectation that nurses and midwives should be ***leading and enabling innovation***. It was within this context that there was also a call for the system to recognise and value the opportunities for role enhancement across the professions. This was considered a critical enabler of services transformation and in improving population outcomes over the next 10 years.

Where do we need to be?

Nurses and midwives are critically positioned to provide the creative and innovative solutions for current and emerging health and social care challenges such as ageing population. We need to invest, therefore, in building improvement and implementation capability at undergraduate and postgraduate levels. Up until now, the potential for the professions to lead improvement science activities has not been fully realised. In their day-today practice nurses and midwives do not routinely receive opportunities to conduct research and contribute to improvement science (Taylor et al. 2010). The ability of the professions to seek the best research evidence, measure care outcomes and use empirical data to assess their current practice (Sherwood 2010) is dependent on the development of improvement science knowledge and skills. Crucially implementation science explores how the latest research and evidence can best be implemented to change healthcare policy and practice. This in turn assists the profession to translate evidence into practice and therefore improve care outcomes[54].

Value based approaches to quality improvement such as human factors and practice development are effective in bringing about cultural change and should also inform quality improvement and innovation. Understanding, applying and deploying such methods needs to be embedded across the HSC. Furthermore, in recognition that nurses and midwives play a key role in determining the quality of health and social care it is essential nurses and midwives are liberated through effective job planning to engage in quality improvement and in generating new ways of thinking, new ways of working and in new ways of utilising enabling technologies.

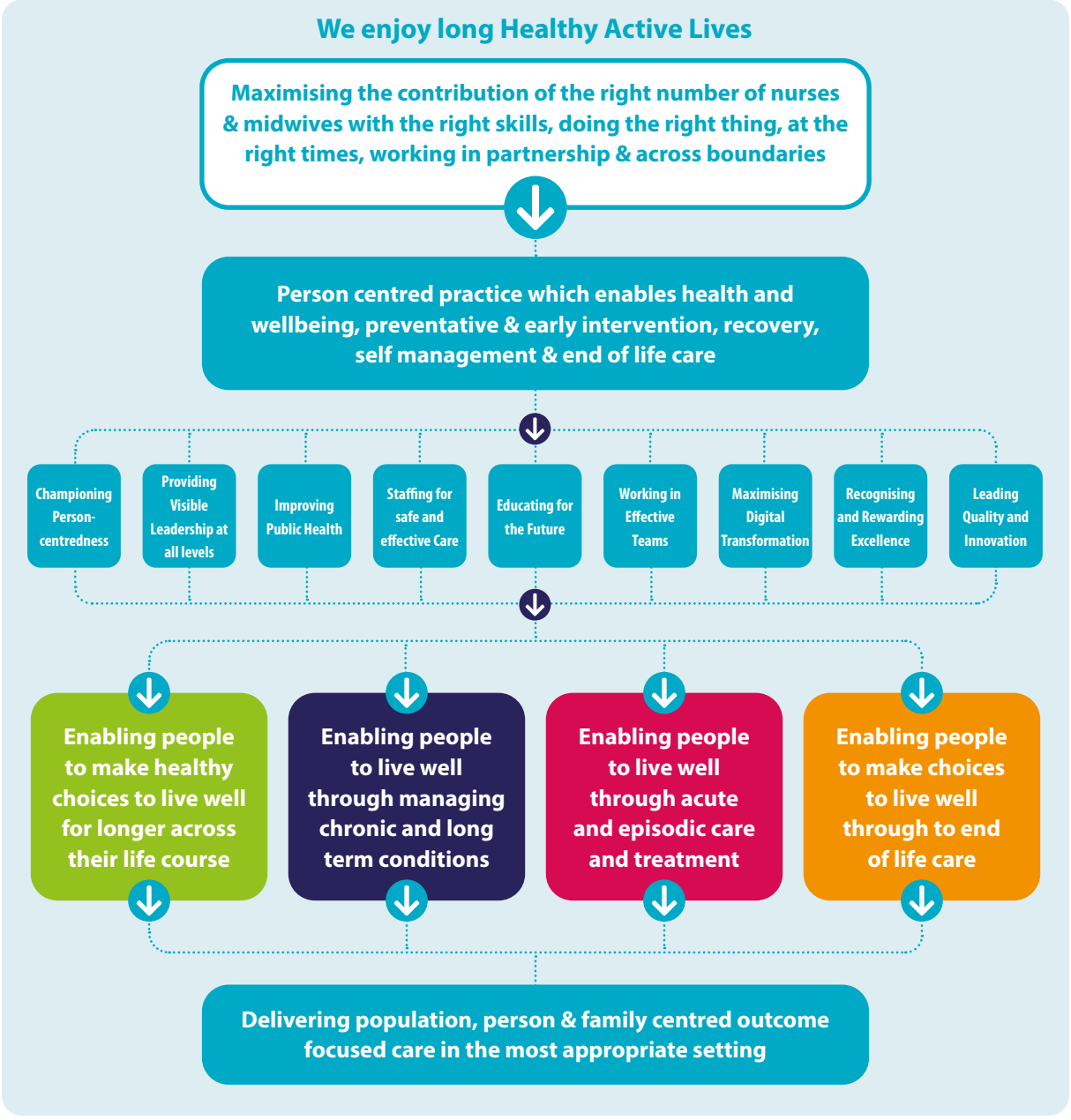
Key Messages

- **Nurses and midwives have the potential to significantly contribute to and to lead in the field of improvement science in healthcare.**
- **Opportunities need to be increased for nurses and midwives to be developed in a range of improvement and implementation science approaches.**
- **Nurses and midwives need to develop skills in gathering, collating and analysing data from across a range of professional and clinical systems for improving practice and driving innovation.**

7

THE WAY FORWARD - RECOMMENDATIONS

SECTION 7: THE WAY FORWARD – WORKING TO ACTION



Realising the Value of Nursing and Midwifery: - A Socio-Economic Perspective

In formulating the recommendations of this report it was important to consider the current and potential value of nursing and midwifery particularly in the context of enabling the population of NI to 'enjoy long healthy active lives'. It has been internationally recognised that the nurses and midwives undertake different roles in different circumstances, but they all share in the combination of knowledge, practical skills and values that has them well placed to meet the current and future needs of the population[55]. Whilst other professions share some or all of these features, the nursing and midwifery

contribution is unique because of its underpinning evidence base, the range and diversity of professional roles and the scale of the workforce. In reality the professions provide around the clock care, are often the first point of contact, and sometimes the only health professional engaging with people in the delivery of care and treatment. They are also an important part of the community, sharing its culture, strengths and vulnerabilities. Furthermore, nurses and midwives can shape and deliver effective interventions to meet the emerging needs of patients, families and local neighbourhoods. Whatever their particular role, they are guided by professional education, knowledge and their deep rooted person centred and humanitarian values.

Enabling people to make healthy choices to live well for longer across their life course.
Nursing and midwifery together spans the life course. When the family of midwives, health visitors, paediatric nurses, school nurses and Child and Adult Mental Health Services work collectively they are crucial to enabling the best start in life. The research shows that when this happens the costs associated with developmental delay, physical, social and mental health problems are significantly reduced[56]. Adverse Childhood Experience (ACE) research demonstrates that multiple ACEs is a major risk factor for many health conditions and represents risks for the next generation (e.g., violence, mental illness, substance use and long term physical health conditions)[57]. The research also shows that children and young people with four or more ACE's are more likely to develop serious long term health conditions, mental ill-health and significant levels of socio-economic disadvantage. Additionally, for early years, the contribution of midwifery has realised substantial health and wellbeing benefits for women, mothers and their infants when high-quality midwifery care is delivered and midwifery care provided by educated and regulated practitioners was found to be more than cost-effective.

Through the work of health visiting and early years nursing it is possible to reduce the cost of long term health conditions and to reduce intergenerational trauma and poor mental ill health. We know that mental ill health costs the NI Economy £3.5 billion[58]. Investing in prevention through enhanced early years and mental health nursing and midwifery roles could therefore significantly reduce the social and economic costs associated with poor mental health. An excellent example of this in practice is the family nurse partnership. A recent evaluation by demonstrated that it adds value through transforming the lives of children and their parents and breaking the intergenerational cycle of disadvantages[59].

Older people, whether in hospitals, care homes or in their own homes, who do not get enough opportunity to mobilise, are at increased risk of reduced bone mass and muscle strength, reduced mobility, increased dependence, confusion and demotivation[60].

These problems can be attributed to the phenomenon of what can be termed as 'deconditioning syndrome'. This affects well-being as well as physical function and could result in falls, constipation, incontinence, depression, swallowing problems, pneumonia and leads to demotivation, and general decline. We know that 10 days of bed rest in hospital leads to the equivalent of 10 years of ageing in the muscles of people over 80. Getting patients up and moving has been shown to reduce falls, improve patient experience and reduce length of stay by up to 1.5 days[61].

Enabling people to live well through acute and episodic care and treatment

As an evidence based profession nursing and midwifery delivers substantial socio-economic benefits[62]. Caird et al (2010), in their systematic literature review demonstrated that nurses and midwives working in a range of areas across the life span, collectively reduced costs by enabling people to be well. This included cost avoidance as result of the preventative roles undertaken by nurses and midwives. Research illustrates that prevention reduces costs, for example, falls by over £3,000[63], sepsis between £2,000 - £5,000[64], pneumonia by £2,000[65] and hospital acquired pressure ulcers between £2,000 -£3,000 per patient[66]. The estimated savings from preventing or delaying dementia for 1 year is £15,000 per person[67] on aggregate this data clearly presents an opportunity to increase productivity and reduce the cost of care failure through effective nursing and midwifery care.

In addition, research also shows preventing and effectively treating mental ill health has significant socio-economic benefit[68]. It is estimated that the cost of physical healthcare is around £2,000 extra when the patient is also mentally ill[69]. So if we treat a physically ill person for their mental illness we can expect to save up to £1000 a year on physical healthcare (due to the 50% recovery rate)[70]. It is also estimated that within two years of recovery following successful treatment, the employment rate for those with moderate/ severe mental health problems who recover is increased by 11.4 percentage points and by 4.3 percentage points for those with mild mental health problems. This means for every person who regains or retains employment an annual saving is made of £12,935 in terms of public expenditure[71].

A recent [72]systemic review of the literature on nurse skill mix, evidenced a correlation between higher numbers of registered [73]graduate nurses and lower risk of mortality: for every 10% increase in graduate nurses there was a 7% reduction in mortality rates. Research shows that [74]richer nurse skill mix (e.g., every 10-point increase in the percentage of professional nurses among all nursing personnel) was associated with lower odds of mortality (OR=0.89), lower odds of low hospital ratings from patients (OR=0.90) and lower odds of reports of poor quality (OR=0.89), poor safety grades (OR=0.85) and other poor outcomes (0.80<OR<0.93), after adjusting for patient and hospital factors.

Each 10 percentage point reduction in the proportion of professional nurses is associated with an 11% increase in the odds of death. Therefore a bedside care workforce with a greater proportion of professional nurses is associated with better outcomes for patients and nurses and thus saves money on terms of beds days and the cost associated with delayed recovery.

Enabling people to live well through managing chronic and long term conditions

Whilst more work is needed on establishing the socioeconomic value of nursing many studies show the beneficial impact of nursing and midwifery across different settings. The Institute of Education, University College London, in 2010 undertook a rapid systematic review of the socioeconomic value of nursing and midwifery.[75] They reviewed 32 international studies and concluded that interventions provided by specialist nurses or led by nurses were shown to have a beneficial impact on a range of outcomes for long-term conditions when compared with usual care.

Further individual studies show benefits from nurse-led care including reduced costs[76], higher patient satisfaction, shorter hospital admissions, better access to care, and fewer hospital-acquired infections[77]. Nurse-led interventions for chronic conditions such as diabetes have resulted in patients making more informed decisions about their care and being more likely to adhere to treatment. ANPs not only improved access to services and reduced waiting times, but also delivered the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up[78]. Similarly, an English study also showed that in a comparison of care effectiveness and cost effectiveness of general practitioners and ANPs in primary health care, outcome indicators were similar for nurses and doctors, but patients cared for by nurses were more satisfied[79].

There is evidence to suggest that person and community centred approaches that empower people to become partners in care create the conditions for self-management. Research by NESTA indicates that self-management approaches for people with particular long-term conditions could equate to net savings of around £2,000 per person reached per year, achievable within the first year of implementation[80]. This is now supported by international evidence that suggests changing the way in which patients and clinicians work (co-production) improved health outcomes across a range of long-term conditions, including diabetes, Chronic Obstructive Pulmonary Disease (COPD), hypertension, heart disease and asthma. Patients were less prone to exacerbation and demonstrated improvements in their core clinical indicators. As a result, there was a reduction in the cost of delivering healthcare of approximately seven per cent through decreasing Emergency Department (ED) attendances, reduced hospital admissions, reduced length of stay, and decreased patient attendances[81]. It was further hypothesized that implementing this approach in England could save the NHS £4.4 billion.

The Health Foundation publications on person-centred practice and self-management also suggest found that people who are supported to manage their own care more effectively are less likely to use emergency hospital services[82]. For example, people who take part in shared decision making are more likely to engage actively in their treatment plan, which results in better outcomes. The Foundation also found that self-management programmes can reduce health care utilisation. Several studies reported that self-management can reduce visits to health services by up to 80%. If implemented within NI, this would have significant impact on population health outcomes considering that one in five people live with a long-term condition. Across the life course nursing and midwifery are therefore uniquely placed to enable recovery and reduced costs associated with length of stay, acuity and adverse health care experience.

Recommendations

Enabling people to make choices to live well through end of life care

Whilst acknowledging there is a need for deeper and more rigorous socio-economic evaluation of the impact of nursing and midwifery, an attempt has been made to place recommendations in the context of the socioeconomic evidence. The recommendations are focused on four key areas presented below.

Maximise the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

1. The development of a new population health management programme for nursing and midwifery.
2. The creation of dedicated population/public health midwife and advanced nurse and nurse and midwife consultant roles across all of our HSC bodies.
3. To increase the numbers of School Nurses, Health Visitors and expand the Family Nurse Partnership programme across all of NI.
4. Recognising the demographic skills, nursing needs to have joint and collective responsibility for the development, planning and leadership of older people services, including all nursing care services provided in the independent sectors.

Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred practice

5. Sustain a minimum of 1000 pre-registration nursing and midwifery places and increase in line with the needs of the population over the next five years.
6. Establish a ring-fenced post education budget commensurate with both the size of the workforce and the HSC transformation agenda and as minimum re-establish the previous investment of £10M.
7. Build and resource a new career framework for nursing and midwifery to ensure that within ten years we have advanced nurse, specialist midwife and nurse roles as well as nurse and midwife consultant roles across all branches of nursing and midwifery.
8. Increase the number of clinical academic careers roles across all midwifery and all branches of nursing.
9. Put Delivering Care Policy (safe staffing) on a statutory footing.
10. Develop arrangements for accelerated pay progression Band 5 to Band 6 grades similar to other professions. This in particular recognises that many Band 5 nurses after several years of practice acquire additional specialist knowledge and skills take on additional responsibilities commensurate with band 6 role as a senior clinical decision maker. Midwives currently move to Band 6 a year after registration.
11. Develop a person centred practice policy framework for all nursing and midwifery services.

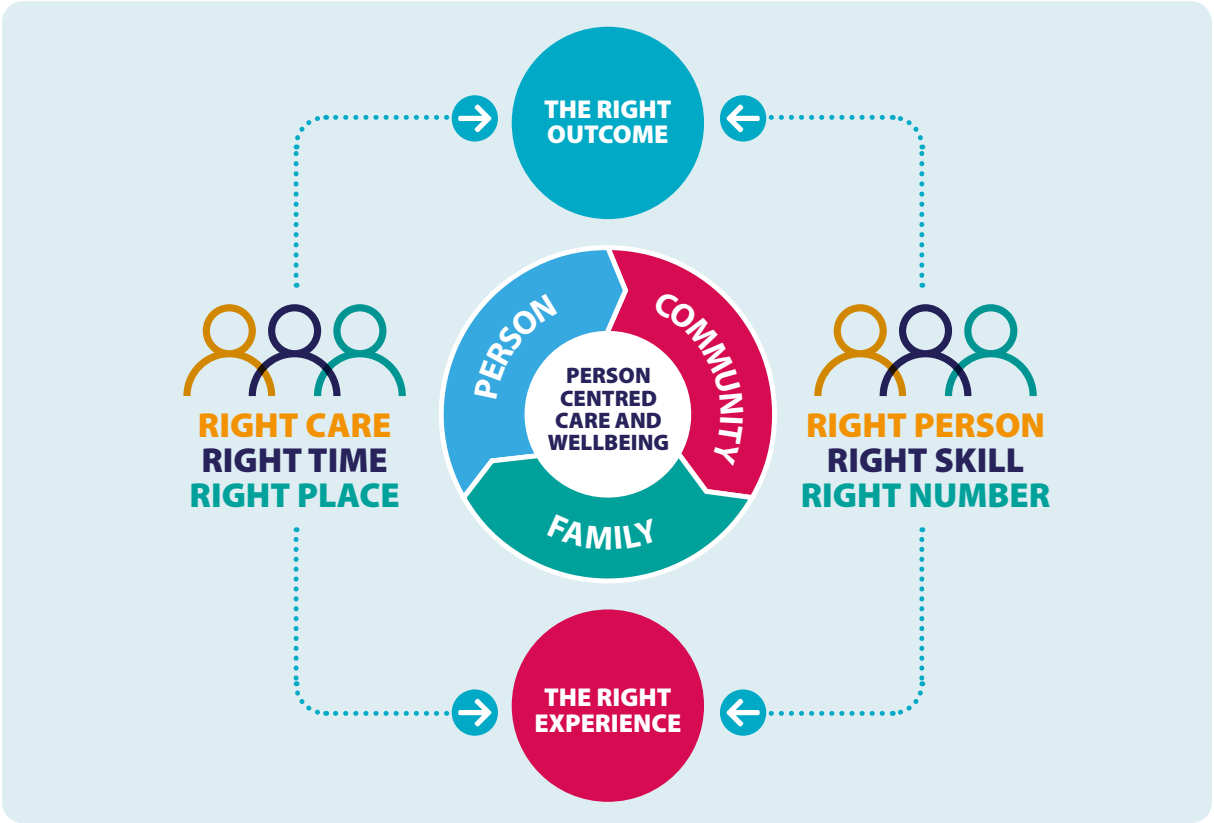
Doing the right thing in the most effective way – working in partnership

12. Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse/midwife leadership framework and investment in leadership training for nurses and midwives.
13. Invest in improvement science training and increase role of leadership in nursing and midwifery in quality improvement initiatives.
14. Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness.
15. Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) of a new digital nurse leadership roles in all HSC bodies.

Conclusion

The recommendations outlined above reflect a new vision/ambition **figure 20** to maximise the contribution of nursing and midwifery, which can be both used to guide decision making, but also to measure progress. It is our ambition that nursing and midwifery deliver the right evidence based care, with the right numbers, at the right time, in right place, by the right person with the right knowledge, and of course most importantly delivering the right experience for persons, families and communities.

Figure 20 - The Nursing and Midwifery Ambition



In order to take forward the recommendations outlined above, a new nursing and midwifery strategy will need to be developed that is in line with *Health and Wellbeing 2026: Delivering Together* priorities. Indeed the Bengoa Report (October 2016) makes clear that system transformation is dependent on the modernisation of practice. Nursing and Midwifery in line with the recommendation of this report will undergo significant practice reforms and clearly with a multi-disciplinary approach which is central to the delivering of better outcomes. The recommendations in this report will inevitably require legislative and ministerial approval and the development of a dedicated action plan. Clearly the recommendations will require additional significant investment over a 10-15 year period and this will be dependent on resources being released through service reconfiguration and/or efficiencies as well as securing new investment.

ANNEX A

Membership

The following members have been appointed to the Nursing and Midwifery Task Group:

- Chair – Sir Richard Barnett
- Expert panel – Bronagh Scott (NHS Wales)
- Education and research / person centred care – Prof Tanya McCance (UU)
- Public Health – Prof Viv Bennett (Public Health England)
- NIPEC – Angela McLernon
- RCN – Dr Janice Smyth
- Population Health Improvement – Dr Mary Hinds (PHA)
- Quality, Safety and Innovation – Dr Anne Kilgallen (DoH)
- Workforce and Education – Caroline Lee (CEC)
- eHealth – Sean Donaghy (HSCB)
- Former Director of Nursing – Alan Corry-Finn
- Deputy Chief Nursing Officer – Rodney Morton (DoH)
- Director of Nursing – Eileen McEneaney (NHSCT)
- RCM – Breedagh Hughes / Karen Murray
- Independent Sector – Carol Cousins (Four Seasons)

Additional Support

Additional support was also provided by the following:

- Angela Reed, NIPEC
- Heather Finlay, DoH
- Mary Frances McManus, DoH
- Verena Wallace, DoH
- Dr. Dale Spence, DoH
- Alison Dawson, DoH

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GLOSSARY

NMTG	Nursing Midwifery Task Group
DoH	Department of Health
LTC	Long Term Conditions
CNO	Chief Nursing Officer
HSCB	Health and Social Care Board
MECC	Making Every Contact Count
ANP	Advanced Nurse Practitioner
CEC	Clinical Education Centre
HV	Health Visitor
WTE	Whole Time Equivalent
MDT	Multi-disciplinary Team
NMC	Nursing Midwifery Council
UHC	Universal Health Coverage
CYP	Children and Young People
WHO	World Health Organisation
CAMHS	Child and Adolescent Mental Health Services
AfC	Agenda for Change
RCN	Royal College of Nursing
NHS	National Health Service
PfG	Programme for Government
MLU	Midwifery Led Unit
FMU	Free Standing Midwifery Led Unit
FNFM	Future Nurse Future Midwife
EITP	Early Intervention Transformation Programme

For Further Information Contact Nursing and
Midwifery Directorate Department of Health
nursingandmidwifery@health-ni.gov.uk

Nursing and Midwifery Task Group

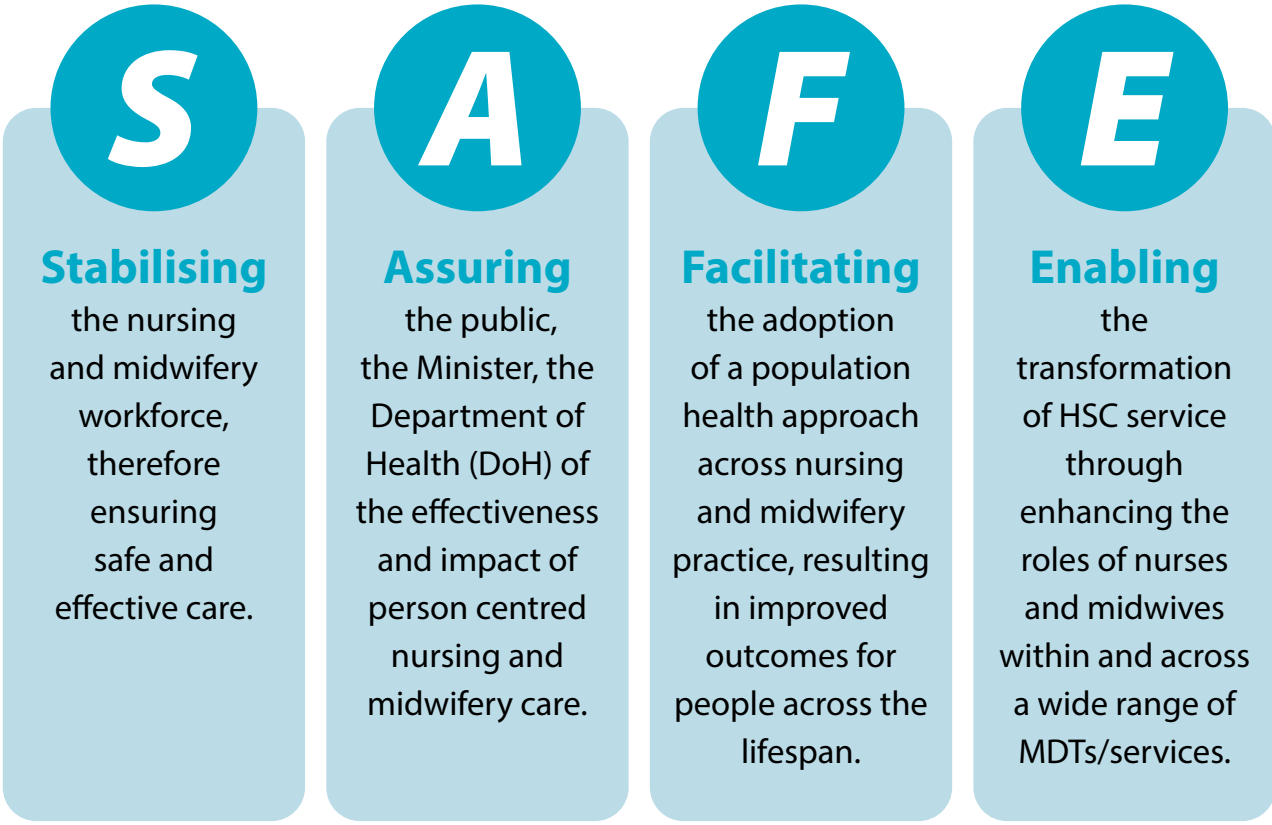
Next Steps Framework – A Three Phased Approach

2020 - 2026

1.0 IMPLEMENTATION CONTEXT:

This plan sets out the key actions required to deliver the recommendations of the NMTG and reflect a new vision / ambition to maximise the contribution of nursing and midwifery, which can be used to guide decision making and measure progress. The recommendations of the task group aim to create the conditions for nursing and midwifery services, to develop and be co-designed to deliver the right evidence based care, with the right numbers, at the right time, in the right place, by the right person, with the right knowledge, and of course most importantly delivering the right outcome and experience for people, families and their communities.

The actions in this plan have been prioritised and modelled on the NMTG '***SAFE'*** principle;-



Whilst the primary aim of the NMTG was to develop a ten to fifteen year road map, this plan adopts a three phased approach aligned with strategic themes outlined in the NMTG report.

STRATEGIC THEME 1:

The adoption of a population health approach, through putting public health, prevention and early intervention at the heart of nursing and midwifery practice.

STRATEGIC THEME 2:

Stabilisation of nursing and midwifery workforce therefore ensuring safe and effective care.

STRATEGIC THEME 3:

Transformation of Health and Social Care Service through enhancing the roles that nurses and midwives will play within and across multi-disciplinary teams.

In line with the Minister's commitment, the plan has also been fully costed and a number of the recommendations have been identified for funding as set out in the 'New Decade, New Approach' Framework and Executive Commitment. These commitments will form part of phase one of the implementation of this plan. It is important to note the pace of implementation will be determined by the budget outcome for DoH, and all subsequent phases will require further strategic prioritisation and resource planning, this will also include the release of resources through efficiencies and transformation.

It is proposed that in 2026 this plan will be refreshed with a new five year strategic action plan, which at that stage, reflects population health needs, new political and policy mandates as well as new ways of working. The NMTG implementation plan and the development of a new Nursing and Midwifery Strategy will be overseen by the Chief Nursing Officer (CNO) in partnership with Central Nursing and Midwifery Advisory Committee (CNMAC) and in partnership with trade unions. Please note the actions outlined are indicative and may be subject to revision. In addition costs quoted in the following tables should be noted as indicative and accumulative.

2.0 STRATEGIC THEME 1

Maximising the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

*(*Recommendations identified for funding under 'New Decade,New Approach' and Executive Commitment)*

NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	WHAT IT WILL COST AND BY WHEN					
			Phase 1		Phase 2		Phase 3	
			20/21	21/22	22/23	23/24	24/25	25/26
1. Put in place a new population health management programme for nursing and midwifery.	Develop a new public / population nursing & midwifery framework & develop a population health practice development programme.	Annually 1,000 nurses / midwives trained in Public Health Care.		£60K	£61K	£63K	£64K	£65K
2. The creation of dedicated Population/Public Health Advanced Nurse and Consultants roles for nurses and midwives across all of our HSC bodies.	*** Recruit a Regional Public/ Population Health Nurse /Midwife Consultant lead.**	16 WTE Public Health Practitioners resulting in improved public health outcomes.	**£70K**	**£102K**	**£104K**	**£106k**	**£108K**	**£110K**
	Strengthen Public Health Clinical Leadership Infrastructure in HSC Trust.			£426K	£434K	£443K	£452K	£461K
	Develop Public Health ANP/Midwife Programme / post.				£55K	£110K	£749K	£761K
3. Increase the number of school nurses, health visitors and expand the Family Nurse Partnership programme across all of NI.	Recruit additional Schools Nurses.	157 WTE Early Years nursing resulting in better outcomes for children young people & families.	£289K	£799K	£1.2M	£1.6M	£2.0M	£2.5M
	*** Implement Delivering Care Phase 4 Health Visiting.**			**£520K**	**£1.0M**	**£1.6M**	**£2.1M**	**£2.6M**
	Roll out Family Nurse Partnership.		£295K	£784K	£1.1M	£1.4M	£1.8M	£2.2M
4. Recognising the demographic trends, nursing should co - lead the development, planning and management of older people services including nursing care commissioned in the independent sectors.	Recruit Older Persons Nurse Consultant Leads in each HSC Trust.	30 WTE Older people nurses – resulting in improved health care across older people services.		£360K	£367K	£374K	£382K	£389K
	Enhance Community District & Specialist Nursing Home In-reach Services.		£248K	£505K	£773K	£1.1M	£1.3M	£1.4M
Total – Strategic Theme 1			**£902K**	**£3.6M**	**£5.1M**	**£6.8M**	**£9M**	**£10.5M**

3.0 STRATEGIC THEME 2

Maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred care.

*(*Recommendation identified for funding under 'New Decade,New Approach' and Executive Commitment)*

			WHAT IT WILL COST AND BY WHEN					
			Phase 1		Phase 2		Phase 3	
NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	20/21	21/22	22/23	23/24	24/25	25/26
1. Develop a person centred policy framework for all nursing & midwifery	Commission the development of Person Centred Digitalised Pathway.	6 WTE leads & new digitised person centred app.		£260K	£319K	£326K	£332K	£338K
2. Sustaining a minimum of 1000 under-graduate nurse & midwife placements for next five years until a position of oversupply is reached.	*** Maintain the undergraduate nursing and midwifery places at 1,000 per year and increase by 300 training places each year for next three years (additional 900 students between 2020 and 2023)**	1,300 student training places per year over the next three years cumulatively increasing to 3,900 students in training by 2023.	*£6.0M	*£11.4M	*£15.8M	£18.1M Review	£18.1M Review	£18.1M Review
3. Invest recurrently in nursing & midwifery post graduate education at a level commensurate with both the size of the workforce and the transformation agenda.	*** Increase post graduate nursing and midwifery education and training.**	Enable growth in specialist nurse training in line with HSC Transformation rising from £7.3M to £11.3M	**£2.7M**	**£4.0M**	**£4.1M**	**£4.2M**	**£4.3M**	**£4.3M**
4. Build & resource a new career framework so that within ten years there are Consultant Midwives & Advanced Nurses across all branches & across nursing specialities. **5. Increase the number of clinical academic roles in midwifery & all branches of nursing.**	Develop strategic plan which will systemically increase the number of Advance Nurse Practitioners, Consultant Nurses & Midwifes and Clinical Academic nurse/midwife roles.	120 WTE ANP in primary & community / secondary care 25 WTE Nurse/Midwifery Consultants. 25 WTE Clinical Academic posts.		£1.9M	£4.6M	£7.2M	£10M	£12.9M
6. Put Delivering Care Policy (normative (safe staffing) on a statutory footing. **(Please note Delivering Care Phase 4 costs covered by recommendation 3 above)**	***Implement Delivering Care Phases 2, 3, 5, & 7 and commission systems dynamic workforce modelling for the entire nursing and midwifery workforce.** Prepare submission for Minister Re:- Delivering Care Legalisation.	Additional 908 WTE nurses (phase, 2, 3, 5, & 7).	**£9.93M** **£100K**	**£19.4M** **£100K**	**£33.9M**	**£48.3M**	**£57.8M**	**£58.9M** **Review**
7. Develop arrangements for band 5-6 pay progression similar to other professions.	**Conduct a review to establish evidence of the cost and benefits of full implementation.**	To be agreed.						
Strategic Theme 2 Totals			**£18.8M**	**£37M**	**£58.7M**	**£78.1M**	**£91M**	**£94.7M**

4.0 STRATEGIC THEME 3

Doing the right things in the most effective way – working in partnership. Transformation of Health and Social Care Service through enhancing the roles that nurses and midwives play within and across multi-disciplinary teams.

*(*Recommendations identified for funding under 'New Decade, New Approach' and Executive Commitment)*

NMTG RECOMMENDATIONS	WHAT WE WILL DO	WHAT THIS WILL MEAN	WHAT IT WILL COST AND BY WHEN					
			Phase 1		Phase 2		Phase 3	
			20/21	21/22	22/23	23/24	24/25	25/26
1. Develop and prepare nurses and midwives for leadership positions. This will require investment in the development of a new nurse leadership framework and investment in leadership training for nurses and midwives	Standardise Nursing & Midwifery Leadership Infrastructure. Strengthen senior clinical nurse & midwife leadership posts. Invest in an Aspiring Nurse and Midwife Leadership Training Programme.	36 WTE clinical leadership posts in midwifery & all branches of nursing. 48 Trainees.	£418K	£852K £160K	£1.3M	£1.8M £160K	£2.3M	£2.8M £160K
2. Invest in improvement science training and increase role of nursing and midwifery leadership in quality improvement initiatives.	Invest in Nurse and Midwife QI and Implementation Science Leads.	5 WTE Qi Leads.	**£353K**	**£360K**	**£367K**	**£374K**	**£382K**	**£389K**
3. Develop a new statutory assurance framework for nursing and midwifery in order to underpin quality, safety, and effectiveness	Put in place a new nursing and midwifery quality assurance framework, and prepare a submission for minister on statutory requirements to underpin the framework.	Provides assurance and evidence of the impact of nursing and midwifery at policy and board levels	**Develop framework by 2022**					
4. Increase the role of nursing and midwifery in digital transformation through the creation (at senior level) of a new digital nurse and midwife leadership role in all HSC bodies.	Establish a digital/innovation nurse/midwife network and appoint a regional digital and innovation nurse/midwife Lead and HSC digital nurse/midwife HSC Trust Leads.	6 WTE nurse / midwifery leads.	£438K	£447K	£456K	£465K	£474K	£484K
Strategic Theme 3 Totals			**£1.2M**	**£1.8M**	**£2.1M**	**£2.8M**	**£3.2M**	**£3.8M**

5.0 SUMMARY OF STRATEGIC THEME COSTS

	WHAT IT WILL COST AND BY WHEN					
	Phase 1		Phase 2		Phase 3	
	20/21	21/22	22/23	23/24	24/25	25/26
Strategic Theme 1 Totals	£902K	£3.6M	£5.1M	£6.8M	£9M	£10.5M
Strategic Theme 2 Totals	£18.8M	£37M	£58.7M	£78.1M	£91M	£94.7M
Strategic Theme 3 Totals	£1.2M	£1.8M	£2.1M	£2.8M	£3.2M	£3.8M
Grand Total	**£20.9M**	**£42.2M**	**£65.9M**	**£87.7M**	**£103.2M**	**£109M**

RECOMMENDATIONS IDENTIFIED FOR FUNDING NEW DECADE NEW APPROACH AGREEMENT AND EXECUTIVE COMMITMENT

	20/21	21/22	22/23	23/24	24/25	25/26
Delivering Care Phase 4 Health Visiting & Public Health Nursing	£70K	£622K	£1.1M	£1.7M	£2.2M	£2.7M
Increasing undergraduate places	£6.0M	£11.4M	£15.8M	£18.1M	£18.1M	£18.1M
Post Graduate Education	£2.7M	£4.0M	£4.1M	£4.2M	£4.3M	£4.3M
Implementing Delivering Care 2, 3, 5, & 7.	£9.93M	£20.1M	£33.9M	£48.3M	£57.8M	£58.9M

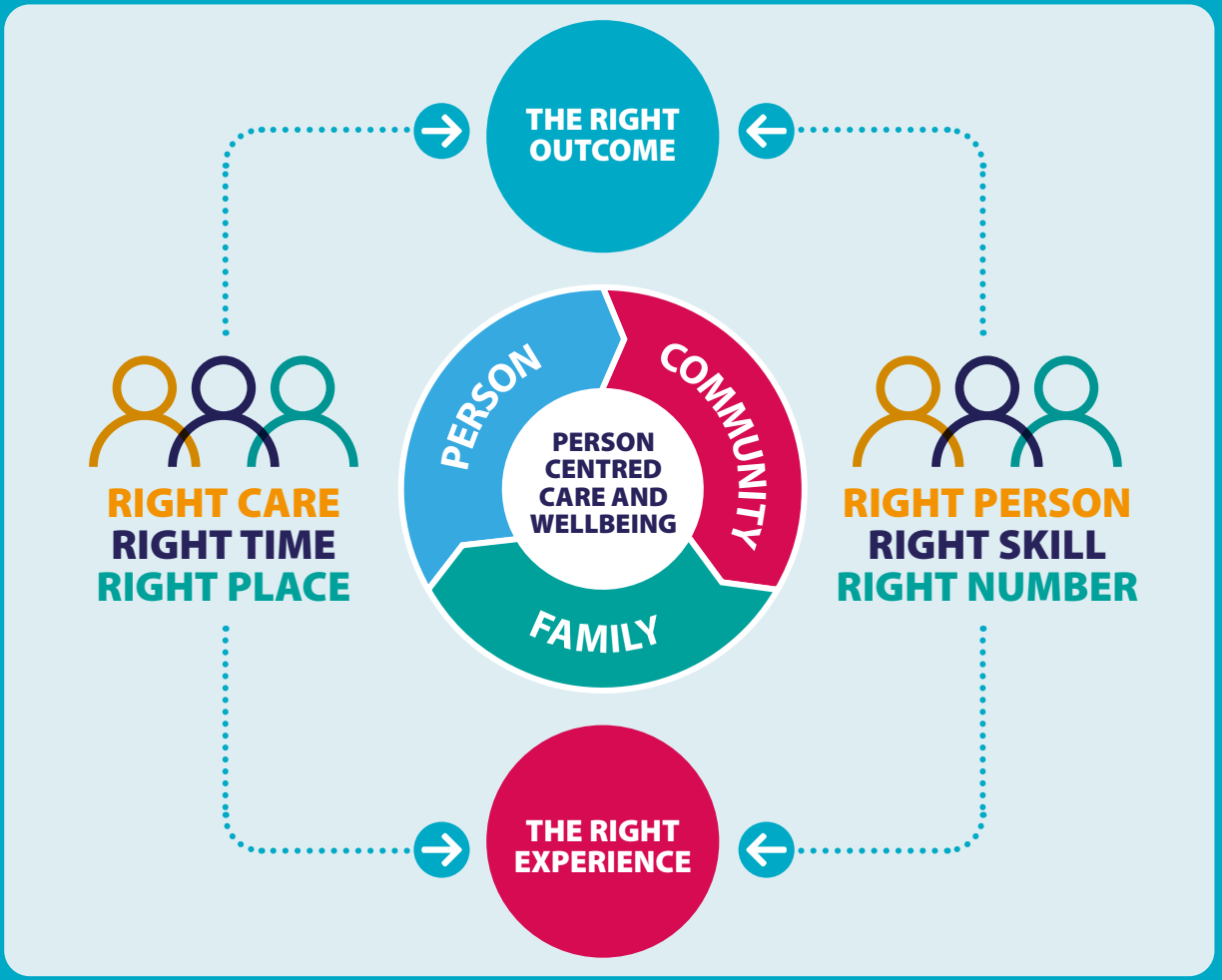
Recommendations Identified For Funding New Decade New Approach and Executive Commitment	£18.7M	£36.1M	£54.9M	£72.3M	£82.4M	£84M
Funding Gap	£2.2M	£6.0M	£11M	£15M	£20.8M	£25M

HOW GAP MIGHT BE FUNDED:

Between 2020 and 2026, in addition to those recommendation identified for funding under the 'New Decade New Approach' Agreement it is estimated that approximately an additional £25Millon would be required to fund the remaining NMTG recommendations over the next five years. The current nursing and midwifery agency spend is £51M (18/19), and assuming this could be incrementally converted into savings, then a proportion of this funding could be reinvested to cover the costs of the remaining recommendations.

MOVING AHEAD:

Our Ambition, Our Commitment:
Nursing and midwifery services dedicated to delivering person centred, evidenced based health and wellbeing care outcomes.



Jim Livingstone
Director of Safety, Quality and Standards

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Phase 2 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

Circular Reference: HSC (SQSD) 08/2010

Date of Issue: 30 April 2010

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NI Blood Transfusion Service
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management, HSC Board
- Directors of Social Services in HSC Board and HSC Trusts
- Director of Dentistry in HSC Board
- Director of Pharmacy in HSC Board
- Directors of Nursing in HSC Board and HSC Trusts
- Director of Primary Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation and Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The purpose of this Circular is to advise HSC organisations of revised arrangements for adverse incident reporting which are being introduced following a review of the existing adverse Incident reporting and learning systems.
The Circular provides guidance on:
(i) the transitional reporting arrangements which will be put in place pending the full establishment of a new Regional Adverse Incident and Learning (RAIL) system, and
(ii) the revised reporting roles and responsibilities of stakeholder organisations.

Enquiries:

Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D 1
Castle Buildings
Stormont
BELFAST

Related documents

DS 154/06 – Emergency Care Reform – Definition & Guidance Framework
HSS(MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports
HSS(MD) 06/2006: Memorandum of Understanding – Investigation Patient/Client Safety Incidents
HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
Letter from Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 1 November 2005
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
Letter from the Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 11 September 2006
HSC(SQSD) 19/2007: Reporting and follow-up on SAIs/Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Departments
Letter from Chief Social Services Officer 'Serious Adverse Incidents involving Looked After Children in Residential Care entering the Juvenile Justice Centre' , 15 May 2008

Status of Contents:

Action

Implementation:

From 1 May 2010

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E-mail: sean.scullion@dhsspsni.gov.uk

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Dear Colleague

LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES REPORTED BY HSC ORGANISATIONS AND FAMILY PRACTITIONER SERVICES

Introduction

In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department and the implementation of the Regional Adverse Incident and Learning (RAIL) model.

The new RAIL model will reflect the statutory responsibilities of Health and Social Care organisations and will introduce a more coherent and comprehensive regional system for reporting incidents. This will ensure that safety messages and regional learning are identified and disseminated in a consistent and effective manner, and will provide a focus on driving improvements in the quality and safety of services through ensuring that important learning is used to inform and improve practice. It will also ensure that the Department and the Minister are informed of significant events in a timely fashion through the establishment of an Early Alert system, and the arrangements for this will be the subject of a separate circular.

The purpose of this circular is to provide specific guidance on:

a) the arrangements which will be in place following the transfer of the existing Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency, pending the establishment of RAIL, **Section 1**; and

b) the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department, **Section 2**.

This guidance will take effect from 1st May 2010. These arrangements will remain in place until the full implementation of the RAIL system, at which point they will be reviewed.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Yours sincerely

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Section 1: Reporting Serious Adverse Incidents

1.1 This section outlines the revised arrangements for reporting and management of serious adverse incidents, pending the full implementation of the new RAIL system.

Changes to the reporting of Serious Adverse Incidents

1.2 The requirement on HSC organisations to routinely report SAIs to the Department will cease with effect from the 1st May 2010. Those SAIs which have been reported to the Department up until this date will be reviewed by the Department, with a view to transferring responsibility for any follow-up action that may be required to the HSC Board, working with the PHA. However, it is likely that the Department will wish to retain oversight responsibility for a small number of incidents reported prior to 1st May 2010 where it considers there are particular or significant issues in relation to regional learning, and these will continue to be considered by the Department SAI Review Group, which will remain in operation for a limited period of time to facilitate this. Consequently the Department may continue to request appropriate follow-up information from reporting organisations in relation to these particular cases.

1.3 ***Reports to the HSC Board –*** In line with the operational guidance[1] issued by the HSC Board and PHA to HSC Trusts in parallel with this circular, all incidents which meet the criteria for SAIs as defined in this operational guidance should be reported to the HSC Board with effect from the 1st May 2010. Family Practitioner Services should maintain their existing arrangements for reporting SAIs to the HSC Board.

1.4 The HSC Board will acknowledge receipt of each SAI notified to it, and will obtain any necessary professional advice from the appropriate health and social care professional within the PHA or HSC Board. The PHA and the HSC Board will jointly determine whether any immediate action is required. The HSC Board will ensure that all relevant professional disciplines are involved as appropriate in the management of the incident. The HSC Board will request an incident investigation be carried out by the reporting organisation, to be forwarded to it within 12 weeks in line with current practice. In this regard, incident reviews should continue to be conducted and submitted in the format outlined in HSS (MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports, included at Appendix 3 of the HSC Board/PHA operational guidance. In addition, the National Patient Safety Agency's toolkit is available for investigations which require a full root cause analysis[2].

1.5 The HSC Board will establish a system to ensure that the reports of investigations are discussed by relevant multi-disciplinary staff from the HSC Board and the PHA to identify any learning recommendations arising, and the most appropriate methods of sharing and/or disseminating the lessons therein. The HSC Board will liaise with the Department as appropriate regarding the most effective mechanisms for disseminating any regional guidance which may be required.

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[1] http://www.hscboard.hscni.net/lnews/22%20April%202010%20-%20HSCB%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010.pdf

[2] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901

1.6 HSC organisations will retain their existing responsibility for reporting, managing, investigating, analysing and learning from adverse incidents/near misses occurring within their organisation in accordance with criterion 4 of the core Risk Management Controls Assurance Standard (CAS). The Risk Management CAS is being updated in line with this circular and will be available on the Department's website from June 2010. These responsibilities are described in more detail in **Section 2**. Similarly the HSC Board will retain existing responsibilities with regard to adverse incidents occurring in Family Practitioner Services.

1.7 ***Reports to the Regulation and Quality Improvement Authority (RQIA)*** - RQIA will continue to require incidents to be reported to it in accordance with the new statutory responsibilities it assumed associated with the transfer of functions from the Mental Health Commission, as detailed in the 2007 UTEC Committee guidance [3]. These include incidents involving ***suspected suicides*** and ***under 18s admitted to adult mental health and learning disability facilities*** as referred to in circular HSC(SQSD) 22/09.

1.8 The RQIA also has extended responsibilities under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Under the 'national preventative mechanism' (NPM), there is a statutory requirement to inform RQIA of the death of any patient or client not resulting from natural causes (including homicides), physical, sexual or other serious assaults and allegations/incidents of abuse in hospital or community services. This should involve, where appropriate, collaborative working with the HSC Board. Further details of RQIA responsibilities in respect of reporting and investigation of incidents are set out in Section 2.

1.9 ***Reporting of suspected suicides -*** From 1st May 2010, SAIs involving suspected suicides are to be reported to both the HSC Board and RQIA in the first instance. However, the management and follow-up of reported incidents with the reporting organisation will be undertaken by the HSC Board and PHA, who will liaise with RQIA in this process.

1.10 ***Reporting of incidents under Children Order Statutory Functions –*** Incidents/events relating to;

(a) the admission of under 18s to adult mental health and learning disability facilities;
(b) children from a looked after background who abscond from care settings, which includes trafficked children and unaccompanied/asylum seeking children;
(c) children from a looked after background who are admitted to the Juvenile Justice Centre or Young Offenders' Centre;
(d) placements outside of the regulated provision for 16-17 year olds; and
(e) serious incidents necessitating calling the police to a children's home

will no longer be reported through the SAI reporting system. With effect from 1st May 2010 such incidents/events should instead be reported directly to the Social Care and Children Directorate at the HSC Board. Details of the arrangements for such notifications are set out in the operational guidance issued by the Social Care and Children Directorate at the HSC Board.

[3] www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

1.11 ***Breach of 12 hours A&E standard*** – the Performance Management & Service Improvement Directorate within the HSC Board will continue to monitor breaches of this standard. The reporting of these should be emailed direct to hscbinformation@hscni.net using the existing proforma.

Section 2: Roles, Responsibilities and Accountability Arrangements for incident reporting pending the establishment of RAIL

Health and Social Care Trusts

2.1 HSC Trusts are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide.

2.2 HSC Trusts are required to:

- Maintain a system to record and track adverse incidents/near misses in their organisation;
- Adhere to guidance issued by the HSC Board/PHA with regard to managing SAIs;
- Take any immediate steps necessary to prevent re-occurrence of harm;
- Investigate incidents using a method proportionate to the incident (and in compliance with the requirements set out in the joint Memorandum of Understanding between the HSC, Coroner's Service, PSNI and Health and Safety Executive on investigating patient or client safety incidents[4]) and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board and PHA that the requirements above are being met.

Family Practitioner Services

2.3 Family Practitioner Services are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses within the context of the services that they provide. They will be required to produce evidence of learning as part of their clinical and social care governance arrangements which the HSC Board may use as part of its performance monitoring and service improvement or contractual monitoring arrangements.

2.4 Family Practitioner Services are required to:

- Maintain a system to record and track adverse incidents/near misses in their practice;
- Report to the RQIA and the HSC Board all actual or suspected suicides of patients registered with a GP practice and in receipt of secondary mental health care services in the last two years;

[4] http://www.dhsspsni.gov.uk/ph_hss(md)_6_-_2006.pdf
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

- Investigate incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally, to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board that the requirements above are being met.

Health and Social Care Board

2.5 In line with the HSC Board's performance management and accountability functions, it will hold Trusts and Family Practitioner Services to account for the effective discharge of their responsibilities in reporting and investigating adverse incidents and near misses, and will provide assurance to the Department that these responsibilities are being met and that learning is being implemented. In general terms, the HSC Board is responsible for maintaining those adverse incident reporting and monitoring mechanisms it considers necessary to enable it to carry out the full range of its commissioning, performance management and service improvement functions effectively, ensuring appropriate multidisciplinary involvement of HSC Board and PHA health and social care professionals.

2.6 The HSC Board, working with the PHA, will be responsible for the management of SAI reporting under the arrangements set out in its operational guidance, pending the full implementation of the RAIL system. In addition, the HSC Board is responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.7 The HSC Board is required to:

- Maintain a system to manage SAI reporting, in partnership with the Agency, in line with the arrangements set out in the operational guidance issued in tandem with this circular, pending the implementation of the RAIL system;
- With input from the PHA, hold Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Hold Family Practitioner Services to account for the responsibilities outlined in paragraph 2.4 and provide assurance to the Department that these responsibilities are being met;
- Maintain a system to record and track adverse incidents/near misses that occur within the HSC Board;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met; and
- Participate as a member of the RAIL implementation project.

Public Health Agency

2.8 The PHA, through its integrated commissioning responsibilities with the HSC Board, will support the HSC Board in holding HSC Trusts and Family Practitioner Services to account for the discharge of their responsibilities and ensuring that regional learning is identified and disseminated, and will work with the Board to maintain a system for managing SAIs, pending the full establishment of the RAIL system.

2.9 The PHA will assume lead responsibility for implementing the RAIL system, including securing professional input as appropriate. In addition, the PHA will have responsibility for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.10 The PHA is required to:

- Work with the HSC Board to maintain a system to manage SAI reporting, pending the establishment of the RAIL system;
- Maintain a system to record and track adverse incidents that occur within the PHA;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met;
- Support the HSC Board in holding Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Work collaboratively with the Department and the HSC Board to develop and progress the support structures and processes which will underpin the new RAIL system;
- Be responsible for the operational management of the RAIL system, once established; and
- Nominate the Project Director and provide administrative support for the RAIL implementation project.

Regulation and Quality Improvement Authority

2.11 From 1st April 2009, RQIA assumed responsibility for those incident reporting requirements which were previously the domain of the Mental Health Commission. This includes oversight of adverse incidents occurring within the mental health and learning disability programmes of care, establishing trend analysis and reporting on regional learning from such incidents or issues.

2.12 RQIA is also a named organisation under the UK's National Preventative Mechanism (NPM) established in accordance with the Optional Protocol to the Convention Against Torture (OPCAT). Under the NPM, RQIA is required to visit places of detention, regularly examine the treatment of persons deprived of their liberty, access all information referring to the treatment of those persons as well as their conditions of detention and make recommendations to the relevant authorities.

2.13 The RQIA will:

- Require HSC Trusts to continue to report adverse incidents to it where there are underlying statutory obligations to do so;
- Require HSC Trusts to share reports of adverse incidents occurring in a mental health and learning disability setting in accordance with discharging its new functions under the HSC (Reform) Act (NI) 2009[5]; and
- Require the HSC Board to share other relevant monitoring information in relation to mental health and learning disability programmes of care.

The Department

2.14 In line with its core functions and the revised accountability arrangements which came into effect from April 2009 following the re-organisation of services as part of the Review of Public Administration, the Department will:

- Continue to host the SAI Review Group for a limited period, and will progress a small number of existing SAIs, along with dissemination as appropriate of any regional learning arising from new incidents;
- Oversee the project management arrangements for the implementation of the RAIL system;
- Seek assurance from the HSC Board/PHA on the effectiveness of the interim incident reporting arrangements within HSC Trusts and Family Practitioner Services;
- Seek assurance from the PHA that it will be in a position to effectively operate the RAIL system, including securing professional input to identifying and cascading regional learning.

[5] 2009 c.1 (N.I.)

Timetable for Implementation of RAIL

3.1 It is planned that the RAIL system will be implemented, in partnership with key stakeholders in the process, on a phased basis over the next one to two years, subject to testing of the feasibility, cost and effectiveness of the system.

3.2 As part of the implementation process, a business case for the establishment of the administrative and IT support structures around the RAIL system will be developed, and a number of pilots will be rolled out and tested across the HSC.

Conclusion

3.3 This guidance circular covers the interim reporting arrangements for the initial phase of that implementation process, setting out the roles and responsibilities of all stakeholder bodies in this period, and will be reviewed when the RAIL system is established. Revised guidance will be issued when the new arrangements are in place.

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

CONTENTS

SECTION TWO - APPENDICES

SECTION THREE - ADDENDUM

FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure was developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;
- fulfilling statutory and regulatory requirements;
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will support governance at a local level within individual organisations and will also improve existing regional governance and risk management arrangements by continuing to facilitate openness, trust, continuous learning and ultimately service improvement.

This procedure will remain under continuous review.

Valerie Watts
Chief Executive

SECTION ONE - PROCEDURE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.

www.health-ni.gov.uk/publications/quality-standards-health-and-social-care-documents

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss__sqsd__19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any

case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

http://webarchive.proni.gov.uk/20101215075727/http://www.dhsspsni.gov.uk/print/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on ‘Untoward Events relating to Children in Need and Looked After Children’ to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance, which are more appropriately reported to the HSCB Social Care and Children’s Directorate.

In 2012 the HSCB issued the ‘Protocol for responding to SAIs involving an alleged homicide’. The 2013 revised HSCB ‘Protocol for responding to SAIs involving an alleged homicide’ is contained in Appendix 14.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required when a serious incident occurs.

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/002%20%20HSCB-PHA%20Protocol%20for%20Safety%20Alerts.pdf

Circular HSC (SQSD) 56/16 (21 October 2016) from the Deputy Chief Medical Officer advises of the intention to introduce a Never Events process and that information relating to these events will be captured as part of the Serious Adverse Incident Process. The circular indicates the Never Events process will be based on the adoption of Never Event List with immediate effect.

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-56-16.pdf

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in Department of Health (DoH) Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation and Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Adverse Incident Process within the Directorate of Integrated Care (September 2016). On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community and Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and reviewed by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS.

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.

3.5 Incidents reported and Investigated/ reviewed by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

The MOU has been agreed between the DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations/reviews by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede a SAI review and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

  It is acknowledged these incidents should already have been reported to RQIA as a ***'notifiable event'*** *by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in

conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

AND

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

[1] Source: DoH - How to classify adverse incidents and risk guidance 2006
http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.

5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be

undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

5.1 Level 1 Review – Significant Event Audit (SEA)

Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;
- assess why did it happened;
  - what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local and regional learning.

(refer to Appendix 5 – Guidance Notes for Level 1 – SEA & Learning Summary Report; Appendix 9 – Guidance on Incident Debrief); and Appendix 10 – Level 1 Review - Guidance on review team membership)

The possible outcomes from the review may include:

- closed – no new learning;
- closed – with learning;
- requires Level 2 or 3 review.

A SEA report will be completed **which should be retained by the reporting organisation** (see Appendices 4 and 5).

The reporting organisation will then complete a **SEA Learning Summary Report** (see Appendices 4 and 5 – Sections 1, 3-6), which should be signed off by the relevant professional or operational director and submitted to the HSCB within **8 weeks** of the SAI being notified.

The HSCB will not routinely receive SEA reports unless specifically requested by the DRO. This process assigns reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This will entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission to the HSCB.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the HSCB within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 review following a SEA.

When a Level 2 or 3 review is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Review Team for

consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).

5.4 Involvement of Service Users/Family/Carers in Reviews

- Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – *A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.*

- In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

- The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroners office and that this is also communicated to the Family/Carer.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Review Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template which will be retained by the reporting organisation (see Appendices 4 and 5). A SEA Learning Summary Report (see Appendices 4 and 5 – Sections 1, 3-6) must be completed and submitted to the HSCB within **8 weeks** of the SAI being reported for all Level 1 SAIs whether learning has been identified or not. The Checklist for Engagement/Communication with Service User/Family/Carer following a SAI' must also accompany the Learning Summary Report.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, timescales for completion of the RCA will be indicated by Trusts via the Learning Summary Report to the HSCB.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 and 3 of the RCA Report, outlining TOR and membership of the review team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.

6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI review and there may be aspects of the complaint which will not be part of the SAI review and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the review of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child and Adult Safeguarding

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these investigations/reviews informing the SAI review (see appendix 17).

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Reporting of Falls

Reporting organisations will no longer be required to routinely report falls as SAIs which have resulted in harm in all Trust facilities, (as defined in the impact levels 3 – 5 of the regional risk matrix - see appendix 16). Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning. See links below to Shared Learning Form and Minimum Data Set for Post Falls Review:

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/033%20Falls_Shared%20Learning%20Template_%20V2_June%202016.rtf

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/032%20Regional%20Falls%20Minimum%20Dataset%202016_V2_June%202016.pdf

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

7.5 Transferring SAIs to other Investigatory Processes

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI.

7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

9.0 TRAINING AND SUPPORT

9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

9.2 Support

9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting seriousincidents@hscni.net

9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when

transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail - At present there is not a requirement to apply encryption to sensitive information transferred across the HSC network to other HSC organisations within Northern Ireland. Information transferred between the HSCB, Trusts and Northern Ireland Department of Health is not sent across the internet. If you are transferring information to any address that does not end in one of those listed below, it is essential that electronic measures to secure the data in transit, are employed, and it is advised that encryption is therefore applied at all times to transfers of sensitive / personal information.

  List of email addresses **within the Northern Ireland secure network:**
  '.hscni.net',
  'n-i.nhs.uk'
  'ni.gov.uk' or
  '.ni.gov.net'

  No sensitive or patient/service user data must be emailed to an address other than those listed above unless they have been protected by encryption mechanisms that have been approved by the BSO-ITS.

  Further advice on employing encryption software can be sought from the BSO ICT Security Team.

  Note: Although there is a degree of protection afforded to email traffic that contains sensitive information when transmitting within the Northern Ireland HSC network it is important that the information is sent to the correct recipient. With the amalgamation of many email systems, the chances of a name being the same or similar to the intended recipient has increased. It is therefore recommended that the following simple mechanism is employed when transmitting information to a new contact or to an officer you haven't emailed previously.

  Step 1 Contact the recipient and ask for their email address.
  Step 2 Send a test email to the address provided to ensure that you have inserted the correct email address.
  Step 3 Ask the recipient on receiving the test email to reply confirming receipt.
  Step 4 Attach the information to be sent with a subject line 'Private and Confidential, Addressee Only' to the confirmation receipt email and send.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient/service user level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel 028 95 362912

11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where 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 SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 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.

Whilst the HSCB will not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

12.0 PROCESS

12.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents@hscni.net

HSC Trusts to copy RQIA at seriousincidents@rqia.org.uk in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with 3.2 and 3.3 of this procedure.

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated

correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

12.2 Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

It is important, in the spirit of honesty and openness, that when staff are engaging with Service Users, Families, Carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a Never Event. However it will be for HSC organisations to determine when to communicate this information to Service Users, Families, Carers.

All categories included in the current NHS Never Events list (see associated DoH link below) should now be identified to the HSCB when notifying a SAI.

A separate section within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.

https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

12.3 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents@hscni.net.

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 12.1 of this procedure.

12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising

of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

- SEA Learning Summary Report for Level 1 SAIs within 8 weeks from the date the incident is reported;
- RCA Report for Level 2 SAIs within 12 weeks from the date the incident is reported;
- RCA Report for Level 3 SAIs within the timescale as agreed at the outset by the DRO;

Where relevant, RQIA will be copied into this receipt.

12.5 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

12.6 Review/Learning Summary Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 review reports.

Timescales for submission of review/learning summary reports and associated engagement checklists will be in line with section 6.0 of this procedure.

On receipt of a review/learning summary report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the review/learning summary report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed. The DRO will also consider the referral of any learning identified for regional dissemination. In some instances the DRO may require further clarification and may also request sight of the full SEA review report.

If the DRO is not satisfied that a report reflects a robust and timely review s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received. When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.

12.7 Closure of SAI

Following agreement to close a SAI, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will also indicate, if further information is made available to the reporting organisation (for example, Coroners Reports), which impacts on the outcome of the initial review, that it should be communicated to the HSCB/PHA DRO via the serious incidents mailbox.

This will indicate that based on the review / learning summary report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On occasion and in particular when dealing with level 2 and 3 SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

12.8 Regional Learning from SAIs

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. However, the management of regional learning and associated assurance is the responsibility of the HSCB/PHA.

Therefore, where regional learning is identified following the review of an SAI, the DRO will refer this for consideration via HSCB/PHA Quality and Safety Structures and where relevant, will be disseminated as outlined in section 8.0.

12.9 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

13 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

SECTION TWO APPENDICES

APPENDICES

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 2

Revised November 2016 (Version 1.1)

Guidance Notes
SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE *Insert the unique incident number / reference generated by the reporting organisation.*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4.** DATE OF INCIDENT: DD / MM / YYYY *Insert the date incident occurred*
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7.** PROGRAMME OF CARE: *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DOB: DD / MM / YYYY GENDER: M / F AGE: years
(complete where relevant)

9. IS THIS INCIDENT A NEVER EVENT? Yes/No *(please select)*	If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)* *Insert CCS Stage of Care Code description*	DETAIL: *(refer to Guidance Notes)* *Insert CCS Detail Code description*	ADVERSE EVENT: *(refer to Guidance Notes)* *Insert CCS Adverse Event Code description*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*
Where relevant *please provide details on the current condition of the service user the incident relates to.*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED *(please select and specify **where relevant**)*	YES	NO	N/A

14. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults*) - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted):*

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)*	YES	DATE INFORMED: DD/MM/YY *Insert the date informed*
	NO	*Specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further review may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further review under the SAI process.

The HSCB/PHA DRO will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full review report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED REVIEW REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

APPENDIX 3
Revised November 2016 (Version 1.1)

HSC INTERFACE INCIDENT NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY **GENDER: M / F** **AGE: years**
(complete where relevant)

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (*full details should be submitted in section 7 below*)	

7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:

8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ DESIGNATION: _____

Email: **Telephone:** **Date: DD / MM / YYYY**

Completed proforma should be sent to: seriousincidents@hscni.net

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1	
1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: ***Complete where applicable***	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY
14. WHAT HAS BEEN LEARNED:
15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?
16. RECOMMENDATIONS (please state by whom and timescale)
17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:
18. FURTHER REVIEW REQUIRED? YES / NO Please select as appropriate If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	24. DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*								
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 5

Revised November 2016 (Version 1.1)

GUIDANCE NOTES
LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1 (To be submitted to the HSCB)

1. ORGANISATION: *Insert unique identifier number*	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory*
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory*	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory*
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory*
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY *Self- explanatory*	
8. SUMMARY OF EVENT: ***As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)***	

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER: *Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10*	10. TEAM MEMBERS PRESENT: *NAMES AND DESIGNATIONS*
11. SERVICE USER DETAILS: ***Complete where applicable*** *DOB / GENDER / AGE*	
12. WHAT HAPPENED? *(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).*	
13. WHY DID IT HAPPEN? *(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)*	

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

All sections below be submitted to the HSCB

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED: *(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)*

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? *Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.*

NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).

Action plans for this level of review will be retained by the reporting organisation.

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

Self- explanatory

18. FURTHER REVIEW REQUIRED? YES / NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
Please select as appropriate

20. PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

Refer to section 2 of appendix 7.

22. TERMS OF REFERENCE(If known or submit ASAP):

Refer to section 3 of appendix 7.

SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME: *Self- explanatory*

24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

SECTION 6

26. DISTRIBUTION LIST:

List of the individuals, groups or organisations the final report has been shared with.

APPENDIX 5

To be submitted to the HSCB

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved**				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2 INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 6

Revised November 2016 (Version 1.1)

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

2.0 THE REVIEW TEAM

3.0 SAI REVIEW TERMS OF REFERENCE

4.0 REVIEW METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 7
Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

The following is a sample list of statements of purpose that may be included in the terms of reference:

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the SAI review.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

[4] *http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787*

[5] *http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355*

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert date informed:				
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:				
	a) Draft review report has been shared and further engagement planned to share final report				
	b) Plan to share final review report at a later date and further engagement planned				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate** (✓)				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

APPENDIX 8

GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the review
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

GUIDANCE ON INCIDENT DEBRIEF

- ## Level 1 - SEA Reviews

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

- ## Level 2 and 3 RCA Reviews

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

APPENDIX 10

LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review of an incident should be proportionate to its significance; this is a judgement to be made by the Review Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The review team should appoint an experienced facilitator or lead reviewing officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

APPENDIX 13

GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient/service user affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the review and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the review and action. There may, however, be good reason to vary this arrangement e.g. where a patient/service user has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the review as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single review report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided, then all services are required to provide information / involvement reports to the review team;
- All service areas should be represented in terms of professional makeup / expertise on the review team;
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved;
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined;
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel;
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought;
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

APPENDIX 14

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIMESCALES

The notification to the Trust of a SAI, resulting in homicide, is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

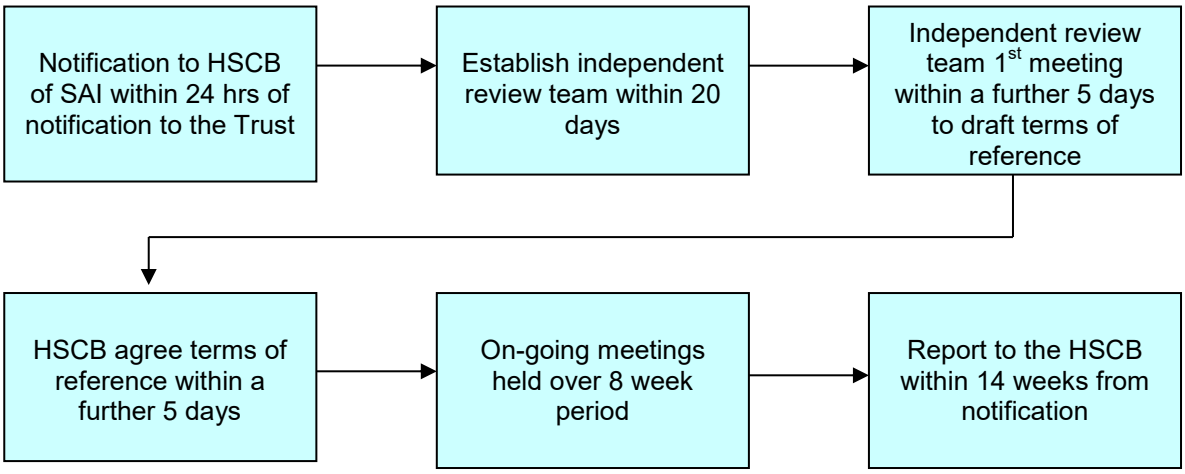
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

APPENDIX 15

ADMINISTRATIVE PROTOCOL

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY AND INDEPENDENT/REGULATED SECTOR

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review/learning summary report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: ***seriousincidents@hscni.net***
and RQIA: **seriousincidents@rqia.org.uk**

[1] **For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.**

APPENDIX 16

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

APPENDIX 17

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

Level 1 Review – Significant Event Audit (SEA). To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

Level 2 Review – Root Cause Analysis (RCA). The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 Review – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children's Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."

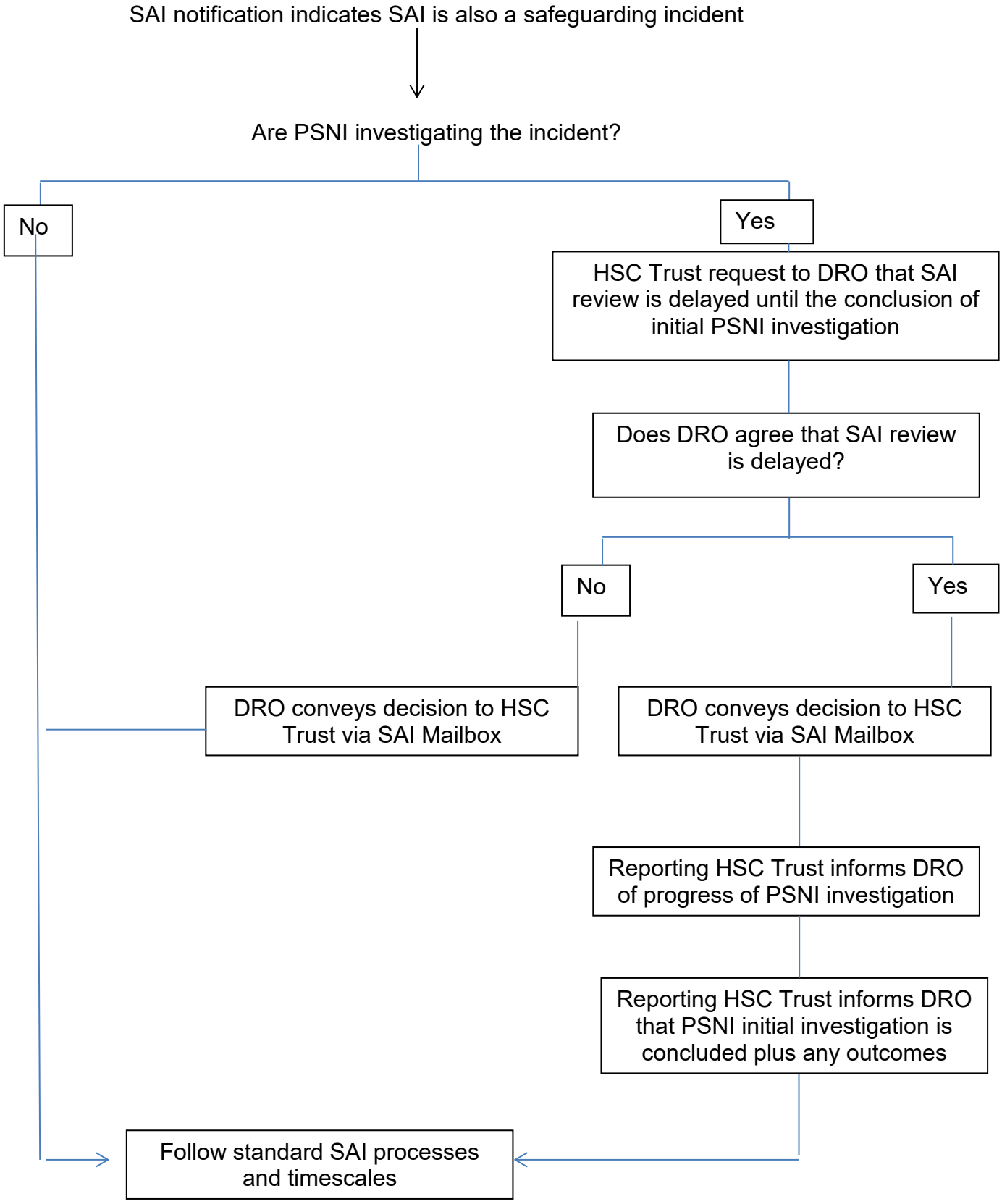
In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES



SECTION THREE ADDENDUM

ADDENDUM

ADDENDUM 1

A Guide for Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

Contents

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;

- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff

should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions

- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social

care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with

the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS	-	Family Practitioner Services
GMC	-	General Medical Council
HSC	-	Health and Social Care
HSCB	-	Health and Social Care Board
HSE	-	Health Service Executive
MDU	-	Medical Defence Union
MPS	-	Medical Protection Society
NIASW	-	Northern Ireland Association for Social Work
NISCC	-	Northern Ireland Social Care Council
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
PCC	-	Patient Client Council
PHA	-	Public Health Agency
RC	-	Royal colleges
RCA	-	Root Cause Analysis
RQIA	-	Regulation and Quality Improvement Authority
SAI	-	Serious Adverse Incident
SEA	-	Significant Event Audit

Appendix 1

Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation's attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone 0800 34 34 34 or Progressive House, 33 Wellington Place, Belfast, BT1 6HN.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Appendix 2

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……..…….

Your link person's job title is……..…..

Contact number …….

Hours of work……..……

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222

Appendix 3

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	"We are here to discuss the harm that you have experienced/the complications with your surgery/treatment" "I realise that this has caused you great pain/distress/anxiety/worry" "I can only imagine how upset you must be" "I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you" "I understand that you are angry/disappointed about what has happened" "I think I would feel the same way too"
Sorry	"I am so sorry this has happened to you" "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation" "I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you" "A review of your case has indicated that an error occurred – we are truly sorry about this"
Story	**Their Story** "Tell me about your understanding of your condition" "Can you tell me what has been happening to you" "What is your understanding of what has been happening to you" **Your understanding of their Story: (Summarising)** "I understand from what you said that" xxx "and you are very upset and angry about this"

	Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) “Am I right in saying that you……..” **Your Story** “Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? “Do you mind if I tell you what we have been able to establish at this stage?” “We have been able/unable to determine at this stage that……..” “We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds” “You may at a later stage experience xx if this happens you should …….”
Inquire	“Do you have any questions about what we just discussed?” “How do you feel about this?” “Is there anything we talked about that is not clear to you?”
Solutions	“What do you think should happen now?” “Do you mind if I tell you what I think we should do?” “I have reviewed your case and this is what I think we need to do next” “What do you think about that?” “These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?” “I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?”
Progress	“Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen” “We will be taking steps to learn from this event so that we can

	try to prevent it happening again in the future” “I will be with you every step of the way as we get through this and this is what I think we need to do now” “We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team” “Would you like us to contact you to set up another meeting to discuss our progress with the review?” “I will be seeing you regularly and will see you next in….days/weeks. “You will see me at each appointment” “Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……” “If you think of any questions write them down and bring them with you to your next appointment.” “Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”

Appendix 4

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	
Agreed professional to act as contact person with the service user / family	

Service user / family informed incident is being reviewed as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	
The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	

It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: _____

***Date*:** _____

DURING ***Note taking***

There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: _____

***Date*:** _____

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: _____

***Date*:** _____

Health and Social Care Board

Public Health Agency

Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) allocated to a Serious Adverse Incident (SAI)

Revised: March 2017

Version 1.0

Contents

1.0 Background

The requirement on HSC organisations to routinely report Serious Adverse Incidents (SAIs) to the Department of Health (DoH) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA). During 2012/13 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013.

A further review was undertaken in November 2016 and issued to all Arm's Length Bodies (ALBs) for full implementation on 1 January 2017. The procedure provides guidance to all Arms Length Bodies in relation to the reporting and follow-up of SAIs arising during the course of business of a HSC organisation/Special Agency or commissioned service.

2.0 Role of the HSCB/PHA in the SAI Process

- Responsible for the effective implementation of the procedure for the reporting and follow up of SAIs across the region;

- Ensuring there are mechanisms in place for SAIs to be reviewed by relevant professionals/senior officers;

- Ensuring there are adequate safety and quality structures within the HSCB/PHA so that trends, best practice and learning is identified, disseminated and implemented in a timely manner in order to prevent recurrence;

- Identify any immediate/medium/long term strategic issues which contributed to the incident and that need to be addressed, and communicate these to the relevant commissioning service;

- Maintain a high quality of information and documentation within a time bound process.

3.0 What are the HSCB/PHA Safety and Quality Structures relating to SAIs?

It is important that when a SAI occurs, that there is a systematic process for reviewing the incident and identify potential learning. The key aim being to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across health and social care as a whole.

The HSCB and PHA therefore have developed a safety and quality structure that provides an effective mechanism for identifying and disseminating regional learning across the province.

- **Quality Safety and Experience (QSE) Group**

QSE is a jointly chaired, group that provides an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Regional Serious Adverse Incident Review Sub-Group (RSAIRSG)**

The RSAIRSG is chaired by the HSCB Governance Manager and the PHA Senior Manager for Safety, Quality and Patient Experience. Membership comprises of professional representatives from the HSCB and PHA; RQIA are also in attendance.

The RSAIRSG has responsibility to ensure that trends, examples of best practice and learning in relation to SAIs are identified and disseminated in a timely manner.

- **SAI Professional Groups**

A number of professional groups from individual programmes of care have recently been established which allow DROs who share the same area of expertise to meet and discuss SAI reviews and where relevant identify regional learning prior to closure of the SAI. These professional groups also provide support to DROs when they may require advice in relation to specific SAIs.

The groups benefit from:

- Multi-professional input / wider circle of experience;
- Group sign off, decisions not focused on one individual;
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends.

- **Safety Quality and Alerts Team (SQAT)**

SQAT, which is closely aligned to the work of QSE, is responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

SQAT is a multidisciplinary group with representatives from the HSCB and PHA and is chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DoH, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

An overview of the Safety and Quality Structures is outlined in Appendix 1.

- **HSCB Governance Team**

The HSCB Governance Team provides the co-ordination, administrative support to all of the above groups and to individual DROs in relation to the management of SAIs from notification to closure of a SAI.

4.0 What is a DRO?

A DRO is a senior professional/officer within the HSCB / PHA who has a degree of expertise in relation to the programme of care / service area where a SAI has occurred.

5.0 What is the role of a DRO?

The DRO has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI;
  - where 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 SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for Level 2 and 3 RCA Reviews, including service user/family/carer engagement and liaising with other professionals (where relevant);

- Liaising with reporting organisations via the Governance Team, where:

  - More information is required in relation to a Level 1 summary report. (Whilst the HSCB will not routinely receive the full Level 1 SEA report, these can be requested.)

  - There may be concerns regarding the robustness of the Level 2 and 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.

- Escalate concerns/issues as necessary to the Director and onwards to the respective Chief Executive as required.

6.0 Process

The following details the systematic approach in relation to the nomination of a DRO to a SAI and the process that follows until such time as the SAI can be closed. (A flowchart reflecting each step of the SAI process is detailed in Appendix 2.)

Step 1 - Notification of SAI

- SAI notified to Governance Team by Reporting Organisation;

- Governance Team.
  - Records SAI on the Datix Risk Management System;
  - Forward SAI Notification to DRO as per Regional DRO Listing or Allocation Flowchart and copy to relevant Directors/Senior Managers (current listing and flowcharts available via the following Link http://insight.hscb.hscni.net/resources/safety/);
  - Where the DRO is not automatically allocated from a Flowchart the Regional Lead/s will assign a DRO (this may be a Regional Lead or another member of staff from within their programme of care / area of specialism). Governance Team will forward SAI Notification to the assigned DRO;

- Acknowledge receipt of SAI Notification to reporting organisation and advise on date for submission of learning summary/review report.

Step 2 - Immediate Actions

- DRO will consider SAI and if they decide it to be of major concern they will liaise immediately with their Director with a view to bringing it to the attention of the Chief Executive;
- If required, the DRO will liaise with the Reporting Organisation regarding any immediate actions required. This will be carried out in conjunction with the Governance Team;
- Governance Team will update DATIX accordingly.

Step 3 - Submission of Learning Summary/Review Report/Additional Information

- Governance Team will liaise with Reporting Organisation with regard to review report deadlines i.e. reminders, DRO queries etc;
- Reporting Organisation submit learning summary/review report to serious.incidents@hscni.net (Governance Team);
- Governance Team forward learning summary/review report to DRO;
- DRO will liaise with other professional leads, including RQIA (where relevant) on receipt of learning summary/review report. For those SAIs that are medication related, the DRO may wish to liaise with the Secondary Care Medicines Governance Team (refer to appendix 2)
- If DRO and professional leads (where relevant) are not satisfied with learning summary/review report, DRO will request additional information from the Reporting Organisation until adequate assurance is provided.
- When a DRO has received all the information it is expected the reporting organisation will be informed within a period of 12 weeks that the SAI has been closed.

Step 4 - Closure of SAI

- When a DRO is satisfied with learning summary/review report, and where relevant any additional information that has been requested, he/she informs the HSCB Governance Team they are content to close the SAI in line with HSCB/PHA 'Criteria for Closing SAIs' (Appendix 3);

- The HSCB Governance Team refers the SAI to the relevant SAI Professional Group;

  - Acute;
  - Maternal and Child Health (Including Acute Paediatrics);
  - Elderly Services and Physical Disability and Sensory Impairment;
  - Mental Health and Learning Disability Services;
  - Prison Health;
  - Integrated Care;
  - Corporate Services;
  - Childrens Services – Social Care;
  - Adult Services – Social Care.

- SAI discussed at SAI Professional Group meeting and the following agreed:
  - SAI closed with regional learning and referred to RSAIRG and/or QSE Group either for noting or discussion;
  - SAI closed without regional learning.

- Governance Team closes SAI on DATIX and informs the Reporting Organisation (and RQIA where applicable) that SAI has been closed.

Step 5 – Regional Learning Identified

- Once regional learning has been identified by the Professional Group a DRO may be required to:
  - Refer learning to Network or Group that has already been established;
  - Draft an article for inclusion within a newsletter or draft a reminder or best practice or learning letter;
  - Attend a meeting of the RSAIRG or QSE group to discuss proposed learning;
  - Be involved in a Thematic Review or Task and Finish Group.

  A flowchart outlining the approval process and dissemination of regional learning can be accessed via the following link.

  http://insight.hscb.hscni.net/resources/safety/

7.0 Supporting the DRO Process

7.1 Datix

In order to ensure Statutory Information Governance requirements are adhered to, all communication for each stage in the process should be communicated by the DRO to the HSCB Governance Team. This ensures the Corporate Record for each SAI is fully documented on the Datix Risk Management System.

7.2 DROs Supporting Information

Appendix 4 provides DROs with some supporting information which they may wish to consider on receipt of SAI notifications and learning summary/review reports**.**

7.3 Escalation Process for DRO Requests

Throughout the process there may be occasions where the reporting organisation does not agree with a DRO request. Examples include:

- escalate a SAI to a higher level review;
- amend a review report;
- issues around family engagement;
- requests for additional information are withheld;
- request for a SAI following notification of an Early Alert;
- where a DRO/Professional has been made aware of an incident that they feel should be reported as a SAI.

On these occasions, DROs should follow the escalation process as detailed below:

Stage 1 – Reporting organisation notifies the DRO that they do not agree with their request

- DRO discusses the SAI at the next relevant SAI Professional Group and if agreed the reporting organisation is notified via the Chair of the Professional Group.

Stage 2 - If the reporting organisation does still not agree:

- The DRO informs the relevant HSCB/PHA Director;
- Relevant HSCB/PHA Director discusses this with the relevant Director within the Reporting Organisation.

Stage 3 – If the Reporting Organisation is still not in agreement:

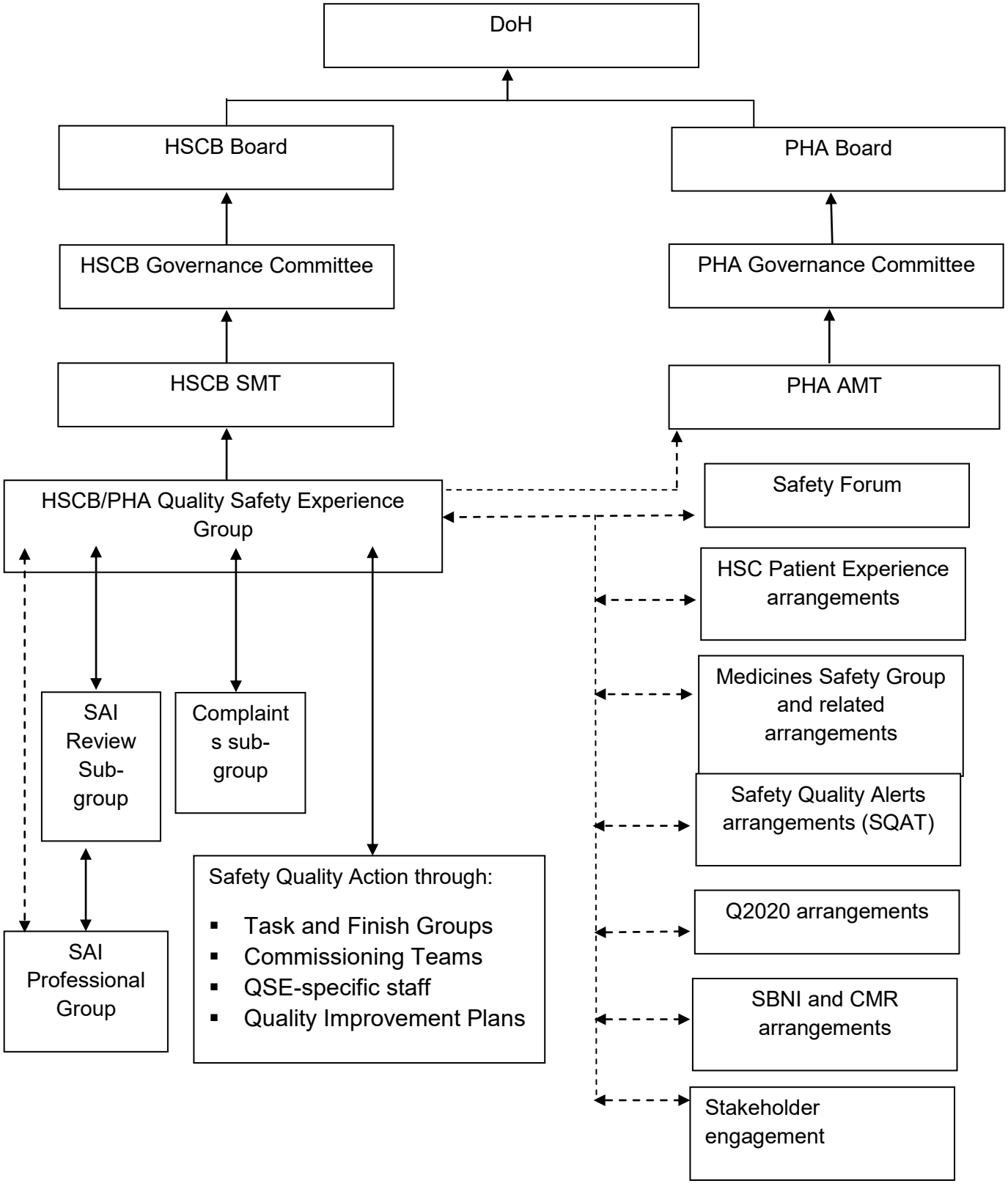
- This should be listed for consideration at QSE.

7.4 Interface Incidents Process

The HSCB/PHA process for the management of interface incidents notified to the HSCB can be accessed via the following link:
http://insight.hscb.hscni.net/resources/safety/

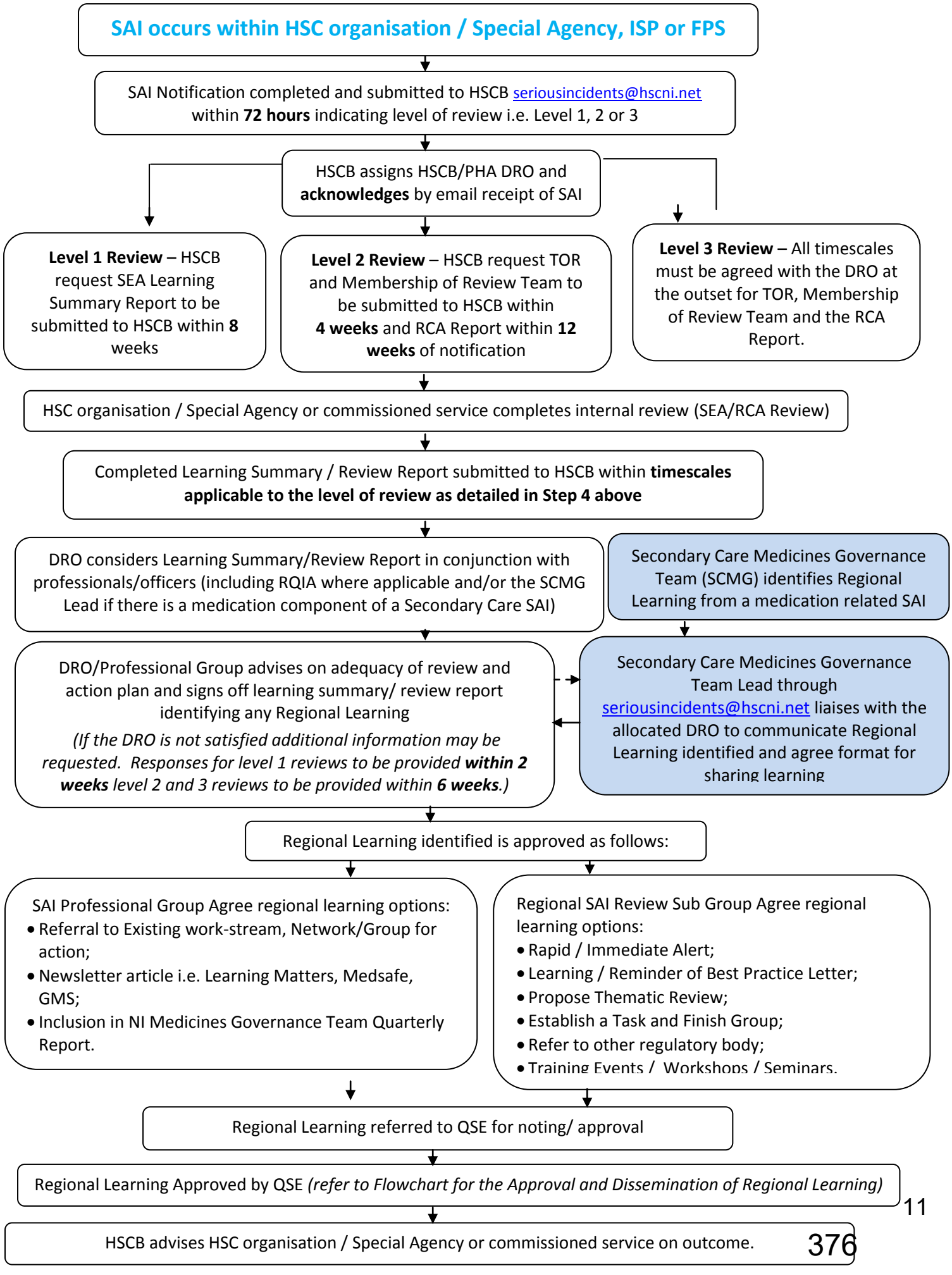
Appendix 1

HSCB/PHA SAFETY AND QUALITY STRUCTURES



Appendix 2

SAI PROCESS AND IDENTIFICATION OF REGIONAL LEARNING FLOW CHART – KEY STAGES



Appendix 3

CRITERIA FOR CLOSURE OF SAIs

A DRO can close an SAI when it meets one of the following three criteria:

1. An independent evaluation of the learning summary/review report received from the reporting organisation has been undertaken by a nominated HSCB/PHA Designated Review Officer (DRO) in conjunction with other officers/professionals (including RQIA) where relevant.

   Prior to closure the DRO must be satisfied that:

   - Format and content of the learning summary/review report is in line with regional templates for Level 1 and level 2/3 Reviews;

   - Review has been carried out appropriately by the reporting organisation (this is only applicable for level 2/3 reviews as the quality assurance of Level 1 reviews is the responsibility of the reporting organisation);

   - All reasonable steps have been taken to prevent recurrence;

   - Recommendations and actions are appropriate and where required there are performance mechanisms in place via the HSCB Governance Team to monitor these;

   - Any queries arising from the learning summary/review report have been resolved including confirmation of how local learning has been disseminated and regional learning identified;

   Other specifics of independent evaluation/review DRO may wish to consider are the Reporting Organisation:

   - has confirmed that it has discharged all statutory requirements;
   - has confirmed that all necessary safeguarding requirements associated with the incident are in place;
   - confirms details of any disciplinary action arising from the incident.

2. DRO has been informed the SAI has transferred to another relevant investigatory process i.e.

    - Case Management Review;
    - Public Inquiry;
    - Independent Expert Inquiry.

3. Following initial notification DRO is advised by reporting organisation that following preliminary reviews, incident is no longer considered a SAI. DRO will consider in conjunction with other officers/professionals, requesting additional information from reporting organisation if necessary; prior to de-escalating SAI and closure.

Appendix 4

Supporting Information for Designated Review Officers

1) At the time the SAI is notified

Immediate Actions

- Is the DRO satisfied that the Trust have taken reasonable actions to reduce the risk of recurrence pending the full review report. HSCB/PHA recognise that this cannot prejudge the outcome of the full review and that what appear to be the circumstances at the time of reporting, may not be substantiated through review;
  - The DRO should also consider if the HSCB/PHA have previously issued regional learning in relation to a similar type incident. In those circumstances, it may be appropriate to ask the Trust whether or not they have:
- Brought the incident to the attention of individual(s) staff involved to ensure that all are aware and to do an immediate review of the circumstances that led to the incident;
- Provided training/refresher training on relevant policies/procedures for the staff involved
- Informed other staff in the unit of the incident.

Level of Review

Do you agree with the level of review the Trust has proposed to undertake?

The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident. The appropriate level of investigation will be proposed by the provider and agreed by the DRO upon notification, however the level of review may change as new information or evidence emerges as part of the review process.

- **Level 1 Review – Significant Event Audit (SEA)**

  Concise, internal review which is suited to less complex incidents which can be managed by individuals involved in the incident at local level.

- **Level 2 Review - Root Cause Analysis (RCA)**

  A comprehensive internal review which includes an independent element and is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors.

- **Level 3 Review - Root Cause Analysis (RCA)**

  This level of review is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors. It is required where the integrity of the review is likely to be challenged or where it will be difficult for an organisation to conduct an objective review internally.

  The HSC Regional Risk Matrix (Appendix 5) assist organisation to determine the level of seriousness and subsequently the level of review to be undertaken. DROs can similarly use this matrix to determine if they agree with the level of review being undertaken.

2) At the time the SAI Review Report is received

In your best professional judgment and from the information available to you:

- Has the family been involved appropriately?
- Where appropriate, has the Coroner been notified?
- Was membership of the Review Team appropriate for the level of review undertaken?
- From the information in the report, does it appear that the Review Team identified and reviewed the factors that led to the incident correctly and thoroughly?
- Do the conclusions reflect the facts of the incident?
- Do the recommendations address the underlying contributing factors?
- Is the Action Plan a reasonable set of actions to address the issues/recommendations identified by the review?
- Is there regional learning and if yes, what is that and how should it be handled
  - Learning Matters newsletter article
  - Learning Letter
  - Bespoke piece of work
  - Other?

- To the best of your knowledge, are you aware of other SAIs where the factors have been similar to this SAI?

- Can the SAI be closed – yes/no?

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

Appendix 5

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016)

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Health and Social Care Board

Public Health Agency

An Overview of the Quality and Safety Processes relating to

SAIs, Early Alerts and SQAs

Section 1- Purpose of Paper

The purpose of this paper and associated appendices is to provide SMT with an assurance on the systems and processes that are in place with regard to the management of Serious Adverse Incidents (SAIs), Early Alerts (EAs) and Safety and Quality Alerts (SQAs) across the HSCB and PHA. The paper will focus on the following:

- Governance and accountability;
- Strategic data overview;
- Areas of concern;
- Action taken/proposed to mitigate areas of risk;
- Covid-19 specific issues;
- Proposed process for improvement/influencing factors.

Strategic Context

The HSCB in partnership with PHA has key responsibility for overseeing the management of all SAI's:

- The Chief Executive and Directors of the HSCB (SMT) has responsibility for governing and ensuring the effective discharge of the SAI process across the health and social care system;

- The Director of Nursing (PHA), Director of Public Health (PHA), Director of Integrated Care (HSCB) and the Director of Social Care (HSCB) provide professional oversight to the SAI/Early Alert and SQA processes.

The HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016), provides the mechanism for all DoH Arm's Length Bodies to report the most serious incidents and to effectively share learning from these events in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for our service users.

The protocol for the management of safety and quality alerts which was initially issued in April 2012 (updated 2018), is a mechanism of ensuring a systematic process is in place for the management and assurances of safety and quality alerts issued by DoH, HSCB, PHA and other regulatory bodies.

The Early Alert system was introduced by DoH in 2010 (revised 2019) as a means of ensuring that the DoH is notified in a timely manner about significant events, which may require the attention of the Minister, Chief Professional Officers or policy leads. All Early Alerts submitted to the DoH are also forwarded to HSCB and managed by way of the HSCB/PHA Protocol for the reporting and follow up of the DoH Early Alert system.

Section 2 - Governance and Accountability

Roles and Responsibilities

Responsibility for the management of SAIs transferred from DoH to HSCB in October 2010. At the same time DoH introduced the Early Alert System which requires all early alerts to be submitted to both DoH and HSCB. The responsibility for managing safety and quality alerts issued by the DoH was transferred to HSCB in February 2010. In summary relevant documents related to these procedures and processes are noted below:

- HSCB Regional Procedure for the Reporting and Follow up of SAIs issued in October 2010 (revised 2013 & 2016) working in conjunction with PHA and collaboratively with RQIA;
- HSCB/PHA for the Reporting and Follow up of the DoH Early Alert system;
- HSCB/PHA Regional Procedure for Safety and Quality Alerts.

Responsibility for the management of these three processes lies within HSCB Corporate Services and specifically the HSCB Governance Team.

Professional input by clinicians into the above processes is provided by colleagues from the HSCB and PHA directorates, through the role of the Designated Review Officer's (DRO) and the various Professional Groups. These include representation from:

- Medical
- Nursing/Midwifery
- Social Care
- Integrated Care – GMS, Pharmacy, Dental, Ophthalmic

There are also a number of other specialist areas which provide expert advice into the above processes such as:

- Information Governance

- Estates Management
- Health and Safety
- HR

The above processes are supported by a robust Safety and Quality structure which permeates through all levels of the HSCB/PHA to the DoH. A diagram of this structure along with further detail can be found at **Appendix 1**.

In summary the SAI, Early Alerts and Safety Alerts is overseen by six inter connecting governing processes.

1. **HSCB Governance Team** who co-ordinate and manage the response to SAI and alerts, which involve the allocation to DRO by programme of care/professional grouping, and ensuring the process of SAI is managed in line with the policy standards and deadline..
2. **Daily Triage:-** SAI/Early notification are screened by professional leads and DRO and matter escalated to Directors as required.
3. **Incident review team**. This multi-professional team (HSCB and PHA) meet weekly to screen all notification and the provide assurance that actions are being progressed.
4. **Professional Groups** review all SAI monthly. This involves all the DRO within their professional grouping meeting to review progress and identify learning.
5. **SQAT:-** SQAT is a senior mutli-professional group who oversee and co-ordinate all learning emerging from SAI's
6. **QSE:** - Is a Director led group which oversee the all Quality and Safety Process in the PHA and as required provide assurance to the CE and PHA/HSCB Boards.

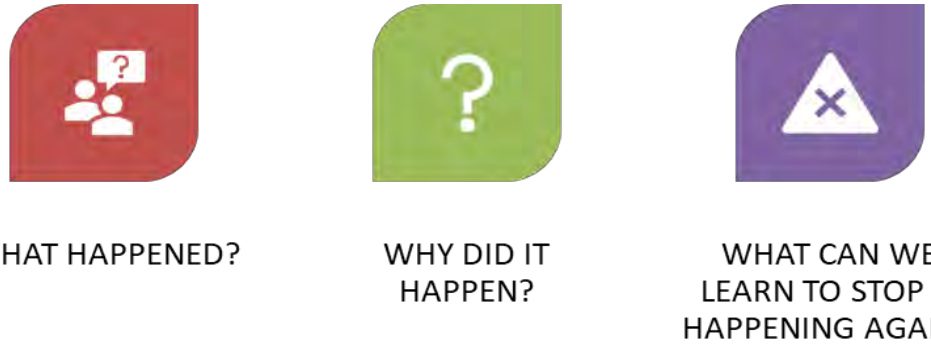
Purpose of the SAI Process, Early Alert and Safety Alert Process

- **SAI Process**

The purpose of the SAI Process is to identify learning from serious incidents which occur within our healthcare system, with the overall aim to reduce as far as possible the risk of the same incident happening again. In summary the aim is to:

- Improve patient safety by learning
- Reduce risk of recurrence
- Ensure full engagement throughout the process

Therefore we aim to find out:

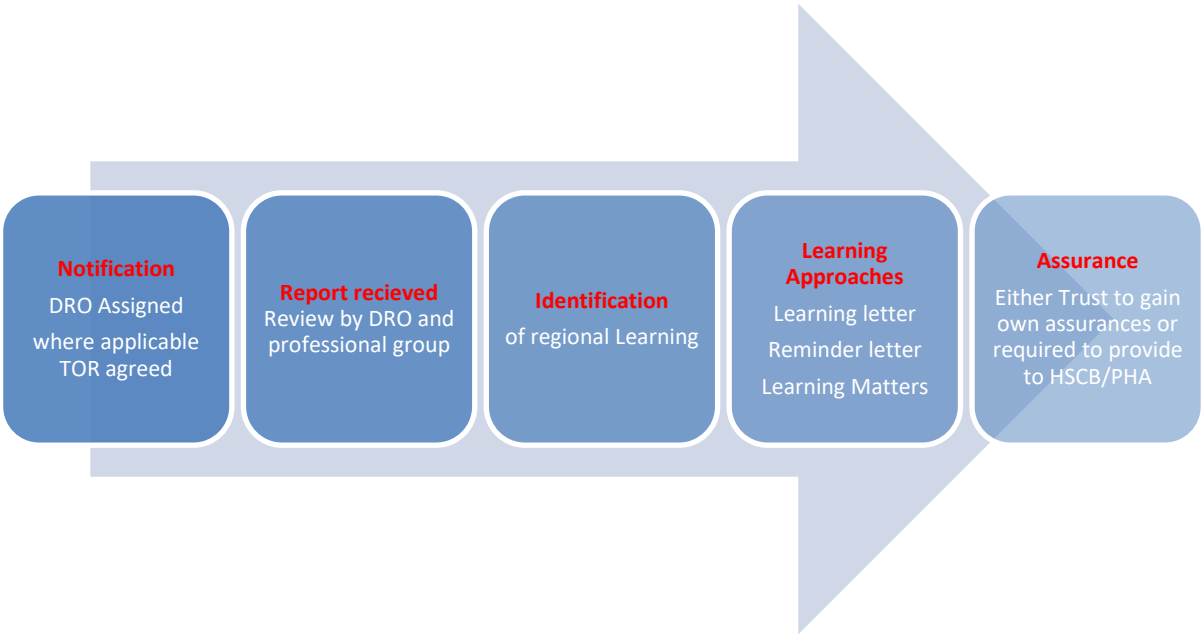


The Role of SAI Professional Groups

This process is facilitated by a number of Professional Groups which were formed to streamline and expedite the above process. The Groups fall under various programmes of care (POC), where the aim is to bring DRO's from each POC together on a regular basis to support the responses/actions to SAIs and importantly agree on the necessary learning if appropriate.

Each Professional Groups are supported by a member of the HSCB governance team and a member of the Safety and Quality nursing team. An overview of the Professional Groups and Terms of Reference are outlined in **Appendix 2**

The SAI process from notification to dissemination of learning is outlined in brief below:



Further detail of the Procedure for the Reporting and Follow up of Serious Adverse Incidents can be found at the link below:

http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf

- **Safety and Quality Alert (SQA) Process**

The SQA process aims to ensure the dissemination, implementation and assurance of safety and quality alerts. The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

- **Early Alert Process**

The Early Alert system was introduced by DoH in 2010 (revised 2019) as a means to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads. All Early Alerts submitted to DoH are also forwarded to HSCB and managed by way of the HSCB/PHA Protocol for the reporting and follow up of the DoH Early Alert system.

The purpose of the HSCB/PHA protocol is to provide guidance to staff working within the HSCB and PHA on the internal processes for the effective management of Early Alerts where:

a) The Early Alert has occurred in HSCB or PHA and is required to be reported to DoH;

   and/or

b) The HSCB has received a copy of the Early Alert from a reporting organisation in line with the DoH circular and it will be managed by the HSCB/PHA lead officer/s in conjunction with the Procedure for the Reporting and Follow up of Serious Adverse Incidents.

<u>Section 3</u> - Strategic Data Overview of Patterns and Trends in SAIs and Early Alerts

- Total Open SAIs by POC as at 31 October 2020

Please note: an additional supplementary paper for Section 3 has been attached which provides a detailed overview of the following:

- SAI/Learning data - active as at 31 October 2020
- SAI/Learning and Early Alert activity for the period 01/11/19 – 31/10/11

Issues and actions for active cases as at 31 October 2020

Overview:

There are curently 776 active open SAIs as at 31 October 2020, 41 of which are level 3 SAIs - See breakdown below:

Current Level of Reviews	BHSCT	HSCB	NHSCT	NIAS	NIBTS	PCARE	PHA	SEHSCT	SHSCT	WHSCT	Total	percent
SAI Report Level 1	179	3	90	41	1	20	1	94	46	104	579	75%
SAI Report Level 2	46		24	3		1	1	10	57	14	156	20%
SAI Report Level 3	12		4					4	18	3	41	5%
Total	**237**	**3**	**118**	**44**	**1**	**21**	**2**	**108**	**121**	**121**	**776**	

Trends

As per Table below Acute and Mental Health services generated the vast majority of SAI's, the top ten SAI outlined in tables 15a-15c (in the supplementary document) show that majority of SAI are generated due to behaviour, diagnostic processes/ procedures and unexpected deaths. This analysis is based on CCS2 (a regional generic coding system) which is for incident reporting within Trusts and does not lend itself to identifying high level regional themes. The weekly incident review meeting recognised this and have developed a set of more meaningful codes which are being applied to notifications and then will be rechecked with reports when they are finalised. This will then mean the CCS2 will provide more meaning moving forward. This will mean we will be able to provide better trend analysis in the future. It is intended to present this (based on notifications initially) to SMT monthly moving forward.

The timescales for submission of SAI reports following notification is:

Level 1 Review – HSCB request SEA Learning Summary Report to be submitted to HSCB within 8 weeks

Level 2 Review – HSCB request TOR and Membership of Review Team to be submitted to HSCB within 4 weeks and RCA Report within 12 weeks of notification

Level 3 Review – All timescales must be agreed with the DRO at the outset for TOR, Membership of Review Team and the RCA Report.

While these are the timescales outlined in the procedure document it is evident from table below these are not being met. Once a timeline for a notification is set the HSCB governance team will begin a process of communicating with Trusts regarding submission of the report. A quarterly report is collated for each trust on their outstanding reviews and the governance teams meet with each trust regularly to discuss their outstanding reports. These are then escalated to the HSCB Chief Executive who historically wrote to each Trust Cx outlining issues and requesting updates.

However this process did not have any impact on outstanding reports and therefore this needed to be reviewed. At its meeting in June 2020, QSE agreed to write to Trust Chief Executives seeking an action plan detailing how they would address any backlog regarding outstanding SAI reports and outstanding Terms of Reference for level 2/3 SAIs. A summary of responses by the trust is below. However moving forward further processes will be developed to improve the management of these issues to include:

- Development of a template for Trusts to indicate timelines and reasons for delays
- Greater role within professional groups to discuss delays
- Escalation to QSE of outstanding reports and reasons as outlined in template for approval or further escalation to SMT if required

These new processes will continue to be tested and changed according to effectiveness.

A number of issues and actions currently being taken forward for the following areas are detailed below:

- **Outstanding reports from HSC Trusts;**
- **Open reviews pending closure by HSCB/ PHA;**
- **Dissemination of regional learning.**

3.1 Outstanding Reports from HSC Trusts

Total outstanding SAI Review reports by POC and Organisation as at 31 October 2020

Programme of Care	BHSCT	HSCB	NHSCT	NIAS	NIBTS	PCARE	PHA	SEHSCT	SHSCT	WHSCT	Total	%
Acute Services	71	0	12	27	0	0	1	8	13	24	156	35%
Corporate Business / Other	5	0	0	0	1	0	0	0	0	2	8	2%
Elderly	10	0	2	0	0	0	0	1	5	8	26	6%
Family and Childcare (inc CAMHS)	24	0	12	0	0	0	0	5	1	4	46	10%
Learning Disability	8	0	1	0	0	0	0	1	3	1	14	3%
Maternity and Child Health	16	1	6	0	0	0	0	2	9	2	36	8%
Mental Health	26	0	33	0	0	0	0	18	37	33	147	33%
Primary Health and Adult Community (inc GP's)	1	2	0	0	0	8	1	0	0	0	12	3%
Total	**161**	3	66	27	1	8	2	35	68	74	**445**	100%

As detailed above, there are **445 SAI** reports outstanding from Trusts which have not been submitted in line with the current timescales as laid out in the SAI Procedure (HSCB, 2016).

In addition there are also 38 Terms of Reference for Level 2/3 SAIs yet to be received. The on-going process in place to address this concern with Chief Executives to ensure they are made fully aware, has been a **quarterly** correspondence sent by the HSCB Chief Executive, which highlights concerns to each Reporting Organisation as to outstanding SAI review reports

From March 2020, due to the unprecedented and imminent impact of the COVID-19 pandemic across the HSC, correspondence was sent to Reporting Organisations informing them of the suspension of some aspects of the SAI Process. Following liaison with Trust Governance leads, additional correspondence was issued on 22 May 2020 to all Trust Chief Executives advising of a phased approach to normal business with an attached Trust specific report outlining revised timescales for submission of SAI reports.

Actions in Progress – Rationale for delays in outstanding SAI review reports and actions taken

There are seven Reporting Organisations which include BHSCT, SHSCT, WHSCT, SEHSCT, NHSCT, NIAS and Integrated Care. Six have responded with explanations of delays as summarised below;

- Many of the reports in final draft awaiting approval
- Difficulty in getting panel members and Chairs
- Impact of the COVID-19 pandemic
- Mental health (suicide) SAI's involve considerable work

HSC Trusts

To date BHSCT have not submitted a response for rationale in delay; however have advised this will be submitted by **Friday, 13th November 2020.**

All of the Trusts who have responded are fully aware that this delay is not in line with the HSCB SAI Procedure (2016) and is unsatisfactory. They have provided reassurance around their commitment to reduce this backlog, whilst recognising the on-going challenges they face with COVID-19.

The PHA Safety and Quality Nursing and HSCB Governance teams have more recently met with Trust Governance Leads in an attempt to address the backlog and agree a way forward. This was extremely productive with Trusts requesting that HSCB/PHA did not issue correspondence to suspend SAI/SQA processes during the 2nd surge of Covid. It was also agreed to convene meetings regularly, at least 4-6 weekly during the time of the pandemic in order to provide support to the process with the overall aim of reducing the number of outstanding SAI review reports.

NIAS

The S&Q Nursing and governance teams met with the NIAS to explore their backlog of outstanding SAI review reports. To improve this NIAS have recruited Associate Consultants from the HSC Leadership Centre to work on the backlog and have since submitted a significant number of reports for review which are underway.

Action taken to address the above issue

The HSCB/PHA will continue to liaise with the Reporting Organisations, highlighting the number of outstanding review reports. Work is underway with the HSC Leadership Centre to develop a training programme for both Chairs of SAI panels and panel members. It is anticipated this will be available for Reporting Organisations in January 2021.

3.2 SAI Review Reports Received and pending closure by by HSCB/PHA as at 31 October 2020

Programme of Care	Total Active Cases	LSR Received	SEA Report Received	RCA Report Received	Total Reports Received	Trust Action Pending
Acute Services	254	19	23	12	**54**	(10)
Corporate Business / Other	16	3	1		**4**	(1)
Elderly	48	5	3	6	**14**	(1)
Family and Childcare (inc CAMHS)	83	9	9	5	**23**	(4)
Learning Disability	27	1	0	4	**5**	(0)
Maternity and Child Health	58	5	5	6	**16**	(4)
Mental Health	263	2	70	19	**91**	(21)
Primary Health and Adult Community (inc GP's)	27	5	6	1	**12**	(2)
Total	**776**	**49**	**117**	**53**	**219**	**(43)**

As detailed above there are **219 reports** submitted to HSCB/PHA which remain **open awaiting action** by a DRO/SAI Professional Group (43 where there is **Trust action** pending, i.e. awaiting response from a Trust following queries from DRO/ Professional Group). There are also an additional 28 Term of References for level 2/3 SAIs which are awaiting approval and a further 4 level 3 SAIs awaiting confirmation of timescales. It is also important to note there are 41 level 3 SAIs active within the system, which require enhanced commitment from DROs/Professional Groups.

Whilst there is currently 219 reports which require action by a DRO/SAI Professional Group it should be noted that during this reporting period (1/11/19 – 31/10/20) DRO/SAI Professional Groups have closed 318 SAIs. See detail below:

Programme of Care	SAIs Closed
Acute Services	122
Corporate Business / Other	3
Elderly	11
Family and Childcare (inc CAMHS)	15
Learning Disability	1
Maternity and Child Health	29
Mental Health	121
Physical Disability and Sensory Impairment	1
Primary Health and Adult Community (includes GP's)	15
Grand Total	**318**

Impact of COVID-19

As described above the DRO's are professionals from HSCB and PHA who are responsible for the overview of SAI's and the identification and dissemination of learning from reports received. Since the beginning of the pandemic there has been increasing demands on these staff which has impacted on their ability to continue with this role to the same extent.

While some of the Professional Groups continue to meet, this is increasingly difficult, particularly in some areas, such as children's services and paediatric specifically. This has put considerable strain on the system for the timely review of received SAI review reports.

The number of review reports open with HSCB/PHA varies according to when professional groups meet and the capacity for DRO's to review.

Actions in Progress to address open SAIs within HSCB/PHA

The HSCB governance team work collaboratively with the Professional Groups and the PHA Nursing, Quality and Safety Team to review all reports received and progress any outstanding reports in order to disseminate learning in a timely manner. Plans are in place for the HSCB Governance Lead for each Professional Group to specifically target all review reports that have remained open for the longest period of time.

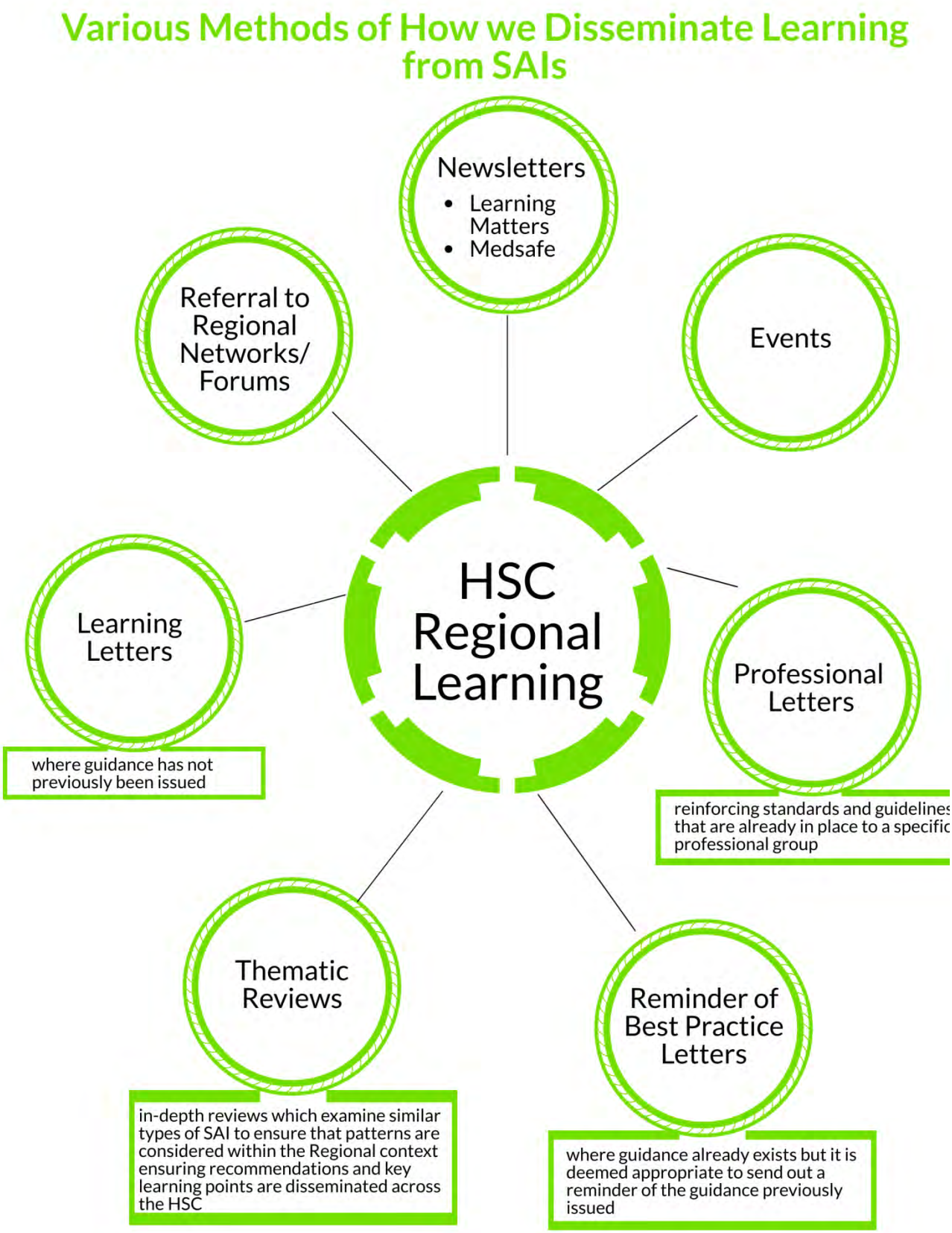
The table below highlights the number of SAIs currently **open** as at **31st October 2020.**

	2015	2016	2017	2018	2019	2020	Total
Serious Adverse Incident	1	4	18	76	244	433	**776**

As already highlighted there has been a marked decrease in capacity of DRO's which has influenced the number of SAIs being reviewed and closed. Measures are being taken within the Children's Services Group to outsource professionals from the HSC Leadership Centre to review final reports, in order to progress to identification of learning and closure. This measure may be required within other professional groups if DRO capacity continues to remain depleted as a result of Covid-19.

3.3 Dissemination of learning

There have been ongoing delays regarding the development and dissemination of learning within certain areas. At the outset of the pandemic there was a pause on the issuing of learning to the system and this allowed the teams to review all the pending learning to ensure it was appropriate, relevant and due for issue in the correct format. The diagram below details all of the various mechanisms in which learning is disseminated across the healthcare system:


Various Methods of How we Disseminate Learning from SAIs
Newsletters
Learning Matters
Medsafe
Referral to Regional Networks/ Forums
Events
HSC Regional Learning
Learning Letters
where guidance has not previously been issued
Professional Letters
reinforcing standards and guidelines that are already in place to a specific professional group
Thematic Reviews
in-depth reviews which examine similar types of SAI to ensure that patterns are considered within the Regional context ensuring recommendations and key learning points are disseminated across the HSC
Reminder of Best Practice Letters
where guidance already exists but it is deemed appropriate to send out a reminder of the guidance previously issued

Actions in Progress – Learning issued and assurances

Since June 2020 (when issuing of regional learning recommenced due to COVID-19) there has been:

- **2 Learning Letters**
- **11 Reminder of Best Practice Guidance Letters** issued to the service **(see Appendix 3)**

As part of the interim arrangements due to COVID-19, a review was carried out of the normal assurance processes of implementing learning, which are normally sought through the SQAT and it was agreed that 'assurances' will only be sought for Learning Letters (usually new learning) issued to the service, recognising that there are already governance processes in place within each Trust to ensure implementation of learning issued.

Outstanding Regional Learning

There are a currently a number of letters in relation to regional learning in progress with DRO's (recognising as above their limited capacity). These are outlined in the table below. The drafting of these letters continue to be monitored closed by the Governance and Safety and Quality Experience Teams in order to have them issued to the wider HSC in a timely manner. If the drafting of these letters continues to pose problems in relation to DRO capacity, further support may be sought from the Leadership Centre.

Summary of outstanding regional learning in process

Letter Type	To be drafted	To be approved	Awaiting signature	Sub Total
Reminder of Best Practice Guidance Letter	10	2	1	13
Learning Letter	4	0	1	5
Professional Letter	0	0	1	1
Overall Total	**14**	**2**	**3**	**19**

Learning Matters Newsletter

A further method of issuing learning to the system from SAIs, complaints etc. is via the Learning Matters Newsletter. Two editions (one general & one maternity special) have been issued since June 2020. Formerly, the production of this document was facilitated by the communications department in the PHA, however due to the pandemic they now have no

capacity for this work and as a result we have secured some funding to access an external company, who have redesigned the Newsletter, making it more interactive and user friendly. It will now be an online resource and the first 'newly improved' edition (edition 13) will be issued on 12th November 2020.

Plans are now in place to issue the next 5 editions before March 2021.

Appendix 3 provides an outline of all future Learning Matters Newsletters to be issued

Section 4 – Overview of processes implemented during the COVID-19 pandemic in assuring robust governance arrangements of the Safety and Quality agenda

At the outset of the pandemic, the HSCB and PHA recognised that whilst some aspects of the safety and quality agenda may need to be suspended, but at the same time it was still critical to oversee the safety agenda which included SAI's, Early Alerts, Interface Incidents and SQAs, including identification of any trends, issues or immediate learning.

Actions in Progress

As noted earlier, a letter was issued to the HSC Trusts in March 2020, informing them that we were cognisant of the pressures that the pandemic would place on services and therefore did not anticipate they would be progressing any SAI reviews at this time, however emphasising that they should continue to notify any SAI/Interface incidents as normal.

Correspondence was also sent to all DRO's in the same period, acknowledging their potential reduced availability to review SAI notifications or Reports that were currently in progress. The correspondence provided comprehensive detail as to what processes would be put in place during this interim and uncertain period of COVID-19.

As a result of this the Safety and Quality Nursing team (PHA) and the Governance team (HSCB) set in place a number of important temporary measures to ensure that the Safety and Quality agenda continued throughout the pandemic. This included the following:

- Forming a 'new' multi-disciplinary **Weekly Incident Review meeting** between the teams (with input from nursing, medical, social care and mental health colleagues) to review all the previous weeks SAI/Interface/Early Alert notifications, to identify if any

urgent action was required, or if we could await the completion of the review process.

- SAI Professional Groups had been stood down due to the pressure on DRO's of COVID-19 during the initial weeks of the pandemic. To mitigate any risk to patient safety, particularly the delay in the issuing of urgent regional learning, the nursing and governance teams put a plan in place to **review all open SAI's** where reports had been received, with a view to progressing any actions. This resulted in both the closing of a large volume of SAI's and identifying those review reports where further action was needed. In addition, this did result in a large number of areas of regional learning to be issued which can be evidenced at **Appendix 3.**

- During the COVID-19 pandemic the SQAT have continued to meet, albeit with an interim Chair, to continue to monitor any assurances and receive new Safety and Quality alerts. This has been important to ensure that the Safety and Quality agenda has not been overlooked during these challenging times.

- A **daily summary** of all Early Alerts/SAI/Interface notifications are reviewed by the Safety and Quality Nursing Team and where relevant escalated to professional leads for immediate action. This is continuing to develop through a testing and changing process as required. This now provides a **double layer** of assurance to the professional leads/ SMT/ AMT, that no major safety issues are being overlooked. A new cover sheet for escalation of any issues for SMT has also been produced and is being tested.

Diagram of this process is below:

Surveillance

The governance measures put in place since the pandemic have ensured the HSCB Governance and PHA Nursing Safety/Quality/Experience Teams closely monitor all notifications, new reports and terms of reference submitted by Trusts. The introduction of the weekly Incident Review meeting has been extremely valuable in progressing this. It is intended to add a further step into the process in the interim, where a monthly meeting will be held with the professional Directors (Nursing, PH, Integrated care and Social care) to escalate any concerns or issues from the daily and weekly reports. This will enable further escalation to SMT/AMT as required. This meeting will also inform any trends identified in notification to the appropriate Director.

Interim Team for SQAT and QSE

It is proposed to establish an interim team who will meet on a monthly basis to continue the safety and quality processes in the absence of normal SQAT and QSE meetings. The group will be comprised of representatives from each directorate who are already core members of either QSE or SQAT.

COVID-19 Notifications

Classification	Total
Early Alert	171
Serious Adverse Incident	39
Grand Total	**210**

Note – incidents above may be directly or indirectly related to Covid

There have been an increased number of notifications (approximately 100 to date) regarding Covid-19, most of which are Early Alerts, regarding either staff outbreaks or reduced staffing capacity. In light of capacity issues across the HSC there is a need to consider if this is the correct process for notifying these types of events or if it would be suffice to capture this information within current Covid-19 reporting mechanisms to HSCB/PHA.

There has also been a number of Level 3 SAI's notified relating to outbreaks of Covid-19 where patients have died. A decision has been made that if a death has occurred due to a health care facility acquired Covid infection this should be notified as an SAI at the appropriate level.

It should also be noted that there have been a number of SAI's notified where the harm was caused due to the impact of Covid as opposed to direct infection (e.g. standing down of services as an impact).

Section 5 - Proposed process for improvement /influencing factors

Influencers to the process

A review of the SAI procedure had been underway in 2019 as an output of a level 3 SAI, particularly to look at service user family engagement in the process. However, due to a number of external factors (listed below) which will clearly influence any revised process it was agreed to suspend this review.

What was agreed in the interim, following the review of a high profile level 3 SAI, that guidance is issued to Trusts in relation to service user/family engagement. This was issued initially by HSCB Director of Social Care and Children's Services in October 2018, with further guidance issued by HSCB Chief Executive in September 2019.

IHRD:

- As part of the IHRD SAI subgroup a "statement of patient rights" on the SAI process has been developed. The output from this will be crucial to the update of the process as it incorporates patient/ family involvement in the SAI reviews.
- IHRD also requested RQIA to carry out a review of the SAI process and it is anticipated this will report in early 2021. This has involved engagement in HSC Trusts, HSCB/PHA, staff and patients/ families. Again the outputs from this report will be key in how we move forward with the review of the process.

RQIA review of Suicides

In 2019 RQIA issued a Report 'A Project Examining Learning Arising from SAIs involving suicide, homicide and serious self-harm. The Report had four main recommendations:

- The reporting arrangements and criteria for incidents involving homicide should remain unchanged and these should continue to be reported via the existing SAI process.

- Incidents of self-harm should be taken out of the SAI reporting system and reviewed at trust level, ensuring that information is reported centrally through a regional Datix system to allow for data analysis.

  However, this approach must allow discretion to report an incident as an SAI when the trust deems it necessary to do so.

- Incidents related to suicide should be taken out of the SAI reporting system. Trusts must continue to review suicides, using an appropriate level of review with discretion to escalate, as an SAI, when the trust deems it necessary to do so; ensuring that information is reported centrally through a regional Datix system to allow for data analysis.

  Suicides that occur within an inpatient setting/trust facility must continue to be reported using the SAI reporting and learning system.

- A task and finish group should be established, with oversight provided by the Department of Health, to develop a standardised process for trusts to follow, for review of the suicide of an individual known to mental health services, that occurs outside an inpatient setting/trust facility and has not been escalated as an SAI.

DoH request to review process for level 3 SAI's

In 2019 the DoH requested that the HSCB/PHA develop an options proposal for how we would manage level 3 SAI's moving forward. This was forwarded to the department outlining 3 options. The DoH responded requesting the HSCB/PHA to develop a business case in regard to option 2 "commissioning and management by a regional organisation". As a result of the pandemic following further correspondence form the DoH as to working in business continuity this has not yet been progressed. However in recent conversations we anticipate the department will shortly ask that we recommence this work.

Development of a Safety Framework for HSCB/PHA

The Director of Nursing PHA has begun to scope the development of a quality and safety framework for HSCB and PHA. To date a scoping exercise of what is happening in other areas across the UK has been carried out and an initial set of objectives developed to:

1. Implement and enhance governance structures within the HSCB / PHA that improve patient safety across the HSC.
2. Develop a regional data matrix dashboard that enables the HSCB / PHA to make informed decisions and identify areas for improvement.
3. Deliver a regional safety & quality improvement programme to support HSC organisations.
4. Enhance systems and processes that listen to, engage with and involve patients in in the design, delivery, evaluation and improvement of HSC services.

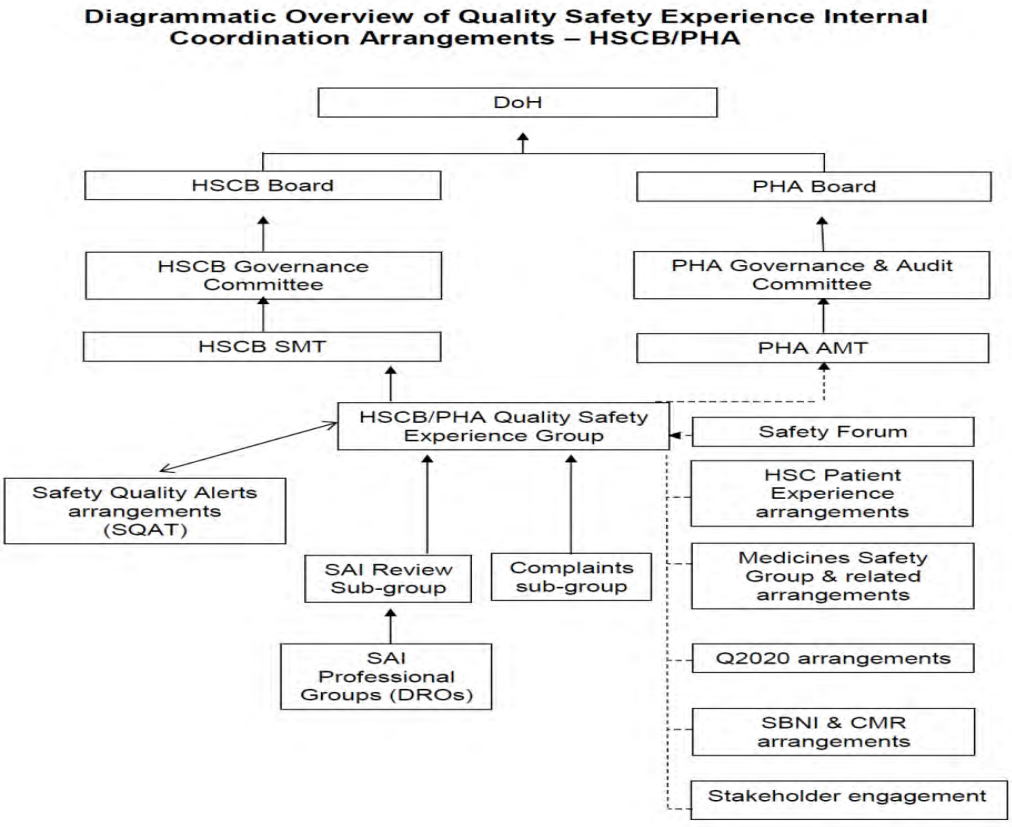
The next step is to consult with HSCB/PHA colleagues and other key stakeholders. It is anticipated an outline plan for the framework will be developed by December 2020.

Section 6 - Conclusion

This paper and associated appendices provides an assurance on the system and processes that are in place with regard to the management of SAIs, Early Alerts and Safety and Quality Alerts. It focuses on the governance and accountability roles within the HSCB and PHA, highlighting areas of concerns and actions taken/proposed to mitigate areas of risk.

Appendix 1

The HSCB/PHA Quality/Safety/Experience Structure



SAIs are reported to the HSC Board (Regional Reporting System) within 72 hours, via a central email account linked to the HSC Board's Governance Team and immediately logged onto the Datix system. On receipt of an SAI report, the HSC Board allocates a Designated Reporting Officer (DRO) to each SAI, who is responsible for the review of investigation/review reports completed by Trusts.

The HSC Board, working closely with the PHA, is responsible for identifying and disseminating regional learning as part of its assurance role in relation to SAIs, complaints and patient client experience. It does this via a number of groups as outlined below:

Quality Safety and Experience (QSE) Group – this multi-disciplinary group meets 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 HSC Board and PHA and agrees appropriate actions to be taken.

Regional SAI Review Subgroup – a multi-disciplinary group. The group reports to, and supports the work of the QSE Group. Membership includes representatives from relevant directorates within the HSC Board and the PHA.

Safety Quality and Alert Team (SQAT) – a multi-disciplinary group that meets fortnightly. The team is responsible for overseeing the implementation and assurance of Regional Learning / Reminder Letters and Guidance issued by HSC Board/PHA and other organisations.

Individual Professional Groups then review reports and/or seek further professional advice and identify themes. Where assurance arrangements are required from Trusts, the SQA Team oversees this role.

Appendix 2

Professional Groups Terms of Reference

- Support DROs with the process for reviewing Level 1 Learning Summary Reports and Level 2/3 Review Reports;
- Facilitate the management of interfaces between DROs and Reporting Organisations and the Governance Team;
- Support DROs with the identification of regional learning from patterns/trends or emerging themes;
- Streamline the process for the submission of regional learning so it is referred onto the appropriate group;
- Support DROs with the closure of SAIs.
- To improve the consistency of SAI Reviews and referring learning to SAI Review Group / QSE / QI Collaborative

Appendix 3 – Learning

(A) Learning Issued

Since June 2020 the following letters have been issued to the system

1. LL/AI/2020/037(PHC) - Medication handout error associated with use of protective screens and facemasks;
2. LL/SAI/2020/038(All PoCs) - Fit Testing Settings;
3. SQR-SAI-2020-061 (PHC/AS) - Prescribing and supply of High Risk Medications in Out of Hours periods;
4. SQR-SAI-2020-062 (MCH) - Need to establish pregnancy status of patient prior to administering treatment/drugs;
5. SQR-SAI-2020-063 (AS) - Failure to remove stent led to episodes of sepsis;
6. SQR-SAI-2020-064 (MCH) - Maternity and Screening;
7. SQR-SAI-2020-065 (OPS & AS) - Care Home Admission and Initial Review;
8. SQR-SAI-2020-066 (All PoCs) - Reducing the risk of oxygen tubing being attached to medical air;
9. SQR-SAI-2020-067 (AS) - IV Fluid management and prevention of harm from hyponatraemia;
10. SQR-SAI-2020-068 (All PoCs) - Cold Chain Storage;
11. SQR-SAI-2020-069 (AS/PHC/OPS) - Risk of serious harm or death from misplaced percutaneous endoscopic gastrostomy (PEG) tubes;
12. SQR-SAI-2020-070 (AS/PHC) - Rubeosis needs urgent referral and treatment to avoid sight loss;
13. SQR-SAI-2020-071 (AS) - Management of Small Bowel Obstruction with Additional Pathology.

(B) Summary of outstanding learning in progress

Letter Type	To be drafted	To be approved	Awaiting signature	Sub Total
Learning Letter	10	2	1	13
Reminder of Best Practice Guidance Letter	4	0	1	5
Professional Letter	0	0	1	1
Overall Total	**14**	**2**	**3**	**19**

(C) Learning Matters Newsletter – Forward Plan/RAG status August - November 2020

Red – outstanding articles to be written (23 articles)

Amber – in progress (15 articles)

Green – completed (issue 11 and 12)

Issue	Comments
Issue 11	• Circulated via email on 13th August 2020 • Hard copies delivered to PHA, Trusts, NIAS on Monday 7th September
Issue 12 Maternity Special	• Circulated via email on 26th August 2020 • Hard copies delivered to PHA, Trusts, NIAS, QUB on Monday 7th September
Issue 13	• Circulated via email on 12th November 2020 • Hard copies in process of being sent to Trusts
Issue 14	• 6 articles in this edition • 5 of these articles have been drafted and need to be reviewed by S&Q professionals then editorial team • 1 article to be written (already sent to author)
Issue 15	• 7 articles in this edition • 4 of these articles have been drafted and need to be reviewed by S&Q professionals then editorial team • 3 articles to be written (already sent to author)
Issue 16	• 7 articles in this edition • No articles completed yet • 7 articles to be written
Issue 17	• 6 articles in this edition • 1 article drafted and needs to be reviewed • 5 articles to be written
Issue 18	• 6 articles in this edition • 2 articles drafted and need to be reviewed • 4 articles to be written
Focus On	• 2 articles in this edition so far, more articles to be included • 1 article drafted and needs to be reviewed • 1 article to be written
Good News Stories	• No articles in this edition yet
Medication Special	• 6 articles in this edition • No articles completed yet • 6 articles to be written
Paediatric Special	• 2 articles in this edition so far, more articles to be included • 2 articles drafted and need to be reviewed

Flowchart for oversight of SAI notifications

Notification received

All notifications are submitted by HSC Trusts to SPPG governance via the Serious Incidents inbox

Daily report

All notifications reviewed by Q&Q team PHA and any required escalations made. Once approved sent to all Directors and Cx/ deputy secretary

Notifications also forwarded to appropriate professional group (level 1) or DRO (level 2/3)

Incident review group

All notifications reviewed by Multi-professional group and any urgent action/ queries sent to Trust or decision made to await the report

As this is a consistent group of staff they can also note any themes or trends and all notifications are coded to assist with looking back if any concerns are noted

Safety Brief

Director of Nursing (PHA) and Director of Strategic Planning (SPPG) meet weekly with the S&Q nursing team and governance teams to discuss any concerns regarding safety for that week including any issues picked up through notifications

ID	Org	Classification	POC	Description	Incident type tier three/Key Theme Identified	Escalation to senior staff required Y/N
21018	BHSCT	**Early Alert**	Acute Services	Critical delays to treatment of patients with potentially curable oesophageal and gastric cancers A multidisciplinary group of specialist clinicians working in oesophageal and gastric cancer has written today to the Chief Exec and Medical Director of the BHSCT to highlight what they describe as an emergency situation. Due to the pressures on Critical Care staffing over the past 4 weeks this team has been unable to carry out any oesophageal resections. As of yesterday, 1 major gastric and 10 oesophageal resections will fail to meet their cancer timeline/post-chemotherapy targets. There are a further patient currently undergoing neo-adjuvant oncological treatment who will require surgery as they complete neo-adjuvant treatments over the next few weeks. In effect, a waiting list for regionally specialised time critical cancer surgery is being generated, which is likely to take several months to work through. The consequence of which is an increasing number of patients who have potentially curable cancers progressing to in-curable disease whilst they wait for an operation. This is difficult to defend in the knowledge that other non-urgent surgery is currently continuing in NI. The clinical teams in Belfast are now reporting a significant level of moral and ethical distress as they undertake difficult discussions with patients about delays and interruptions in their treatment pathways. The OG service alone requires 2 full ICU beds daily when averaged over the year. It is difficult to see how these patients can be accommodated		Highlighted to Director of Commissioning and Director of Strategic planning

ID	Org	Classification	POC	Description	Incident type tier three/Key Theme Identified	Escalation to senior staff required Y/N
				without further resource allocation and 'ring-fencing' of complex elective critical care at BCH as previously agreed by the region and supported by the Minister. Further letters of this nature highlighting failure to deliver time critical regional cancer surgery and flagging the moral distress in our clinical teams, is expected, over the next few days and weeks. **Criteria under which event is being notified:** - Urgent regional action - Contacting patients/clients about possible harm - Regional media interest		

ID	Org	Classification	POC	Description	Incident type tier three/Key Theme Identified	Escalation to senior staff required Y/N
21019	BHSCT	**Serious Adverse Incident Level 1**	Family and Childcare (inc CAMHS)	Confidential report hand delivered by staff member to wrong address. Service-User's name on envelope. Staff member's signature and date with "hand-delivered" recorded on envelope. Individual at address returned home and saw envelope. Opened envelope and identified UNOCINI report. Individual is a professional in education and contacted RESWS to advise and arranged for RESWS to retrieve report. Individual reports to not have read UNOCINI report acknowledging confidential information.		

ID	Org	Classification	POC	Description	Incident type tier three/Key Theme Identified	Escalation to senior staff required Y/N
21020	BHSCT	**SAI Never Event Level 1**	Acute Services	An incident relating to a retained swab has occurred and requires reporting as an SAI/Never event. Incident occurred in Theatre 6 BCH site on 06/05/2021. Patient A was brought from ICU to Theatre 6 for removal of abdominal VAC dressing and closure of midline laparotomy wound following previous surgery and massive blood loss two days prior. An abdominal swab was found by the surgeons on examination of the abdominal cavity in theatre. The abdominal swab was removed from the wound and kept separate from the scrub nurse's count. Theatre manager informed and X-ray requested by surgeon to look for any other swabs which may have been in the wound. The surgeon reviewed the imaging and confirmed that no more swabs were inside the abdominal cavity. The abdomen was closed with all subsequent counts being confirmed as correct and patient was transferred back to ICU. The incident had been graded as insignificant and closed on the Datix system as investigation complete. Neither had it been coded as relating to a missing swab which has contributed to the delay in reporting. **DOB:** 24/09/1980 **Gender:** Male **Age:**40 years		

ID	Org	Classification	POC	Description	Incident type tier three/Key Theme Identified	Escalation to senior staff required Y/N
21021	BHSCT	**Serious Adverse Incident Level 1**	Family and Childcare (inc CAMHS)	Young person A was settled in his room prior to the incident. At 00:25 on 07/08/21, young person A came out from his bedroom and knocked on young person B's bedroom door asking for tobacco. Voices were raised and young person A subsequently became aggressive towards young person B, delivering several punches to his face. Young person A was directed by staff from the bedroom into the hallway. A further altercation ensued with Young person A punching young person B, who at this stage was holding his arms up in self-defence. Due to the continuing aggression, staff directed young person B into the office to place a physical barrier between him and young person A. Young person A and another peer continued to shout out at young person B. Young person B (who was still in the office) punched the glass partition in the office window resulting in this breaking. He then picked up a pair of scissors stating he would kill the two other boys. Staff removed the scissors and provided emotional support. Young person A left the home and was arrested by Police. Young person A was subsequently admitted to JJC. Young person B's injuries included a laceration below his left eye, bruising to eye and to both lower forearms. **DOB:** 07/07/2004 **GENDER:** M **AGE:** 17 years (assaulted other yp – yp A)	Physical contact (actual assault)	

ID	Org	Classification	POC	Description	Incident type tier three/Key Theme Identified	Escalation to senior staff required Y/N
				DOB: 25/11/2003 **GENDER:** M **AGE:** 17 years (yp who was assaulted – YP B) **Current Condition of Service User:** Young person B has a laceration below his left eye and bruising to same. Also bruising to lower forearms. YP attended hospital in relation to another matter and had his injuries examined. No bone or ocular damage noted. Young person A's emotional/ mental health has deteriorated while in custody, including ligatures x2 and an assault on staff. Young person has access to in Reach CAMHS in JJC.		

Terms of Reference

Incident and Learning Review Group

1.0 Purpose of the Group

The purpose of the Incident Review Group is to provide assurances that all notifications submitted to the HSCB's Serious Incidents mailbox are reviewed and managed in line with guidance for the:

- Procedure for the Reporting and Follow up of Serious Adverse Incidents (November, 2016)
- HSCB/PHA Protocol for the reporting and follow up of the DoH Early Alert System (February, 2017)
- HSCB/PHA Regional Procedure for Safety and Quality Alerts (July, 2018)

The Group ensures collective, multidisciplinary decision making on the management of all notifications received into the SAI mailbox in a timely manner. Any urgent action required is identified and areas of concern or importance are highlighted to Safety Brief each week.

In line with the above procedures, the Group also reviews safety and quality alerts that have either been issued to the HSC by DoH or due to be issued by HSCB/PHA as a result of learning from SAIs, AIs and complaints.

2.0 Objectives of the Group

- All notifications, including SAIs, Early Alerts, Interface Incidents and Shared Learning Notifications are reviewed to ensure:

    - Immediate action is taken forward, if required
    - Appropriate allocation to DRO / POC
    - Appropriate level of Review for SAIs is undertaken
    - A SAI is requested following an Early Alert / Interface Incident notification if required
    - Early Alerts / Interface Incidents are closed where appropriate
    - Shared Learning Notifications are reviewed and forwarded to the relevant Professional Group for action

- Apply a set of regional codes which can be used in conjunction with CCS2 Coding to identify regional recurring themes / trends.

- Review all Safety and Quality Alerts upon receipt, identifying if any immediate action is required and assign a Lead.

- Consider and approve draft professional, learning and reminder of best practice letters prior to noting at Safety Brief and final signature of relevant Directors.

- Escalate areas of concern as appropriate to Safety Brief on a weekly basis.

- By exception, the Group will review / discuss any issues escalated from the SAI Professional Groups if an urgent issue requires discussion before the next meeting of Professional Group.

3.0 Accountability of the Group

The Incident Review Group provides assurance to safety brief on a weekly basis that any urgent action is taken following the receipt of notifications and that any areas of concern are promptly escalated.

4.0 Group Membership

Jointly Chaired	Assistant Director of Nursing, Quality and Safety Governance Lead
Members	Deputy Governance Lead
	Nursing Representative
	Medical Representative
	Social Care Representative (Children's and Elderly)
	Mental Health Nursing Representative
	Integrated Care Representative (Pharmacy)
	HSCB Assistant Governance Manager
	AHP representative
	Project manager Safety and Quality

5.0 Frequency of Meeting

The group will meet weekly.

6.0 Quorum

The Incident Review Group shall be quorate by the attendance of three members of the Group, with a minimum of two professions.

6.1 Revision of Terms of Reference

The Terms of Reference will be reviewed in twelve months (January 2023) or earlier as required.

MAHI - STM - 308 - 418
Safety Brief - Terms of Reference

June 2022

1. Purpose of the Group

The purpose of the joint SPPG/PHA Safety Brief meeting is to provide Directorate oversight of all safety and quality issues and is uniquely placed to connect issues and triangulate learning arising from SAIs, complaints, confidential enquiries, RQIA recommendations, NCEPOD reports etc. The group is jointly chaired by the Director of Strategic Performance and the Director of Nursing, however other relevant Directors or appropriate representation are invited to attend as required.

The group aims to provide a systematic oversight of Safety and Quality issues and enforce a proactive approach to manage patient safety across all areas.

2. Objectives of the Group

- Provide a platform for discussion of Safety and Quality issues and agree actions to be taken
- Escalate appropriately any urgent action required or areas of concerns, such as identified themes / trends arising from the weekly Incident Review Group and agree next steps
- Review / sign off professional, learning and reminder of best practice letters prior to dissemination.
- Put in place mechanisms to ensure continued improvements across all safety and quality processes.
- Escalate any Safety and Quality issues requiring oversight by all Directors to the fortnightly Directors meeting or monthly Group Head meeting as required.
- Each Director to escalate non-compliance to any of the Safety & Quality processes and seek resolution within their organisational construct.

3. Accountability of the Group

The Lead Directors for SPPG/PHA are individually responsible for providing assurance to their respective Boards/Senior Management Team/NEDs (PHA only) ensuring they are appraised on all Safety and Quality issues and matters arising.

4. Frequency of Meeting

The group will meet weekly.

5. Quorum

Safety Brief shall be quorate by the attendance one Director and Senior representation from both PHA and SPPG.

6. Revision of Terms of Reference

The Terms of Reference will be reviewed in twelve months (June 2023) or earlier as required

Summary Paper

Report of Choking Serious Adverse Incidents and Adverse Incidents in Northern Ireland (2016 – 2021) and Regional Learning from the work of Dysphagia NI and service user and carer experience

June 2021

Executive Summary

The review of both choking incidents and dysphagia interventions have identified a number of improvements required to further reduce the likelihood of avoidable choking incidents. The focus of the recommendations is to set out targeted action required in high risk areas. Going forward the recommendations will be focussed on 6 key areas:

1. Roll out standardised recommendations for the management of EDS difficulties and an associated programme of audit and monitor of same to ensure that these remain at the fore of care.
2. Develop a framework for standardised care to reduce the risk of death by choking and support standardised practice and audit.
3. Roll out pilot initiatives which have been shown to deliver improvements and reduce risk
4. Undertake further capacity-building for staff, service users and carers, including the introduction of mandatory awareness training
5. Develop a framework to help balance risk and personal choice
6. Deliver a sustained and targeted EDS improvement programme which has a strong QI ethos

Whilst much work has been undertaken and demonstrable improvements have been made, the SAIs and deaths as a result of choking remain unacceptably high. The report brings forward an assessment of further regional interventions deemed necessary to reduce the risks of choking.

Contents

Purpose

Choking remains a prevalent Public Health issue in Northern Ireland, with 18 choking-related Serious Adverse Incidents and 1383 choking-relating Adverse Incidents reported from 2016-2021.

This summary paper presents a PHA and HSCB assessment of additional regional interventions required to further reduce the risk of choking, and should be read in conjunction with the Supporting Paper – Report of Choking Serious Adverse Incidents and Adverse Incidents in Northern Ireland (2016-2021) and Regional Learning from the work of Dysphagia NI and service user and carer experience. All Appendices referenced herein can be found in the Supporting Paper.
This paper is informed by 3 key programmes of work:

- Choking and Learning review of Serious Adverse Incidents (SAIs) and Adverse Incidents (AIs) related to choking (data 2016-2021)
- Dysphagia NI work to meet the 7 actions set out in the Regional Choking Review Analysis – thematic review (2018)[1] (Appendix 1 and Appendix 2), and
- 10,000 More Voices, Your Experience of Living with a Swallowing Difficulty (2020) report

1. Background

In 2018 the PHA and HSCB produced a 'Report on the Regional Choking Review Analysis – thematic review' which reinforced the need for co-ordinated efforts to facilitate learning and inform future quality improvement work with the aim of preventing or reducing the risk of choking in future.

Since 2018 a significant programme of regional work has been undertaken, primarily by Dysphagia NI, to reduce the risks associated with choking and to understand the experiences of those living (or caring for people) with Dysphagia.

On 3rd February 2021, the HSCB/PHA released a Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods

[1] Report on the Regional Choking Review Analysis – thematic review (2018)

(SQR-SAI-2021-075)[2]. In response the Chief Medical Officer (CMO) wrote to the HSCB and PHA outlining extreme concern at the preventable deaths which 'appear to continue despite previous interventions and guidance issued'. The CMO stipulated that such omissions in care must be considered as 'never events' and requested the HSCB/PHA bring forward an assessment of further regional interventions deemed necessary. The PHA and HSCB undertook a rapid review of SAIs and AIs related to choking from 2016 – 2021 as the key driver for the identification of further regional interventions.

2. Choking and Learning Review of Serious Adverse Incidents (SAIs) and Adverse Incidents (AIs) related to choking occurring between 2016 – 2021

Analysis was carried out on 18 SAIs and 1383 AIs, the methodology for which is outlined in Appendix 3. This focussed on a root cause analysis of 18 SAIs identifying the causes of choking, cases where different care may have made a difference to the outcome. High level information from HSC Trusts was analysed in terms of AI findings and the extent of learning since the report on the Regional Choking Review Analysis – thematic review (2018).

3. SAI Review Key Findings

- This Choking and Learning Review (data 2016-2021) considered 18 SAIs, 17 of which (94%) tragically resulted in death.
- The age profile of SAIs has changed with most now occurring in the over-70 age group (n=11, or 61%)
- SAIs continue to occur most frequently occur in Nursing Homes (n=10, or 56%)
- The profile of high risk Programmes of Care has changed. Reduced numbers of SAIs have occurred in Mental Health (from 41% to 17%, n=7 in a 6-year period to n=3 in a 5-year period) and Learning Disability (from 35% to 17%, or

[2] Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)

n=6 to n=3). The highest number of SAIs 2016-2021 occurred in the Elderly Programme of Care (n=10, or 55%).

- People with a confirmed diagnosis of EDS under the care of Speech and Language Therapy remain at the highest risk of choking (n=13, or 72%).
- Clear root causes have been identified and themed accordingly. While not directly comparable, the root causes of SAIs identified in this Choking and Learning Review (2021) are largely consistent with the themes identified in the previous Thematic Review (2018).

4. AI Review Key Findings

Whilst it is challenging to draw comparisons between AI data in this Choking and Learning Review (2021) and the previous Thematic Review (2018) due to variation, the lack of consistency of coding and collating of AI Datix information, nonetheless there is value in reflecting on the findings of both reviews.

- In this Choking and Learning Review (2021), 1383 Adverse Incidents relating to Choking were recorded, with on average 276 AIs reported per year.
- Since the last Thematic Review (data 2010-2016) there has been an exponential growth (73%) in AIs reported.
- The profile of AIs has changed since the Thematic Review (2010-2016). AIs in Day Care settings have reduced from 46% to 24% (n=367 to n=277[3]), and AIs in Hospitals have reduced from 28% to 17% (n=222 to n=196). Nursing and Residential AIs in 2010 - 2016 accounted for 15%, and AIs in Supported Living settings accounted for 7% (22% in total or n=173 incidents). In the 2016-2021 Choking and Learning Review, Nursing, Residential and Supported Living settings collectively account for 42% (or n=485 incidents that data is available for).
- Key themes remain consistent between both reviews, however this Choking and Learning Review (data 2016-2021) has facilitated the identification of key AI themes in ranked order of frequency. The top three are:
    - Interpretation, understanding & documentation

[3] Of the 1155 Adverse Incidents that data relating to settings is available for

- Training – food preparation, Dysphagia, CPR & First Aid
- Recommendations not adhered to

Appendix 4 contains a table summarising all of the key figures from the Regional Choking Review Analysis – thematic review (2018), and the present Choking and Learning Review of Serious Adverse Incidents (SAIs) and Adverse Incidents (AIs) related to choking (2021).

The findings above provide updated analysis regarding SAIs and AIs reported in the period 2016-2021 to inform the current position. Since the publication of the previous Report on the Regional Choking Analysis - Thematic Review (2018) there has been a significant focus across Northern Ireland on reducing the risks associated with choking. This work, including the seven actions set out in the Thematic Review (2018), has been primarily driven by Dysphagia NI, which is a whole system, Public Health partnership approach to Eating, Drinking and Swallowing (EDS) difficulties established in 2018.

5. Dysphagia NI work to meet 7 actions of the Regional Choking Review Analysis – thematic review (2018)

Since its establishment in 2018, Dysphagia NI has undertaken significant safeguarding actions to: improve professional and public awareness, develop standardised approaches to identifying and managing people with EDS, improve access to specialist intervention and coproducing with service users and families. Of particular note are the following actions:

- Implementation of the International Dysphagia Diet Standardisation Initiative (IDDSI) across NI which introduced a standardised common language for describing texture modified foods and thickened fluids for people with Dysphagia.
- SQR-SAI-2021-075 (OPS/MH/AS) was published (03.02.2021). This set out actions to improve and standardise practice, policy and audit to support safe eating and drinking across care settings targeting six key areas.

- Raised potential safety issue relating to PEG laxatives and starch-based thickeners. The Medicines and Healthcare Products Regulatory Agency issued a National Alert[4].

Appendix 5 describes in full the 7 actions of the Thematic Review (2018), the specific work of Dysphagia NI to address these actions, and related regional outcomes/impacts.

Integral to effective whole-system EDS transformation is the engagement of service users and carers. The 10,000 More Voices report examining the experiences of 82 people living with Eating, Drinking and Swallowing difficulties has provided very important insights.

6. Key Messages from 10,000 More Voices, Your Experience of Living with Eating, Drinking and Swallowing Difficulties

People shared details of their high levels of anxiety living with the risk of choking (85%), outlined their confidence in the services provided to support them (70%) and reflected quite positively on their meaningful involvement in care planning (62%). 59% shared positive experiences relating to the nature and timeliness of information. Significantly 38% accessed help in secondary care settings, which suggests reduced and delayed identification and access to specialist care, and 18% waited up to 12 months plus before seeking help.

The 10,000 More Voices report also outlined a range of areas requiring regional reflection and learning. These related to the provision of information, training for carers, system-wide awareness including strategies engaging the hospitality sector, individualised management plans, and the need to develop a risk/choice decision-making framework.

Taking into consideration the PHA/HSCB Choking and Learning Review (2021), the work of Dysphagia NI and the 10,000 More Voices Report, the PHA and HSCB present the following assessment of additional regional interventions required.

[4] Drug Safety Update - Polyethylene glycol (PEG) laxatives and starch-based thickeners: potential interactive effect when mixed, leading to an increased risk of aspiration

7. PHA and HSCB assessment of additional regional interventions required

This Choking and Learning Review (2021) considered 18 SAIs, 17 deaths and 1383 AIs or near-misses. Work to reduce the risk of death by choking and safeguard people with eating, drinking and swallowing difficulties continues to be a priority for Health and Social Care. A summary table of the key safeguarding actions taken to reduce the risk of choking across Northern Ireland since the publication of the Report on the Regional Choking Review Analysis – thematic review in February 2018 can be found in Appendix 6. The establishment of Dysphagia NI in 2018 is the first attempt in the UK to improve and standardise care for people with eating, drinking and swallowing difficulties across a whole system.

SAIs have continued to occur most frequently in Nursing and Residential care settings since the previous Thematic Review (2018). This Choking and Learning Review (2021) further showed that the majority of AIs are now also taking place in Nursing, Residential and Supported Living settings, rather than in Day Care settings as had previously been identified, thus highlighting these as long-standing high-risk environments and indicating the need to target and support these settings in ongoing programmes of work with focussed safeguarding attention and action.

The profile of both SAIs and AIs has changed since the previous Thematic Review (2018) in a number of ways. The age profile of SAIs has changed with most now occurring in the over-70s age group, and this observation aligns with the data indicating that most SAIs are now taking place in Elderly Programmes of Care, with numbers in Mental Health and Learning Disability Programmes of Care having reduced.

This Choking and Learning Review (2021) has established the root causes of SAIs and themed them accordingly to inform and focus regional learning. While not directly comparable, the root causes of SAIs identified in this review (2021) are largely consistent with the themes identified in the previous Thematic Review (2018). Trust-reported key AI themes again remain relatively consistent and there are clear similarities between the Trust-reported key themes of AIs and the root causes of SAIs. This confirms that there are still fundamental issues that require further definitive action.

The number of SAIs where the person concerned was known to SLT has also remained consistent. This supports the need for timely access to SLT services. Given that the root causes of the majority of SAIs relate to people being given, or having access to, food that they should not, it also highlights the need for clarity and understanding of the full range of SLT recommendations for people with EDS difficulties, the communication and availability of the recommendations, and the application of all recommendations.

While it is challenging to demonstrate that changes observed since the Thematic Review (data 2016-2021) are directly related to the work of Dysphagia NI alone, the dramatic increase of 73% in the number of AIs reported suggests that this has been influenced to a significant degree by Dysphagia NI's substantial work since 2018 which has focussed on raising awareness both with clinical staff and the general public, and improving clinical knowledge and reporting processes through the development of regional resources, training programmes, and clinical (including AI reporting) guidance. It is possible that this work may also be contributing towards addressing the potential 'blame culture' surrounding such incidents. Taking into account the shorter reporting period of the second review, it can be estimated that the number of AIs reported over the equivalent 6-year period will have more than doubled.

It is vital that patterns and trends identified through enhanced reporting are routinely monitored and analysed to then inform and target the planning and development of future work in order to build on the foundation work completed to date for long-term sustainable improvement. The identification of key themes and, now, root causes will continue to inform *what* needs to be done, and analysis of the numbers and the profile of settings and programmes of care where incidents are taking place will inform *where* it should be done and *with whom*.

In response to SQR-SAI-2021-075, the Chief Medical Officer (CMO) stipulated that omissions in care must be considered as 'never events' and requested that the PHA/HSCB bring forward an assessment of further regional interventions deemed necessary. Never Events are defined as serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. Based on this Choking and Learning

Review (2021), the PHA and HSCB have established that up to 75% of SAIs for which regional learning was available were preventable.

Recommendations

Taking the learning into account, to consolidate and build upon the foundation work carried out to this point, this paper recommends further strengthening of the regional systemic protective barriers[5] now in place. This work will align with the categorisation of relevant SAIs as 'Never Events'.

To support this, the PHA and HSCB will:

- Progress targeted work in Care Settings and Programmes of Care identified as 'at risk'
- Roll out standardised recommendations for the management of EDS difficulties and an associated programme of audit and monitor of same to ensure that these remain at the fore of care.
- Develop a framework for standardised care to reduce the risk of death by choking and support standardised practice and audit.
- Roll out pilot initiatives which have been shown to deliver improvements and reduce risk
- Undertake further capacity-building for staff, service users and carers, including the introduction of mandatory awareness training
- Develop a framework to help balance risk and personal choice
- Develop a mechanism to deliver ongoing analysis of AIs
- Deliver a sustained and targeted EDS improvement programme which has a strong QI ethos
- Review Trust plans to implement SQR-SAI-2021-075 (OPS/MHS/AS) (03.02.2021) and action plans to implement Dysphagia NI recommendations and resources.

A full summary of the further regional interventions required can be found in Appendix 7.

[5] NHS England Revised Never Events policy and framework

How Will We Know There is Reduced Risk?

For a period of time AIs are likely to increase, illustrating greater awareness and reporting of incidents. The numbers of SAIs, including deaths, should stabilise and then reduce. Dysphagia NI will evidence specifically how interventions reduce risk.

8. Conclusion

Choking and choking near-misses are distressing for people with Dysphagia, families, carers and healthcare professionals. People with Dysphagia report high levels of anxiety and embarrassment around their condition.

On 3rd February 2021, the HSCB and PHA released a Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075) and the Chief Medical Officer in turn wrote to the HSCB and PHA outlining extreme concern at the preventable deaths outlined which 'appear to continue despite previous interventions and guidance issued'. The CMO stipulated that such omissions in care must be considered as 'never events' and requested the HSCB and PHA bring forward an assessment of further regional interventions deemed necessary.

This Choking and Learning Review (2021) considered 18 SAIs, 17 deaths and 1383 AIs, and examined the work Dysphagia NI has undertaken to meet 7 actions set out in the Regional Choking Review Analysis – thematic review (2018) and the experiences of service users and carers in the 10,000 More Voices, Your Experience of Living with a Swallowing Difficulty (2020) report.

Whilst much work has been undertaken and demonstrable improvements have been made, the SAIs and deaths as a result of choking remain unacceptably high. The report brings forward an assessment of further regional interventions deemed necessary to reduce the risks of choking.

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Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

Welcome to this Special Edition (issue 18) of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Special Edition Learning Matters: Risk of serious harm or death from choking on foods

Background

Welcome to this Special Edition Learning Matters Newsletter on risk of serious harm or death from choking on foods. This edition will focus on the serious patient safety issue of choking, which unfortunately remains a prevalent public health concern for the Northern Ireland adult population. From 2016 to the present day, there have been **23** choking related Serious Adverse Incidents (SAIs) reported across Health and Social Care (HSC) and the private and independent sector. Of these 23 SAI's, 21 have tragically resulted in death due to choking. Five of these SAIs have occured since February 2021.

In addition, there have been approximately **1383** choking related Adverse incidents (AI's) reported across Northern Ireland HSC Trusts (2016-Feb 2021).

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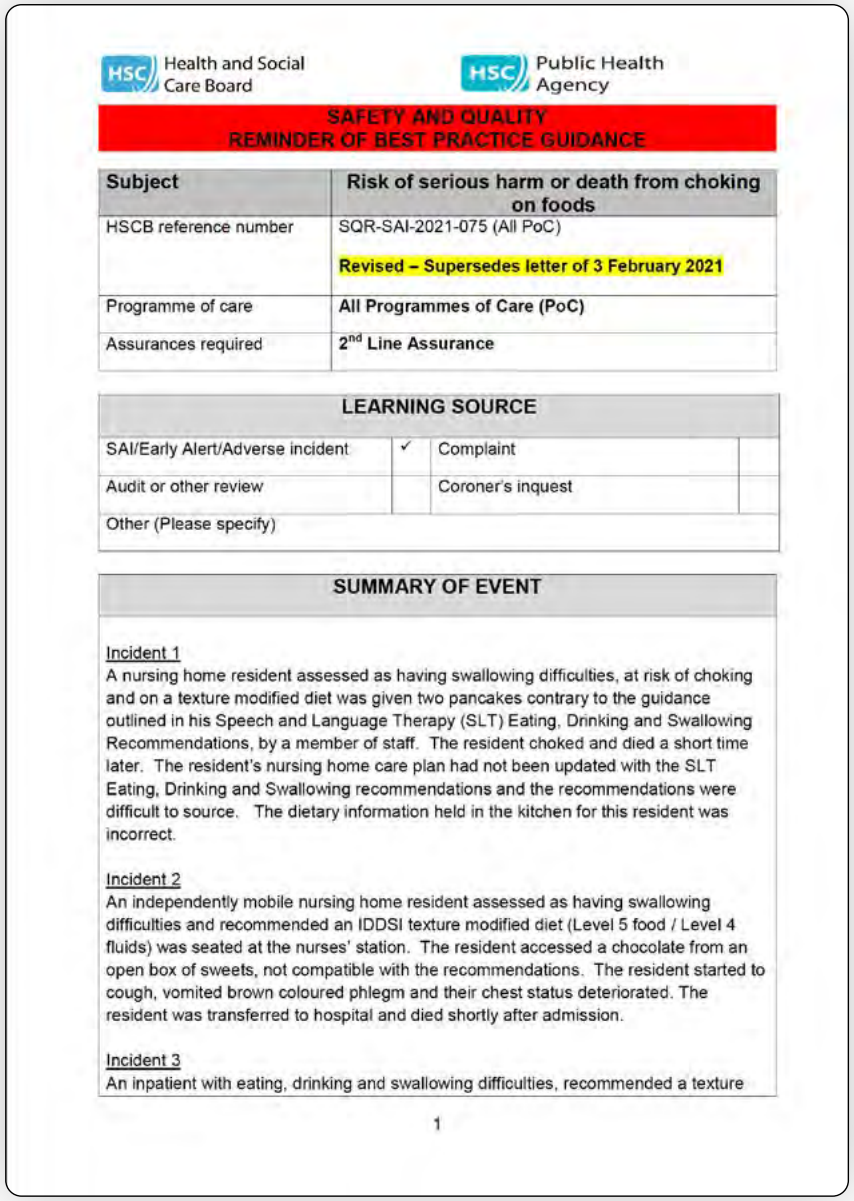
Recent regional learning issued in relation to harm from Choking

On 3rd February 2021, the HSCB / PHA issued a Safety and Quality Reminder of Best Practice Guidance Letter – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)[1]

The letter outlined five choking serious adverse incidents attributed to a failure to recognise and support the needs of people with eating, drinking and swallowing difficulties and at risk of choking. **Six key learning points/recommendations** for all health and social care staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing (EDS) difficulties were highlighted. This letter was reissued in June 2021 to include all Programmes of Care.

Whilst much regional work has been undertaken to maximise the safety of people with EDS difficulties, the ongoing deaths as a result of choking remain unacceptably high. In response to the Safety and Quality Reminder of Best Practice Guidance letter, the Chief Medical Officer (CMO) wrote to the HSCB and PHA outlining extreme concern at the preventable deaths which continue, despite previous interventions and guidance issued.

This Special Edition Learning Matters is part of this work and aims to keep the spotlight on this serious patient safety concern. Health and Social Care staff must be aware of the **6 recommendations** for all staff involved with supporting the care of adults and children who present at risk of choking.



HSC Health and Social Care Board | HSC Public Health Agency

SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE

Subject	Risk of serious harm or death from choking on foods
HSCB reference number	SQR-SAI-2021-075 (All PoC) **Revised – Supersedes letter of 3 February 2021**
Programme of care	**All Programmes of Care (PoC)**
Assurances required	**2nd Line Assurance**

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

Incident 1
A nursing home resident assessed as having swallowing difficulties, at risk of choking and on a texture modified diet was given two pancakes contrary to the guidance outlined in his Speech and Language Therapy (SLT) Eating, Drinking and Swallowing Recommendations, by a member of staff. The resident choked and died a short time later. The resident's nursing home care plan had not been updated with the SLT Eating, Drinking and Swallowing recommendations and the recommendations were difficult to source. The dietary information held in the kitchen for this resident was incorrect.

Incident 2
An independently mobile nursing home resident assessed as having swallowing difficulties and recommended an IDDSI texture modified diet (Level 5 food / Level 4 fluids) was seated at the nurses' station. The resident accessed a chocolate from an open box of sweets, not compatible with the recommendations. The resident started to cough, vomited brown coloured phlegm and their chest status deteriorated. The resident was transferred to hospital and died shortly after admission.

Incident 3
An inpatient with eating, drinking and swallowing difficulties, recommended a texture

1

1 Safety and Quality Reminder of Best Practice Guidance – Risk of serious harm or death from choking on foods (SQR-SAI-2021-075)

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SAFEY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE LETTER: RISK OF SERIOUS HARM OR DEATH FROM CHOKING ON FOODS - KEY LEARNING

The reasons why people choke are complex and often have numerous contributory factors. Recognition of patients' difficulties, implementation of Speech and Language Therapy Eating, Drinking and Swallowing Recommendations into a care plan, alongside coordinated multidisciplinary team efforts, reduces the risk of serious harm or death.

- SAFETY AND QUALITY REMINDER OF BEST PRACTICE GUIDANCE Letter 'Risk of serious harm or death from choking on foods' (SQR-SAI-2021-075) outlines **six recommendations** for all staff involved with supporting the care of adults and children who present at risk of eating, drinking and swallowing difficulties. They are:

1. When a person has identified eating, drinking and swallowing difficulties this should be centered on an **up to date** Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet, within individual care plans.
2. Clear mechanisms for the **communication** of swallowing recommendations to those who are providing food or caring directly for individuals with swallowing difficulties should be in situ within the care setting, including when transferring between locations, include all staff (domestic and catering staff) and where appropriate families and visitors. Nil By Mouth signs should be clearly visible to all staff.
3. The needs of individuals with swallowing difficulties should be **communicated at pivotal times**; handover, meal and snack times, if people move facilities, attend day centres or go out in the care of others.
4. The development of a process for a **safety pause** before any meals and snacks should be considered e.g. "what patient safety issues for meal and snack times do we need to be aware of today?"
5. Ensure foods or fluids that pose a risk to individuals with eating, drinking and swallowing difficulties are stored securely.
6. The **training** and **development** needs of staff providing care for individuals with eating, drinking and swallowing difficulties should be identified and arrangements put in place to meet them.

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Serious Adverse Incidents reported since February 2021

Since issuing the Safety and Quality Reminder of Best Practice Guidance Letter in February 2021, six further SAIs have been reported to the HSCB/PHA. An overview of those with regional learning are provided below:

- A resident in a Private Nursing Home was passing a tea trolley in the corridor which had a plate of buns on it. The resident ate one of the buns. Five minutes later they were found choking by a member of staff in the corridor. An ambulance was called and the resident was transferred to hospital. The resident had a Speech and Language Therapy (SALT) care plan which recommended their food as IDDSI Level 6 (soft, "Food should be cut into small pieces (no bigger than 1.5cm)". The resident required supervision at meal times as they were identified as being at risk of choking. The resident's capacity regarding their dietary needs had not been assessed. Sadly the resident was pronounced dead a short time later.

- A hospital inpatient was not provided IDDSI Level 1 (Slightly Thick Fluids) from admission and 5 days later they experienced a choking episode. They were commenced on antibiotics for pneumonia/aspiration. The patient's family advised that they should have been on IDDSI Level 1 from the outset. The patient deteriorated and sadly passed away.

- A patient with a history of aspiration and diagnosis of dysphagia was transferred between sites within a hospital. Nursing handover noted a requirement for modified diet and fluids. Speech and Language Therapy Eating Drinking and Swallowing Recommendations could not be located. The patient aspirated on food which did not meet the Speech and Language Therapy recommendations. The patient's condition deteriorated and they were transferred for medical management.

- An inpatient in an acute mental health care setting was discovered unresponsive and sitting on the bed in a lent over position by nursing staff. Food was observed on the person's shoulder. CPR was commenced and the patient was transferred to the Intensive Care Unit. The patient died eight days later and the cause of death was recorded as cerebral hypoxia secondary to cardiac arrest which resulted following choking on food. The patient had been recommended an IDDSI Level 7 diet at the time of the incident and food intake was to be supervised.

In summary, these SAIs relate to adults with eating, drinking and swallowing difficulties and the failure to recognise and support their needs. On each occasion, there was a failure to confirm the eating, drinking and swallowing needs of the person, and a failure to communicate their needs to the wider team and ensure safe communication and meal time processes were in place.

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Current Guidance

Current guidance relevant to these Serious Adverse Incidents which all Health and Social Care workers must be aware of is:

1. International Dysphagia Diet Standardization Initiative
2. In 2018 NHS Improvement issued Patient Safety Alert NHS/PSA/RE/2018/004 “Resources to support safer modification of food and drink” detailed at
   HSC (SQSD) 16 18 - Resources to support safer modification of food and drink (hscni.net)

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Fundamentals of Care – Identifying and supporting the needs of people with Eating Drinking and Swallowing (EDS) difficulties

The following measures will support identification of EDS difficulties and the complex needs of people at risk of choking. In adult inpatient care settings all registered nursing staff must ensure that every patient has a robust Person-centred Nursing Assessment and Plan of Care completed on admission. The section on Eating and Drinking (see below) must be accurately completed to ensure early identification of any eating, drinking and swallowing difficulties, support referral to Speech and Language Therapy for further assessment and /or support identification of any existing SLT recommendations.

Eating and drinking

Person – All About Me	Assessment
Able to eat and drink:	Nil by mouth ☐ Yes ☐ No
☐ Independently ☐ Help required ☐ Full assistance	Last ate: _____
Difficulty swallowing: ☐ Yes ☐ No	Last drank: _____
Appetite: ☐ Good ☐ Fair ☐ Poor	Enteral feeding: ☐ Yes ☐ No
Appetite change: ☐ Yes ☐ No	Type of feed:
Dietary Requirements/Modifications including preferences:	Regime:
	Route/ Device type:
Food intolerances:	Size:
	Frequency of change:
Do you wear dentures: ☐ Yes ☐ No	Date next change due:
Top present: ☐ Yes ☐ No	Are you taking oral steroids: ☐ Yes ☐ No
Bottom present: ☐ Yes ☐ No	Do you wish to be involved in your insulin administration: ☐ Yes ☐ No ☐ NA
Secure fitting: ☐ Yes ☐ No	If Yes, Person able and agrees to administer insulin under supervision: ☐ Yes
Diabetes: ☐ Type1 ☐ Type 2 ☐ None	
Controlled by: ☐ Diet ☐ Tablet ☐ Hormone ☐ Insulin	
Other: _____	

Figure one: Person-centred Nursing Assessment and Plan of Care

All other healthcare settings

For all other health care settings that do not use the inpatient Person-centred Nursing Assessment and Plan of Care document, such as nursing and residential settings, the same principles must apply and the regional Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet (REDS) must be central to safe management of the person's needs.

Interface between primary and secondary care

All relevant healthcare staff must ensure effective communication between the primary and secondary care interface, regarding any patients/clients who have identified eating, drinking and swallowing difficulties. An up to date Speech and Language Therapy Eating, Drinking and Swallowing Care Plan specific to their needs, must be in place.

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The Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

FOR ALL STAFF: When a person has identified eating, drinking and swallowing difficulties this MUST be centred on an up to date Speech and Language Therapy Eating, Drinking and Swallowing Recommendations Sheet. This document is central to supporting the needs of people with dysphagia. Robust communication and meal time systems must be in place to support its implementation and communicated widely with all staff.

For adults, the Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet (REDS) was launched in October 2021, to help maximize the safety of people with EDS difficulties.

This document must be kept in its **original format** and **not translated or modified!**

Speech and Language Therapy
Eating, drinking and swallowing recommendations

Swallow Aware
HSC Health and Social Care

Patient name: ..... **Health and Care number:** ..... **Date of plan:** .....

Important information to help when eating, drinking and swallowing

Food .....

Drinks .....

Bread .....

Supervision .....

Additional considerations .....

Contact your Speech and Language Therapist if you experience:

- Coughing and or choking when eating and drinking.
- Frequent chest infections (always contact your GP if chesty).
- Difficulty managing the food or liquid consistencies you have been advised to follow.
- Your voice sounds gurgly after meals or drinks.

Ask your doctor or pharmacist about prescribed medications or supplements.

Supplementary information given: .....

Speech and Language Therapist ..... **Signature** ..... **Print name** ..... **Contact no.**

Discussed with: ....

Figure two: Regional Speech and Language Therapy Eating Drinking and Swallowing Recommendations Sheet

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Staff roles and responsibilities in supporting people with EDS difficulties.

Dysphagia NI has developed guidance on the roles and responsibilities of Health and Social Care staff in supporting the safety of people with eating, drinking and swallowing difficulties. The regional document can be accessed at the following link: 'Are you caring for someone with Eating, Drinking and Swallowing difficulties?'

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Other Key Patient Safety Alerts

1. Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder

In 2015, NHS England issued a Patient Safety Alert on Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder (health-ni.gov.uk). This alert was issued following an incident where a care home resident died following the **accidental ingestion** of the thickening powder that had been left within their reach. Thickening powder formed a solid mass which caused fatal airway obstruction.

Whilst it is important that thickening products remain accessible, all relevant staff must be aware of **potential risks to patient safety**. **Appropriate storage and administration** of thickening powder needs to be embedded within the wider context of protocols, bedside documentation, training programmes and access to expert advice required to safely manage all aspects of the care of individuals with dysphagia.

2. Polyethylene glycol (PEG) laxatives and starch-based thickeners: potential interactive effect when mixed, leading to an increased risk of aspiration

In April 2021 the Medicines and Healthcare Products Regulatory Agency (MHRA) issued their Drug Safety Update volume 14, issue 9: April 2021: 1. Of note:

- There have been reports of a possible **potential harmful interaction** between **polyethylene glycol (PEG) laxatives and starch-based thickeners** when they are mixed together.
- Combining the two compounds can counteract the thickening action and result in a thin watery liquid — patients with swallowing difficulties (dysphagia) are potentially at **greater risk of aspiration** of the thinner liquid.
- **Avoid directly mixing together PEG laxatives and starch-based thickeners**, especially in patients with dysphagia who are considered at risk of aspiration, such as elderly people and people with disabilities that affect swallowing.
- Report suspected adverse drug reactions (ADRs) to the Yellow Card Scheme

3. Risk to patient safety: prescribing and dispensing thickeners and thickened oral nutrition supplements

HSCB has received reports of adverse incidents where people with dysphagia received thickeners or thickened oral nutritional supplements that were not suitable for them. Reasons for this include:

1. Parallel imported products were dispensed from community pharmacies that could cause confusion and increased risk to patient safety; these include thickening products that are not IDDSI compliant and thickened oral nutritional supplements in packs using older “Stage” terminology rather than the new “Level” description.

2. GPs prescribe these products on the recommendation of a SLT or dietitian. Non-specific product descriptions e.g. “Thickening product” may result in an inappropriate product being prescribed. Product details should be clearly described in letters of recommendation to avoid any confusion.

People with dysphagia must receive IDDSI compliant food and fluid consistencies and IDDSI compliant products to reduce the risk of complications such as choking and aspiration. See letter issued from HSCB ‘Risk to patient safety: Parallel imports of thickeners and thickened oral nutritional supplements’

LEARNING MATTERS

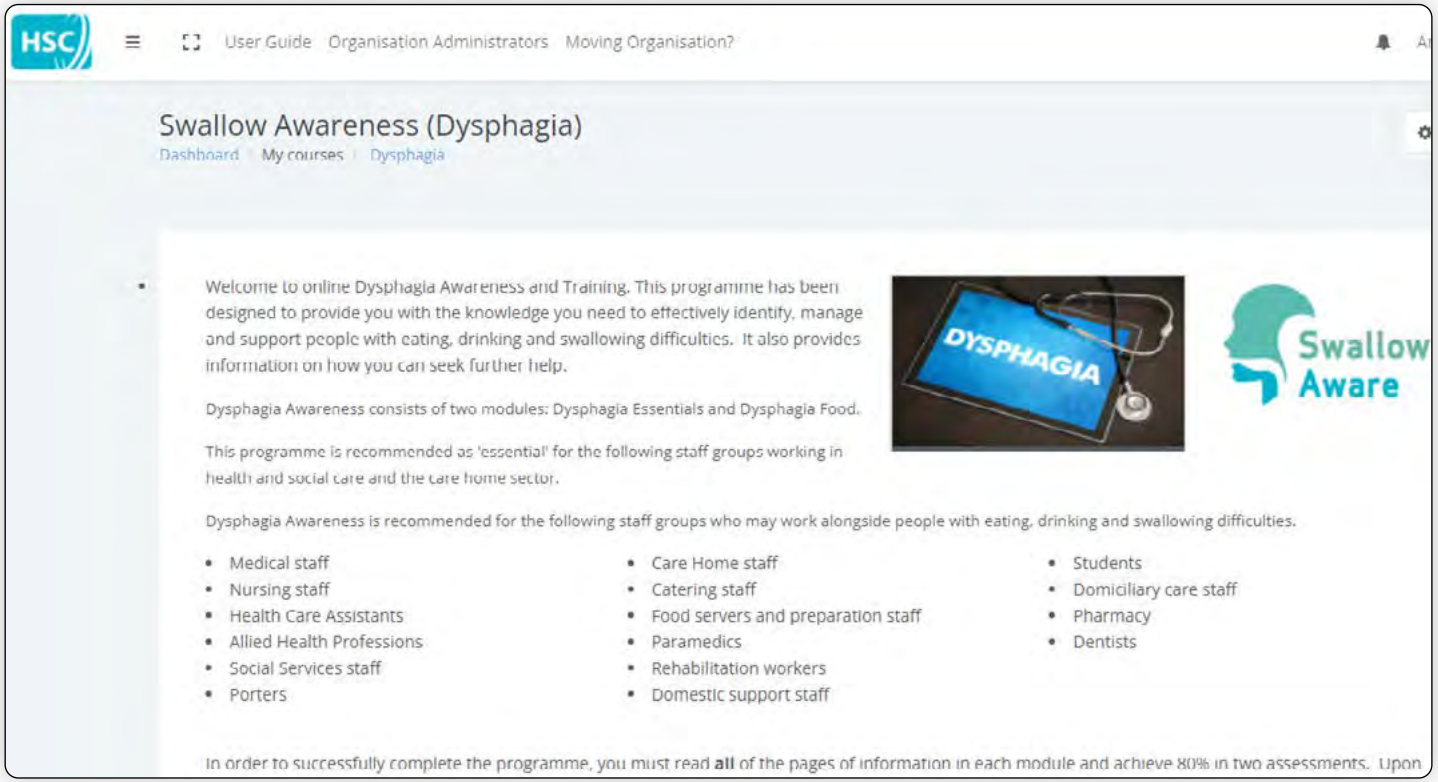
ISSUE 18
OCTOBER 2021

IN THIS EDITION

Link below to previous Learning Matters:
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

REGIONALLY ENDORSED E-DYSPHAGIA AWARENESS TRAINING TO SUPPORT STAFF:

One of the 6 recommendations of the Safety and Quality Reminder of Best Practice Guidance letter is to ensure the training and development needs of staff providing care for individuals with eating, drinking and swallowing difficulties are identified and arrangements put in place to meet them. To support this recommendation, it is advised that staff access regionally endorsed e-Dysphagia Awareness training via the HSC Learning Centre. This training has been designed to help all staff identify, support and manage the needs of people at risk of choking and / or eating, drinking and swallowing difficulties. This e-learning programme is available at: Dysphagia (hsclearning.com)



LEARNING MATTERS

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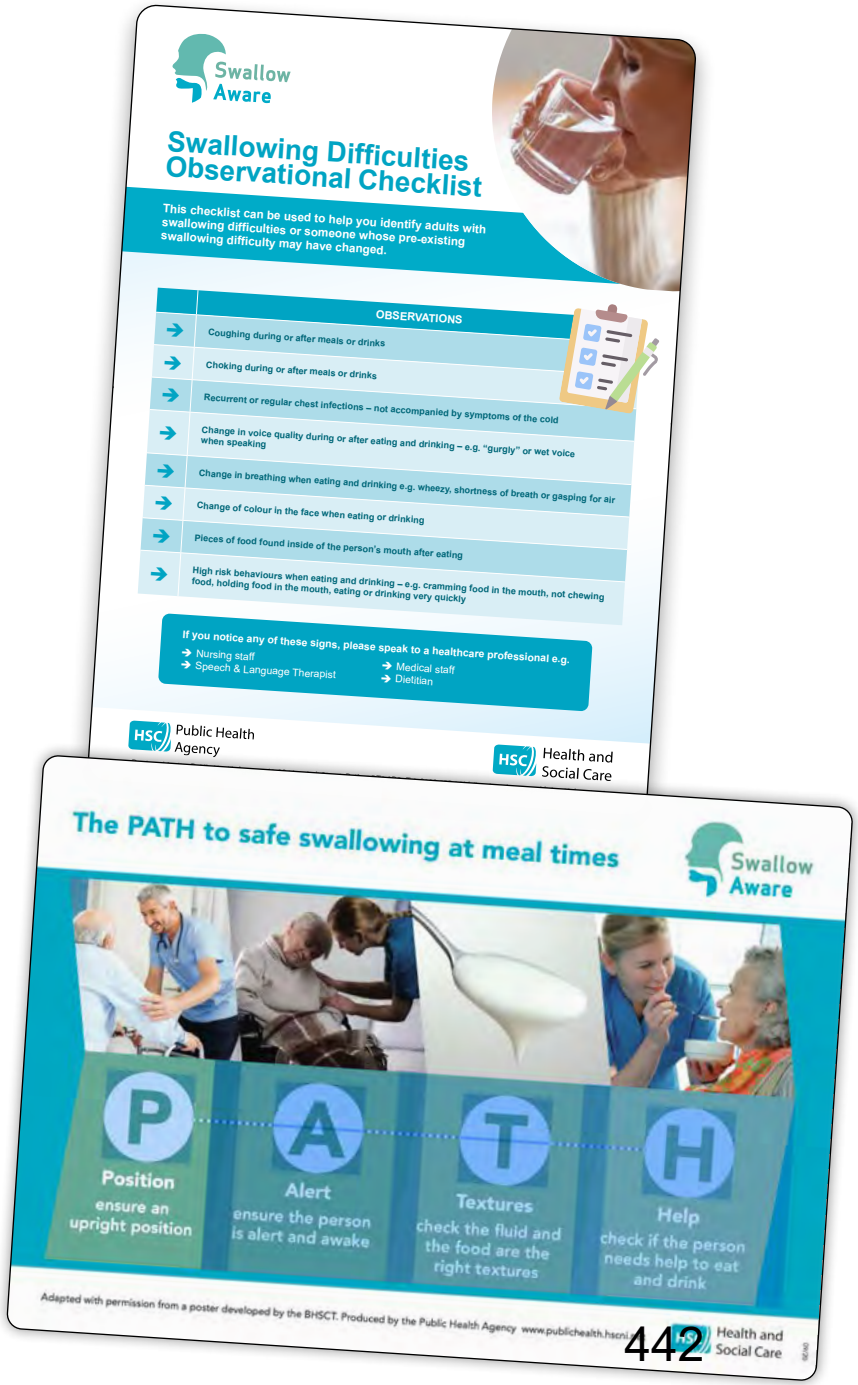
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

Practical resources to support staff:

- International Dysphagia Diet Standardization Initiative IDDSI - Home
- Resuscitation Council UK (2021), Choking Guidance; available at: Adult Choking Algorithm 2021.pdf (resus.org.uk)
- Resuscitation Council UK (2021), Paediatric Choking Guidance; available at: Paediatric Choking Algorithm 2021.pdf (resus.org.uk)
- Dysphagia Northern Ireland, Public Health Agency, practical resources to support staff available here: Dysphagia | HSC Public Health Agency (hscni.net)
- Staff Roles and Responsibilities supporting people with EDS
- **Swallowing Difficulties Observational Checklist** – a checklist to help staff identify adults with swallowing difficulties or someone whose pre-existing swallowing difficulty may have changed
- **PATH Resource** – Position, Alert, Textures, Help – feeding support for carers and staff to support safe swallowing at mealtimes



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Practical resources to support staff:

- How to Help People with Swallowing Difficulties Keep Their Mouths Clean – guidance for carers and staff to support oral hygiene for people with swallowing difficulties
- Dysphagia Adverse Incident Trigger List – Information for staff on reporting swallowing related incidents or "near misses" using local risk management systems
- NI Formulary Website Poster – Medication information for adults with swallowing difficulties – everything at just one click for healthcare professionals, patients and carers

If you have any comments or questions related to this Special Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

All previous editions of the Learning Matters Newsletter can be accessed here:
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

SAI Professional Group

Terms of Reference

1. Purpose of the Group

To ensure collective, multidisciplinary decision making on the management of SAI Reviews and the identification of regional learning in line with the 'Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)'.

SAI Professional Groups provide a systematic process for reviewing incidents to identify and agree on potential regional learning to be disseminated across the wider service to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across Health and Social Care as a whole.

2. Objectives of the Group

Level 1 Reviews

Members of the SAI Professional Group must:

- Ensure review reports have been signed off by the relevant professional or operational director within the reporting organisation given that the process assigns reporting organisations the responsibility for quality assuring Level 1 SEA reviews, ensuring the robustness of the report and identifying learning prior to submission to the SPPG;
- Establish if regional learning identified by the reporting organisation should be shared with the wider service and consider the most appropriate method of dissemination.

Level 2/3 Reviews

Members of the SAI Professional Group must:

- Consider and approve Terms of Reference and Team Membership for Level 2 and Level 3 reviews, as required;
- Consider Root Cause Analysis (RCA) Reports to ensure a robust review has been conducted. If there are concerns, SAI Professional Group members should liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received;
- Consider all recommendations of suggested / proposed learning documented within the review report. In addition, identify any related learning to be communicated across the HSC and consider the most appropriate method of dissemination;
- Review Action plans ensuring they clearly set out how/when each recommendation will be implemented, with named leads responsible for each action point. As required, SPPG/PHA to follow up with the reporting organisation to ensure successful delivery of the action plan;
- Identify any immediate/medium/long term strategic issues which contributed to the incident and need to be addressed, communicate these to the relevant commissioning service.

All Levels of Review

Members of the SAI Professional Group must:

- Agree on appropriate closure of the incident;
- Ensure the timely development of regional learning for approval by the Weekly Incident and Learning Review Group and onward referral to Safety Brief;
- Ensure timely and appropriate level of engagement afforded to service users/families/carers by the reporting organisation throughout the review;
- Liaise with other Professional Colleagues as required;
- Escalate areas of concern as appropriate to Safety Brief for guidance;
- Record any local learning identified following a SAI Review;
- Surveillance of SAIs to identify patterns/clusters/trends;
- Verify regional codes, as assigned upon notification, to be used in conjunction with CCS2 Coding to identify regional recurring themes / trends;
- Ensure all communication between SPPG/PHA and reporting organisation is conveyed between the SPPG Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the SPPG DATIX risk management system.

3. Accountability of the Group

Each SAI Professional Group provides assurance to safety brief that any urgent action is taken following the receipt of SAI Review Reports and that any areas of concern are promptly escalated.

4. Frequency of Meeting

SAI Professional Groups reviewing Level 1 SAIs meet on a fortnightly basis however Groups considering Level 2/3 reviews meet on a monthly basis.

Meetings will be held more frequently, as required, in line with the number SAI review reports within the system to ensure a timely review and identification of learning.

5. Quorum

Each SAI Professional shall be quorate by the attendance of three members of the Group. Expertise / advice can be sought from SPPG/PHA colleagues as required.

6. Revision of Terms of Reference

The Terms of Reference will be reviewed in twelve months (March 2023) or earlier as required.

Development of a PHA / HSCB Patient/ Client Safety Framework

Scoping exercise

A scoping exercise of frameworks in other areas was undertaken

Republic of Ireland

Patient Safety Strategy: Our Commitments

1 Empowering and Engaging Patients to Improve Patient Safety
We will foster a culture of partnership to maximise positive patient experiences and outcomes and minimise the risk of error and harm. This will include working with and learning from patients to design, deliver, evaluate and improve care.

2 Empowering and Engaging Staff to Improve Patient Safety
We will work to embed a culture of learning and improvement that is compassionate, just, fair and open. We will support staff to practice safely, including identifying and reporting safety deficits and managing and improving patient safety.

3 Anticipating and Responding to Risks to Patient Safety
We will place an increased emphasis on proactively identifying risks to patient safety to create and maintain safe and resilient systems of care, designed to reduce adverse events and improve outcomes.

4 Reducing Common Causes of Harm
We will undertake to reduce patient harm, with particular focus on the most common causes of harm.

5 Using Information to Improve Patient Safety
We will use information from various sources to provide intelligence that will help us recognise when things go wrong, learn from and support good practice and measure, monitor and recognise improvements in patient safety.

6 Leadership and Governance to Improve Patient Safety
We will embed a culture of patient safety improvement at every level of the health and social care service through effective leadership and governance.

Charter for Patient Safety

Strategy Commitments:
The six commitments set out in the Strategy serve as a health service Charter for Patient Safety. We aim to embed these commitments at every level of the health service so that they serve as a basis for building a movement for patient safety.

Strategy Actions:
Each commitment comes with a set of associated actions. These actions are designed for adoption by local services. They recognise work already being taken, highlight further actions required, and they will be supported by the HSE nationally.

Patient Safety Improvement Priorities

This Strategy identifies a number of initial priority areas for reduction of harm and patient safety improvement:

In partnership with patients, we will constantly be reviewing our patient safety priorities to ensure that we are focussing our efforts on the areas that require it most.

NHS England

- Design for safety as opposed to responding to harm
- Sustained reduction of risk rather than a reactive process.
  - **Insight**
    - How safe is care?
    - Metrix used to measure key safety indicators
    - Digital system to support learning
    - SAI Process
    - Understanding complaints / litigation
    - Alerts
  - **Involvement**
    - Creation of patient safety partners
    - Co-production
    - Patient Safety syllabus
    - Safety 1 & Safety II
  - **Improvement – Patient Safety Improvement Programme**
    - Deteriorating patient / sepsis
    - Maternity & neo-natal
    - Medicines management
    - Mental Health
    - Older people (ant-microbial / LD)
    - Research & Innovation

Scotland

EVERY PERSON EVERY TIME

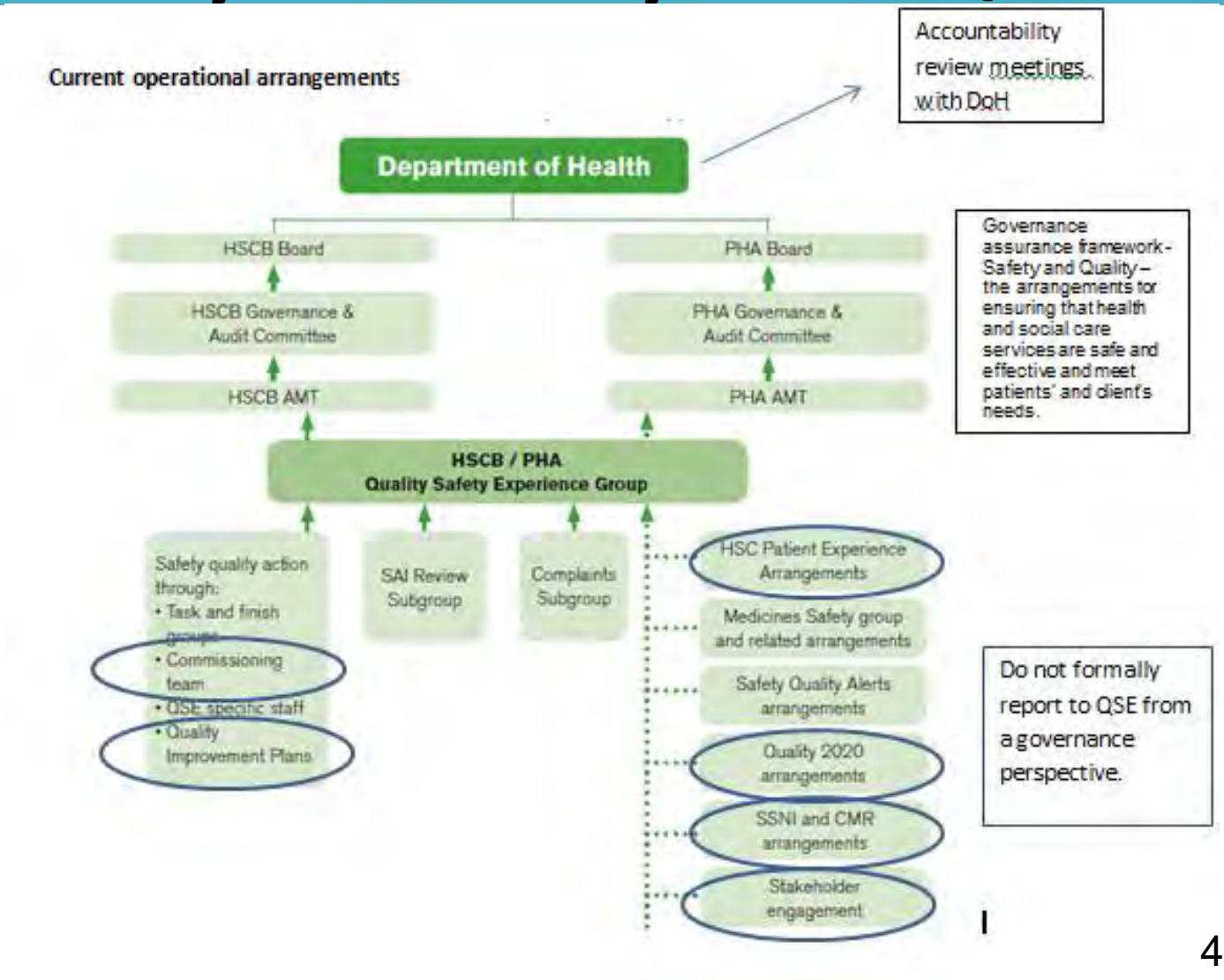
SCOTTISH PATIENT SAFETY PROGRAMME

There's always room for improvement

The Scottish Patient Safety Programme (SPSP) is a unique national initiative that aims to improve the safety and reliability of healthcare and reduce avoidable harm, whenever care is delivered. From an initial focus on acute hospitals, the work of SPSP now includes safety improvement programmes for the following areas:

- Acute adult
- Healthcare Associated Infection
- Maternity and children
- Medicines
- Mental health
- Primary care

Current operational arrangements for Quality and Safety in PHA / HSCB



What is our role?

Understand

We will ensure that we understand the context in which care is being delivered.

We will help to identify the barriers to improvement and the factors which will enable sustainable continuous improvement.

Assure

We will support organisations to conduct their own internal assurance to allow them to continuously improve.

We will conduct robust and independent assurance of the quality of care, with rigorous and systematic follow up whenever necessary

Advise

We will provide advice on the most up-to-date evidence from which to design high quality care.

We will provide intelligence on the quality of care, which can guide and inform best practice.

We will work with people to ensure that the design of services meet their needs.

Enable

We will use a range of approaches to enable service providers to design and implement high quality systems of care.

We will ensure meaningful approaches to engagement with those that need care.

Possible objectives for HSCB / PHA Safety Framework?

1. Implement and enhance governance structures within the HSCB / PHA that improve patient safety across the HSC.
2. Develop a regional data matrix dashboard that enables the HSCB / PHA to make informed decisions and identify areas for improvement.
3. Deliver a regional safety & quality improvement programme to support HSC organisations.
4. Enhance systems and processes that listen to, engage with and involve patients in in the design, delivery, evaluation and improvement of HSC services.

Thoughts on a page

What?

How

Is anyone better off?

Data matrix information

- SAI
- AIs
- CMRs
- Alerts
- Complaints / litigation
- Patient Experience
- Data from improvement programme (TBC)

What does this information tell us?

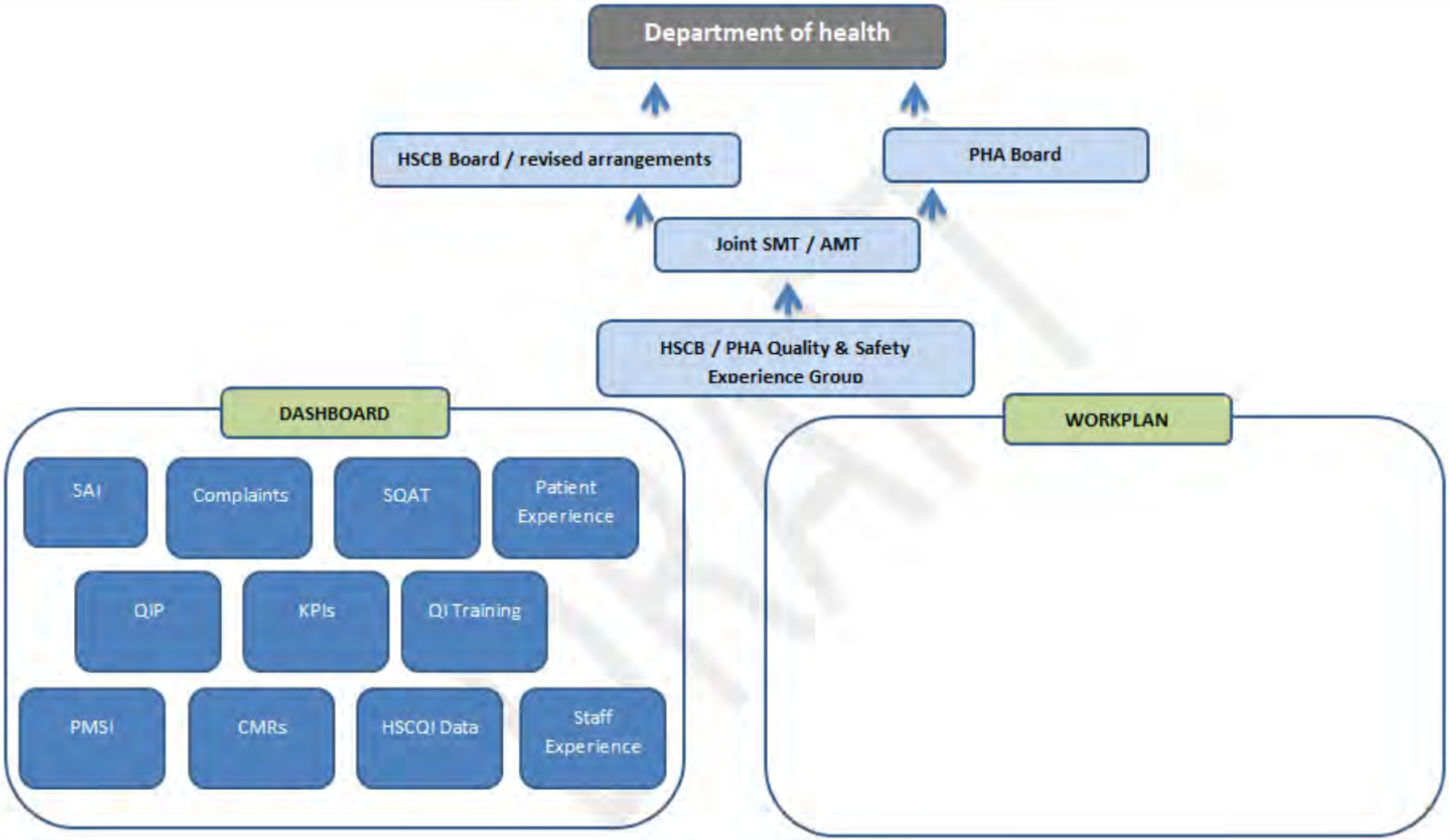
Reactive

- SAI reviews investigations
- Complaints reviews
- Alerts
- Learning letters / newsletter
- Thematic reviews

Proactive

–Regional Patient Safety Improvement Programme (based on data matrix – should change every few years). Key topics to be identified.

Proposed model



MAHI - STM - 308 - 455

Key Stakeholders

- Medicine
- Nursing
- AHP
- Midwifery
- Social Work
- Integrated Care
- Corporate Services
- Patient Experience / PPI
- Commissioning
- DoH
- Finance
- RQIA
- PCC
- Independent services commissioner
- Domestic homicide review
- ?how we link learning from litigation
- Learning from enquiries

Next Steps

- Engagement with Key Stakeholders individually to understand the current operational arrangements for Safety & Quality within their areas.
- Hold a Workshop to agree model for framework, core components of Safety Framework and timescales for implementation.

V1 PHA / HSCB Safety Framework

1.0 Background

The PHA / HSCB jointly have a regional responsibility for ensuring that health and social care services are safe, effective and meet the needs of patients and clients. The need for a regional Safety Framework which encompasses a range of key areas has been identified as a key priority in order to fulfil this responsibility. Building on the existing Quality and Safety structures and processes within the HSCB / PHA and learning from other countries, an implementation model for a regional safety framework has been developed.

2.0 Learning from other countries

England

NHS England implemented a patient safety strategy in 2019 entitled *'Safer culture, safer systems, safer patients'*, which focuses on designing for safety as opposed to responding to harm. It highlights the importance of maintaining a sustained reduction of risk rather than introducing a reactive process. There are 3 key elements of the NHS England Strategy.

1. **Insight**
    - How safe is care?
    - Metrix used to measure key safety indicators
    - Digital system to support learning
    - SAI Process
    - Understanding complaints / litigation
    - Alerts

2. **Involvement**
    - Creation of patient safety partners
    - Co-production
    - Patient Safety syllabus
    - Safety 1 & Safety II

3. **Improvement – Patient Safety Improvement Programme**
    - Deteriorating patient / sepsis
    - Maternity & neo-natal
    - Medicines management
    - Mental Health
    - Older people (ant-microbial / LD)
    - Research & Innovation

https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

Republic of Ireland

Within the Republic of Ireland a Safety Strategy was developed in 2019. It outlines 6 commitments which include:

- Empowering and engaging patients to improve patient safety
- Empowering and engaging staff to improve patient safety
- Anticipating and responding to risks to patient safety
- Reducing common causes of harm
- Using information to improve patient safety
- Leadership and governance to improve patient safety

They have a number of patient safety priority areas for reduction of harm which makes up a patient safety improvement programme. These priorities are constantly reviewing to ensure efforts are focused on areas that need it most.
https://www.hse.ie/patientsafetyconsultation/

Scotland

NHS Scotland Patient Safety Programme was published in 2017-2022 entitled "Making care better – better quality HSC for everyone in Scotland". It has a number of strategic priorities in order to achieve their aim of better quality health and social care against five strategic priorities.

- Enable people to make informed decisions about their own care and treatment.
- Help health and social care organisations to redesign and continuously improve services.
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve.

- Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve.
- Make best use of all resources.

In addition to its Strategy, Scotland also has a patient safety programme which focuses on similar patient safety priorities to those in other parts of UK and RoI.

http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/strategy_2017-2022.aspx

http://www.scottishpatientsafetyprogramme.scot.nhs.uk/

Wales

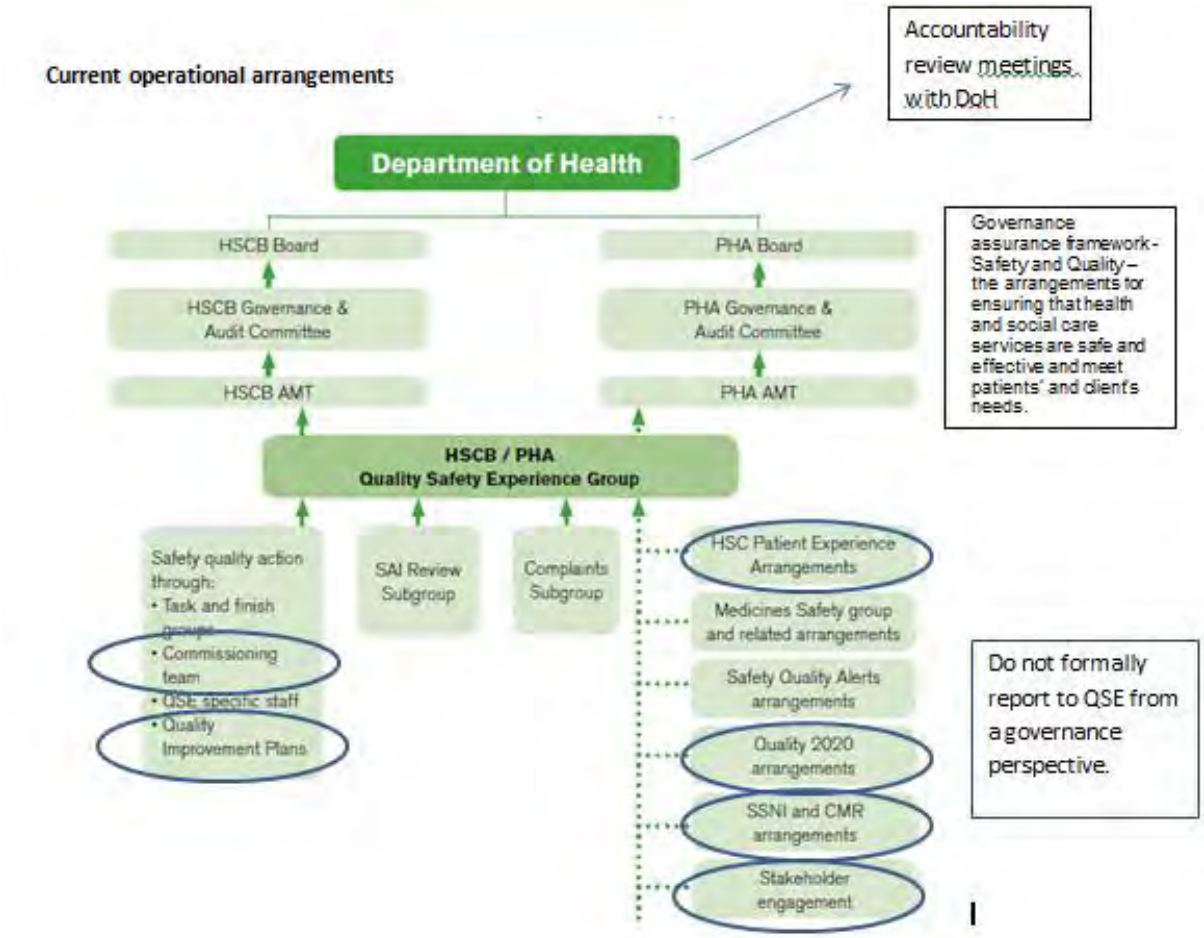
The NHS Wales Delivery Unit supports organisations in NHS Wales in improving safety and quality, developing safer environments and reducing avoidable harm. Patient Safety assurance and improvements are the priority across the whole Delivery Unit and a dedicated Quality and Safety Team provide leadership and support on incident reporting, learning from incidents and never events, compliance with patient safety solutions and, where required, assurance reviews in NHS Health Boards and Trusts. The teams focus on 4 areas:

- Patient Safety Incidents
- Patient Safety Solutions: Alerts & Notices
- Patient Safety Solutions: Compliance
- Never Events

https://du.nhs.wales/patient-safety-wales/

3.0 Current operational arrangements within PHA / HSCB

The PHA / HSCB have delegated responsibilities for improving safety and quality as outlined in the HSC Framework Document 2009.



The joint HSCB / PHA Quality Safety and Experience Group currently provides a platform to operationalise the arrangements for improving Safety Quality and Patient Experience, by providing an overarching structure for advice, guidance and accountability. However, since its establishment there have been a range of policies, procedures and new areas of work developed which don't all necessarily fall under the QSE structures. Given the current climate in relation to responding to COVID-19, managing competing demands, the planned closure of the HSCB and the transfer of roles to the DoH we have a unique opportunity to revise the current operational arrangements to enhance the current structures and make improvements where necessary.

An internal scoping exercise was completed in September 2020 which looked at the individual groups / areas of work which currently feed into QSE structures in order to understand from

- a) a governance perspective, the accountability structures around the area of work
- b) The types of information that is shared with QSE and how regularly these appeared on the agenda.

The scoping exercise provided an excellent opportunity to understand how QSE was currently operating. It highlighted that a range of robust information and data was being presented on a regular basis which enabled informed decisions relating to safety and quality to be made from a regional perspective. The scoping exercise also identified some areas for improvement in relation to QSE structures providing the opportunity for triangulating data, making links between areas of work and proactively identifying learning based on the wealth of intelligence available within the HSCB / PHA.

4.0 Objectives of PHA / HSCB Safety Framework

1. Implement and enhance governance structures within the HSCB / PHA that improve patient safety across the HSC.
2. Develop a regional data matrix dashboard that enables the HSCB / PHA to make informed decisions and identify areas for improvement.
3. Deliver a regional safety & quality improvement programme to support HSC organisations.
4. Enhance systems and processes that listen to, engage with and involve patients in in the design, delivery, evaluation and improvement of HSC services.

5.0 Proposed Safety Framework model

What do we know?

Intelligence available within the HSCB / PHA

- SAI
- AI
- CMRs
- Alerts
- Complaints / litigation
- Patient experience
- Staff experience
- QIPs falls, pressure ulcers
- Nursing KPI
- Waiting lists (PMSI data)
- HSCQI Data
- Social Care
- Integrated Care

What does this info tell us?

How do we shape our Safety & Quality work plan based on evidence?

How do we use this information?

Reactive / Safety 1

- SAI reviews
- Complaints reviews
- Alerts / guidance
- Learning letter / newsletter
- Thematic review
- Learning events

Proactive / Safety 2

Learning from excellence

Introduction of Patient Safety Improvement Programme

- Priority areas based on intelligence
- Regularly reviewed and updated (?2 yearly)

Training for staff (all levels) in Quality Improvement.

Is anyone better of?

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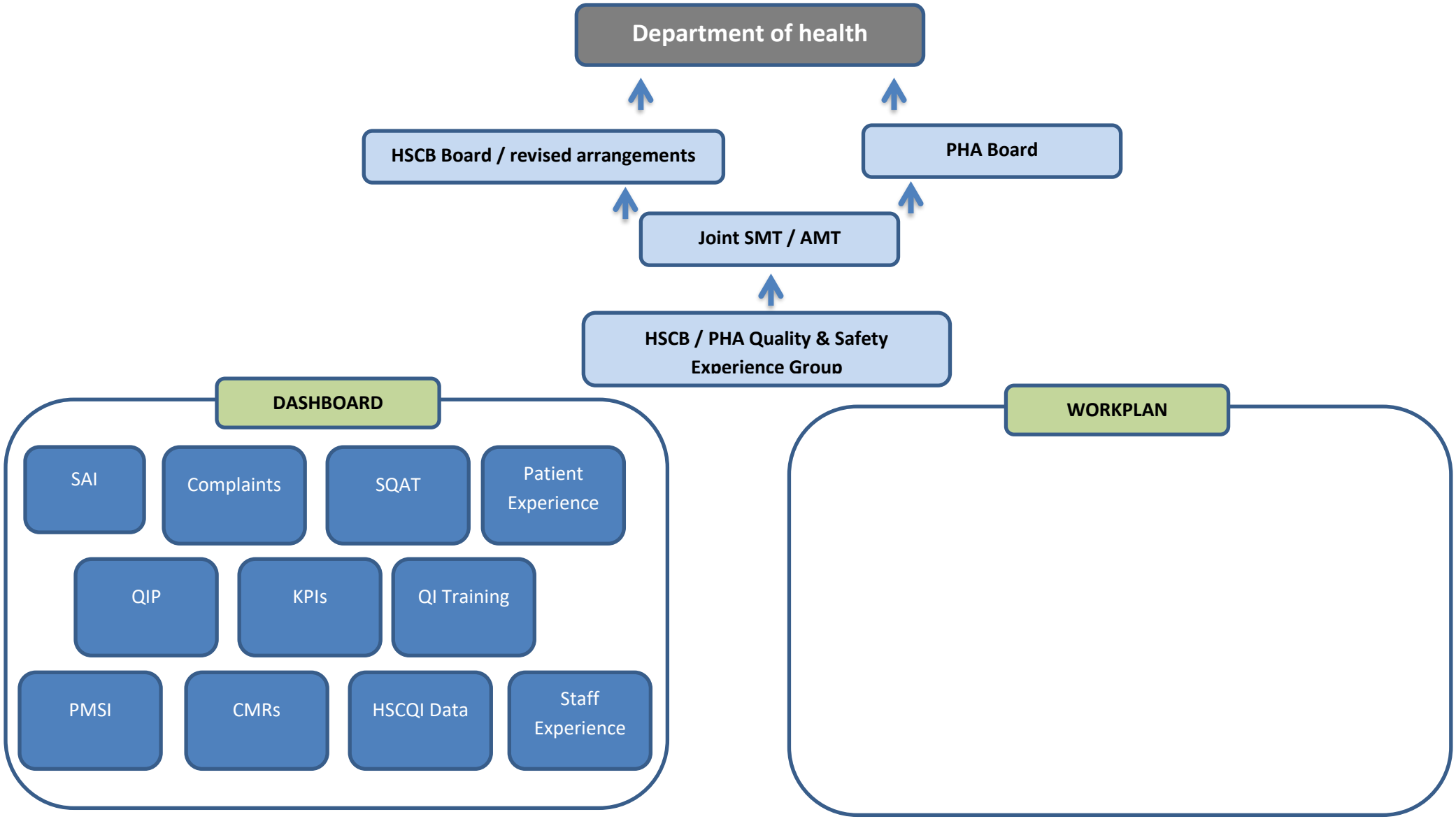


HSC Public Health Agency

Management Team Paper for	PHA AMT	**Item**	7

Date	6 July 2022
Title of paper	Safety and Quality Update
Reference	AMT/04/07/22
Prepared by	Denise Boulter/ Grainne Cushley
Lead Director	Rodney Morton

Recommendation For **Approval** ☐ For **Noting** ☒

Summary

As part of the audit recommendations an overview of how SPPG/PHA are managing safety Issues, highlighting any risks and advising on how responsibilities are triangulated and discharged at system level is to be presented to AMT quarterly. This is the first quarterly report.

Background

As part of the audit recommendations an overview of how SPPG/PHA are managing safety Issues, highlighting any risks and advising on how responsibilities are triangulated and discharged at system level is to be presented to AMT quarterly. This is the first quarterly report.

Process

PHA and SPPG colleagues have prepared a position report for each area of Safety and Quality as listed below. Individual reports have been amalgamated into one overview paper highlighting current status; risks and risk mitigation (see Appendix 1).

1. Serious Adverse Incidents (Governance with input from PHA)
2. Safety & Quality Alerts (Governance with input from PHA)
3. RQIA Reports (Governance with input from Commissioning & PHA)
4. NCEPOD Report (Governance with input from Commissioning & PHA)
5. Complaints (Complaints with input from PHA)
6. NICE Guidance (Commissioning with input from PHA)
7. Safety Framework (PHA with input from SPPG)

Currently the above areas fall under the leadership of individual teams with support as indicated above.

Key Issues/Risks (in relation to sections 1-6 above)

- **SAIs** – There is a substantive delay in the submission of SAI Review Reports ultimately impacting on the dissemination of local and potential regional learning across the HSC.

  Action: Continue to work closely with Trusts via robust performance management arrangements and consider options for external assistance with backlog of level one SAI review reports which will provide further insight as part of the regional review of the SAI Procedure.

- **RQIA Reports** – The Governance Team have completed a full review of the 22 RQIA reports currently open across SPPG/PHA as at 31st May 2022. Of the 22 reports reviewed 6 have been identified as not on target for completion due to the impact of the pandemic.

  Action: Final report to be approved by Safety Brief and issued to Deputy Secretary and Chief Executive PHA via submission. 6 reports not on target for completion will be escalated to Safety Brief to agree action.

- **NCEPOD and other confidential reports** - The Governance team are currently undertaking a review of NCEPOD and other confidential reports. There are currently 30 open reports, 9 of which require reassignment of a new PHA/SPPG Commissioning lead.

  Action: 9 NCEPOD reports without assigned leads to be escalated to Safety Brief.

- **Safety and Quality Alerts** – no significant risks at this time aside from recognition that the Safety and Quality Alerts procedure is due for review.

- **Regional Complaints Process** – there is insufficient information on regional learning from complaints being shared with SPPG.

  Action: Issues have been raised with Trust Governance Leads at a recent meeting in June 2022. Consideration is also being given to enhancing the complaints monitoring returns.

- **NICE Guidance** – Key issues and required action will be identified by NICE lead at Group Head's Meeting.

- **Regional Safety Framework** - Key issues and required action will be identified by PHA lead

Next Steps

The PHA/SPPG currently have recently established a Safety Quality and Experience Oversight Group which gathers intelligence of all safety and quality related activity across PHA and SPPG. Whilst the Group have no direct management of the above

processes, it has identified a number of gaps in the system and actions to be taken forward:

- Some of the above processes are working in isolation, a more streamlined approach is required to review and consider information holistically as and when received by PHA/SPPG.

  There is a need to further enhance the triangulation of learning particularly in relation to RQIA reports, NCEPOD reports, NICE guidance and Safety and Quality Alerts. The intention is to establish a subgroup of the above oversight group who will consider the above reports as and when received ensuring a holistic approach to how recommendations are being taken forward within the relevant programmes/specialities.

- Introduction of new methods of learning including triangulation analysis papers on key patient safety topics, engagement with clinical networks, evaluation of ECHO programme and formal integration of Patient Safety issues into training programmes will continue to be tested over coming months. The group have already developed an initial learning paper that has focused on the triangulation of learning from SAIs, Complaints and Patient Safety Experience on Stroke, see appendix 2.

- Work will continue over the coming months to further refine the 3 core components of the Safety Framework and develop measurement framework associated with the objectives.

- A business case will be developed to strengthen capacity around Patient Safety work and further development of Safety framework within PHA / SPPG.

Recommendation

AMT is asked to note updates on Quality and Safety

Funding Requirements

In-year	N/A
Full Year	N/A
Source of Funding	N/A

Assessments

Equality Screening Assessment	Attached	☐	Not required	☒
Rural Needs Assessment	Attached	☐	Not required	☒
Data Protection Impact Assessment	Attached	☐	Not required	☒

Signed	
Title	Director of NMAHP
Date	4 July 2022

Safety and Quality Assurance Processes

A Serious Adverse Incidents

Background:
Since May 2010, the SPPG working in partnership with the PHA are responsible for the Procedure for the Reporting and follow up of Serious Adverse Incidents (November 2016).

Current Position:
The Governance and Safety & Quality Nursing Teams have continued to work collaboratively with DRO's to make continued improvements to internal processes for the management of SAIs. Significant improvements have been made over the last 18 months since the commencement of the Improvement plan with a 48% decrease in the number of reports awaiting review by SPPG/PHA. All SAI Professional Groups now have manageable workloads, upon receipt reports are considered at the next scheduled SAI Professional Group and outcome of review is communicated to the Trust.

SPPG will continue to monitor this position and escalate any concerns to Safety Brief with quarterly reports to Group Heads, the next report is due on 2nd August 2022.
There are concerns regarding the increasing backlog of overdue SAI reports from all HSC Trusts. Despite numerous attempts to address the backlog which included Touchpoint meetings with HSC Trusts governance leads and meetings with SPPG/PHA at Director Level there has been no improvement, with 620 reports currently overdue – breakdown below.

Level of Review	BHSCT	NHSCT	NIAS	SEHSCT	SHSCT	WHSCT	Total	%
Level 1	248	100	15	46	50	39	**498**	80%
Level 2	50	15		4	24	16	**109**	18%
Level 3	5	3			5		**13**	2%
Total	**303**	**118**	**15**	**50**	**79**	**55**	**620**	**100%**

Risk:
The delay in submission of final reports will ultimately impact on the dissemination of potential Regional Learning across the HSC.

Next Steps:
We are currently liaising with an external organisation, CLS Educate, to assist with reviewing Level one SAIs alongside HSC Trust colleagues. In doing so, HSC colleagues will learn from the experienced reviewers from CLS whilst SPPG/PHA will also gain an understanding of the complexities/time involved in carrying out reviews and engaging with families. This insight will be invaluable when reviewing the SAI Procedure over the coming months.

B RQIA Report Recommendations:

Background:

- Previously the implementation of accepted RQIA recommendations relevant to both HSCB and PHA was monitored through routine joint HSCB/PHA reporting to SMT and HSCB Governance Committee. This process was historically led by the PHA Medical Director supported by the HSCB Governance team. In more recent years DoH, Corporate Policy directorate put in place a regional process to monitor all RQIA recommendations and HSCB/PHA provided a joint progress report. This process was postponed by Corporate Policy directorate in 2020 due to the response to the Covid19 pandemic.

Current position:

- The current process is that we report the Corporate Policy directorate however this was postponed in 2020 and has not yet been reinstated. However, in light of the migration of HSCB to the DoH, the Governance Team, in conjunction with professional leads from SPPG and PHA, undertook a review as at 31 January 2022 with an updated position as at 31 May 2022.
- There are currently 22 RQIA Reports open on the SPPG Safety and Quality Alerts system.
- A full progress report on all 22 reports has been completed and approved by Safety Brief on 1st July 2022 for onward submission to the Deputy Secretary.

Risks:

- From the recent progress report 6 reports have been identified as not on target for completion, which has been summarised below:

  - **Specialist Sexual Health Northern Ireland** – Work has been impacted due to legislative requirements, pandemic and funding requirements;
  - **Review of the Diabetic Retinopathy Screening Programme** – Work has been impacted due to service recovery in 2019/20 and pandemic;
  - **Review of Perinatal Mental Health Services in Northern Ireland** – Work has been impacted due to pandemic and funding requirements;
  - **Review of Emergency Mental Health Service Provision across Northern Ireland** - the delay in meeting the timescales has been due to the onset of Covid and the redeployment of Trust, PHA and SPPG staff to respond to the pandemic and retirements of staff;
  - **RQIA review of NICE Clinical Guideline 174, Intravenous (IV) Fluid Therapy in Adults in Hospitals in Northern Ireland** – There was a need to establish a network of task and finish Groups, alongside oversight groups to take forward the work required to implement the prioritised recommendations; This has since been established and work is continuing;
  - **RQIA Review of General Paediatric Surgery in Northern Ireland** – Work has been impacted due to pandemic and funding requirements.

Next steps/Mitigation:

- The Governance Team will link with DoH Corporate Policy Directorate to share outcome of report and where possible seek revised timescales for those RQIA reports where progress has been delayed due to the pandemic and escalate reports to Safety Brief as required.

C NCEPOD and other Confidential Inquiry Report Recommendation:

Background:

- Previously the implementation of accepted NCEPOD and other confidential enquiry recommendations relevant to both HSCB and PHA was monitored through routine joint HSCB/PHA reporting to SMT and HSCB Governance Committee. This process was historically led by the PHA Medical Director supported by the HSCB Governance team.
- This process was postponed by Corporate Policy directorate in 2020 due to the response to the Covid19 pandemic.

Current position:

- Departmental colleagues have requested a progress report be provided, which is currently in the process of being produced for period ending 30 June 2022. Once finalised the progress report will be reported to Safety Brief prior to submission to Deputy Secretary.
- There are currently 30 reports open on the alerts module to be reported on.

Risks:

- Difficulties have been encountered in receiving names of reassigned leads to replace leads who have since left the service or moved to new posts for 9 of these reports.
- Ockenden Report published on 31 March 2022 has not been formally issued as yet by DoH.

Next steps/Mitigation:

- A partnership arrangement is currently under development with SPPG and PHA.

D. Safety and Quality Alerts

Background:

- The SPPG/PHA has in place a Regional Safety and Quality Alerts Procedure which oversees the identification, co-ordination, dissemination and assurance on implementation of regional learning issued by the SPPG/PHA/DoH/Regulation and Quality Improvement Authority (RQIA) and other independent/regulatory bodies.

- Once a Safety and Quality Alert (SQA) has been issued to Arm's Length Bodies (ALBs) it is the responsibility of the SPPG/PHA to ensure adequate responses on assurances to the actions specified within relevant SQAs have been implemented accordingly. Previously this process was overseen by the PHA/HSCB Safety and Quality Alerts (SQA) Team which was formed in April 2012. This team met fortnightly and provided a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

Current position:

- As from May 2021 a new assurance model was put in place for the management of Safety and Quality Alerts (SQAs). The assurance model introduced three lines of assurance for SQAs. The categorisation of line of assurance assigned to SQAs is dependent on the degree of assurance required – refer to table below. A schematic overview of the SQA assurance model is attached as addendum 1.

Line of Assurance	Trust/ALB Internal Assurance	Assurance to SPPG/PHA	Timescale for response to SPPG/PHA	SPPG/PHA Internal Assurance
1st Line Assurance SQA	Trusts/ALBs are responsible for gaining assurances through their own safety and quality assurance processes.	No response to actions is required to SPPG/PHA;	N/A	N/A
2nd Line Assurance SQA	Trusts/other ALBs are responsible for gaining assurances through their own safety and quality assurance processes.	Response to SPPG/PHA required confirming the actions have been added to the organisations safety and quality assurance work-plan.	4 weeks from issue of SQA	Reviewed by SPPG Governance Team and escalated to 3rd line of assurance group as required
3rd Line Assurance SQA	Trusts/other ALBs are responsible for gaining assurances through their own safety and quality assurance processes.	Response to SPPG/PHA required confirming actions specified within the SQA have been completed.	12 weeks from issue of SQA	Responses reviewed by SPPG/PHA 3rd line of compliance group which is held fortnightly

- This process is now overseen by relevant directors within the SPPG and PHA by way of weekly Safety Brief Meetings. SQAs requiring escalation are referred to relevant professional groups / Safety Brief Meetings as required.

- Performance meetings are held bi-monthly with Trusts and SPPG Integrated Care Team to discuss performance issues.

Risks:

- Current procedure has been in place since 2018 and requires a substantial review.

Next steps/Mitigation:

- The review will be undertaken In parallel with review of the Regional Procedure for the reporting and follow up of SAIs which is due to be commenced following the issue of RQIA report on the review of the SAI process.

E Regional Complaints

Background
Under the Guidance on Implementation of the HSC Complaints Procedure (April 2022) SPPG is required to monitor how those providing care on its behalf, deal with and respond to complaints. This includes:

- Outcomes
- Service Improvements
- Monitoring complaints processes

SPPG must maintain an oversight of all FPS 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.

Process of Monitoring
The RCSG reviews complaints information received from HSC Trusts and FPS Practices. 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.

The complaints are shared with professionals relevant to the following subject areas:- Emergency Departments, maternity 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.

This monitoring process ensures that complaints information is routinely linked into existing work streams/professional groups, for example: -

- Food and Nutrition (Mealtime work)
- Falls
- Development of Pathways for Bereavement from Stillbirths, Miscarriages and Neonatal Deaths
- Development of Pathways for End of Life Care/Palliative Care
- Maternity Commissioning Group
- Patient Experience Working Group (10,000 more voices)
- Regional Discharge Group
- Stroke
- Sepsis

Under the HSC Complaints Procedure all FPS practices are required to forward to SPPG anonymised copies of any letters or statements of complaint together with the respective responses, within three working days of the response having been issued.

Progress to date:

Recent examples of identification of areas of concern/patterns of complaint identified through the RCSG include safe discharge arrangements and presentation of typical and atypical stroke. Demonstrate what we have achieved with this, ie the triangulated paper being fed back into the Regional Discharge Group, and the Stroke presentation going into the Stroke Network, but emphasising that this work originated from review of complaints

- **Monitoring Protocol**

This has been agreed with the Trusts which includes an agreed learning template providing details of complaints where it is envisaged or recommended that regional learning could gained.
A learning from complaints email address at SPPG has been established to enable Trusts to forward the templates. Additional information can subsequently be asked for if required.

Risks:

- Current monitoring returns do not provide sufficient information.
- Trusts not complying with the requirement to forward a Learning Template if there is a potential for learning.

Mitigating Actions / Next Steps:

SPPG met with HSC Trusts' Governance/Complants Leads on 22 June 2022 at SPPG/HSC Trust Complaints Monitoring meeting and reminded colleagues their requirements under the Complaints Monitoring Protocol.

Consideration is being given to enhancing the monitoring returns template to require Trusts to confirm if regional learning has been identified.

F NICE processes

Background

- HSC organisations including the Strategic Planning and Performance Group (SPPG) have a range of responsibilities in regard to the implementation, monitoring and assurance of various types of NICE guidance in Northern Ireland.

- The DoH has published circulars setting out the roles and responsibilities for four types of NICE guidance including:
  - NICE Technology Appraisals (TAs)
  - NICE Clinical Guidelines (CGs)
  - NICE Interventional Procedures Programme (IPGs)
  - NICE Public Health Guidance (PHGs)

- All four circulars were revised in April 2022 to reflect the migration of the HSCB to SPPG (DoH). However, no substantive review of the content of the circulars has taken place since 2015.

Technology Appraisals (TAs)

Current Position

- Since the beginning of the process in 2011, 464 NICE TAs have been endorsed by the DoH. Of the 464 TAs endorsed by DoH, 410 TAs have had service notifications completed and issued to the service.

- 15 service notifications are currently being completed within the required 15 week timescale, however there remains a backlog of 39 service notifications which are at various stages of production.

- Trusts are expected to implement TAs within 9 months of issue. The SPPG has sought assurance on the implementation of TAs from Trusts in advance of the next round of the SPPG/Trust accountability meetings.

Risks

- There is currently no Finance or PHA support available to support the production of Service Notifications

- Clarity is needed on the requirement to complete service notifications for NICE TAs which are part of the Cancer Drugs Fund. These TAs represent a significant element of the current backlog.

Mitigation / Next steps

- Access to NICE TAs are not primarily determined by the adherence to the NICE TA Circular. Rather, the SPPG Managed Entry Process for New Medicines facilitates the introduction of the majority of new medicines before final publication by NICE and endorsement by DoH.

Clinical Guidelines (CGs)

Current Position

- Since the beginning of the process in 2011, 232 CGs have been endorsed for implementation in NI. These CGs are at various stages of implementation with the majority of CGs currently classified as not being fully implemented.

- Trusts are expected to implement TAs within 12 months of issue unless additional resource or regional co-ordination is required. The SPPG has sought assurance on the implementation of TAs from Trusts in advance of the next round of the SPPG/Trust service delivery meetings.

- Following a DoH review of the adherence to the CG Circular, a number of issues regarding existing processes were identified.

Risks

- CGs are wide ranging and often complex in nature. Capacity across organisations is often limited e.g. CG174 – Fluid Management in adults. Following a review undertaken by RQIA, work on CG174 has been ongoing over the last 18 months to support Trusts to establish a plan for implementation of this guideline, with task and finish groups set up to assist. It is not possible to replicate this focus across every CG.

- Positive assurance is currently sought from Trusts at 'a point in time', i.e. 12 month implementation position. No further assurance on implementation is sought thereafter. The SPPG does not have oversight of the 'live' implementation status.

- There is no dedicated financial resource to support the implementation of CGs. The costs associated with the full implementation of all CGs would be significant.

Next Steps /Mitigation

- Following the initial review of the circular in April 2022, it was agreed with DoH Colleagues that a more comprehensive review of the HSC Circular with DoH policy colleagues would be required. This work requires increased focus in the coming months.

- SPPG continues to seek assurance from Trusts and will prioritise the implementation of any safety concerns highlighted.

Public Health Guidance (PHGs)

Current Position

- Public Health Guidance is assessed by the Department and endorsed under one of three broad headings:
  - to take account of in the design and delivery of services;
  - to highlight specific recommendations for particular consideration in the design and delivery of services; or
  - to be implemented, monitored and assured

- Unless a recommendation is endorsed specifically for implementation, there is no requirement for PHA or HSC organisations to report on the implementation of Public Health Guidance. The majority of guidance is endorsed under the first heading.

Risks

- It is not clear whether current processes within SPPG and PHA are fit for purpose where there are recommendations highlighted for implementation.

Mitigation / Next steps

- Review of the current arrangements within both SPPG and PHA is required to re-establish processes following the pandemic.

Interventional Procedures (IPGs)

Current Position

- The NICE Interventional Procedures Programme sets out what clinicians need to do prior to performing an interventional procedure they have not used before in the HSC.
- The SPPG seeks positive assurance from HSC Trusts that NICE interventional procedures guidance with a "do not use" recommendation are not being used via routine director level Service Issues and Performance meetings..
- There are currently no 'live' do not use IPGs in the system.

Risks

- *None*

Mitigation / Next steps

- *None*

G Safety Framework

Background:

The regional Safety Framework Is currently under development led by the PHA and SPPG. The Framework will aim to streamline and enhance existing safety & quality processes to provide an overarching leadership and governance, embedded at all levels of the organisation. Phase 1 of the framework relates to the PHA / SPPG, the bodies who currently have regional oversight of a range of Patient Safety processes. It is envisaged that the Framework will be developed in such a way which enables it to be spread across the HSC as a standard way of approaching Patient Safety.

Current Position:

The Framework currently has 3 strategic components which are under development using an outcomes based accountability approach. These include:

1. Streamlining Leadership & Governance to improve Safety.

What are we trying to achieve?

- Collective leadership responsibility for Patient Safety across HSC organisations
- Robust governance and assurance structures relating to Patient Safety issues across HSC
- Strong workforce capacity & capability in Patient safety & governance

How will we achieve it?

- Design an assurance framework for Safety issues and a reporting schedule to management committees and Boards to include information relating to Patient Safety such as SAIs, AIs, Complaints, Experience, KPIs, and the implementation of NICE Guidance, RQIA reports, NCEPOD Reports, Confidential enquiries.
- Establish a Patient Safety & Governance sub-committee, chaired by NED for Executive Boards which will provide a challenge function in respect of Patient Safety & Governance. .
- Establish a HSC Director Oversight structure with collective leadership responsibility for patient safety & risk to ensure maximum opportunities for learning are utilised.
- Co-ordinate an annual culture climate survey to understand attitudes towards patient safety and governance and develop a work plan as a result.
- Develop professional leadership in Patient Safety by providing capability opportunities through training and education in areas such as human factors, RCA, Improvement methodologies etc.

How will we know if anyone is better of?

- Short term, medium terms and long term measurement framework for this ambition is currently being developed.

2. Utilising safety surveillance systems to improve outcomes

What are we trying to achieve?

- A regional safety surveillance system which enables the timely triangulation of intelligence and identification of risk from a range of sources.
- Increased staff capacity & capability to interpret information in order to anticipate and respond to risks about patient safety

How will we achieve it?

- Develop a regional analytics platform which will display an agreed metrics relating to patient safety issues such as SAIs, complaints, experience, regional KPI's information such as falls, pressure ulcers; and performance against a number of agreed areas.
- Create opportunities for staff to analyse and triangulate information to both pro-actively and re-actively respond to risks and common causes of harm.
- Facilitate the robust professional analysis of the data overtime to enable accurate conclusions to be drawn from the data and to support the narrative behind the data to ensure a holistic approach to data analysis.
- Facilitate the production of timely data information to Teams, Management Teams and Boards providing an assurance of oversight processes in operation.

How will we know if anyone is better of?

- Short term, medium terms and long term measurement framework for this area is currently being developed.

3. **Improving outcomes for people through systematic learning**.

What are we trying to achieve?

- Measurable improvement in outcomes associated with the dissemination and implementation of regional learning
- Access to a suite of learning tools / techniques to support the translation of learning into a change in behaviour including the triangulation of information and integrated working. .
- Regional innovative platform to sharing learning and interact with the wider HSC in a systematic manner.

How will we achieve it?

- Development of a measurement framework including outcome, process and balance measures for the dissemination, implementation and associated behaviour change relating to learning received.
- Engage with HSC to understand various ways of learning and develop an improvement plan to continuously improve methods of learning.
- Design and deliver a bi-annual Patient Safety Improvement Programme focusing on areas of both pro-active and re-active causes of harm.

How will we know if anyone is better of?

Short term, medium terms and long term measurement framework for this area is currently being developed.

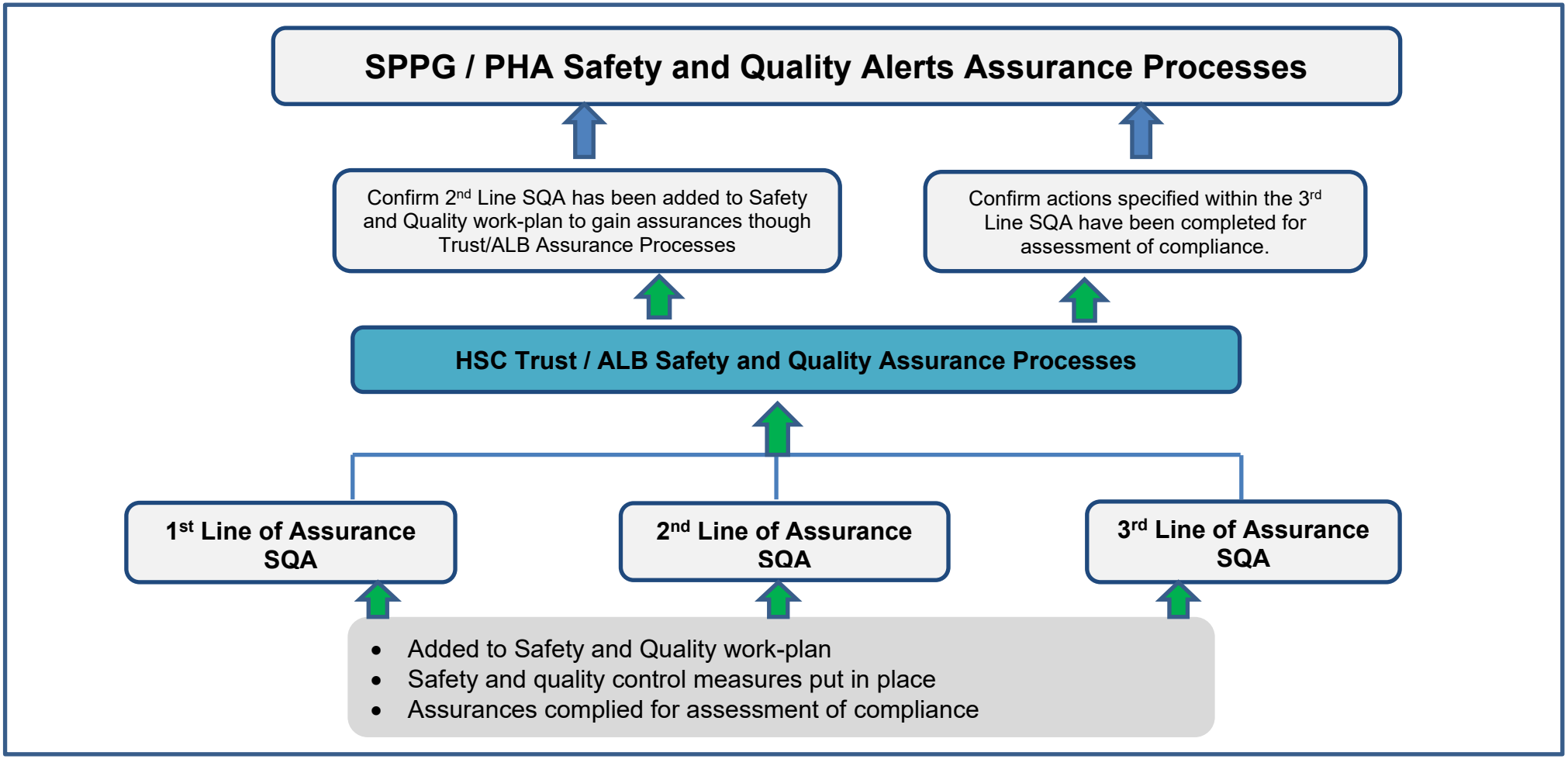
Next Steps:

- Work will continue over the coming months to further refine the 3 core components of the Safety Framework and develop measurement framework associated with the objectives.
- Post migration, teams across PHA / SPPG are working to further enhance and streamline the governance / leadership structures around safety & quality.

- Discussions are ongoing with data analytics team around the establishment of surveillance system, which has the potential to umbrella the current systems that currently being used to monitor data relating to patient safety.
- Work is ongoing around engaging with the HSC in terms of the core components of a ‘learning system’
- Introduction of new methods of learning including triangulation analysis papers on key patient safety topics, engagement with clinical networks, evaluation of ECHO programme and formal integration of Patient Safety issues into training programmes will continue to be tested over coming months.
- A business case will be developed to strengthen capacity around Patient Safety work and further development of Safety framework within PHA / SPPG.

Addendum 1

Safety and Quality Alerts (SQA) Assurance Model



Health and Social Care Safety Framework

Progress Report Aug 22

Background:

The core components of a regional Safety Framework are currently under development led by the PHA. The Framework will ultimately aim to provide clarity and direction to HSC to support them to streamline and enhance their safety & quality processes and provide an overarching leadership and governance relating to Patient Safety.

Following a literature review of various different countries approach to Patient Safety, 3 strategic objectives for the regional Framework are currently being explored using an outcomes-based accountability approach. Phase 1 of the framework relates to the PHA / SPPG, the bodies who currently have regional oversight of a range of Patient Safety processes. It is envisaged that the Framework will be developed in such a way which enables it to be spread across the HSC as a standard way of approaching Patient Safety.

Current Position:

The Framework currently has 3 strategic objectives which are under development using an outcomes based accountability approach. These include:

1. **Streamlining Leadership and Governance to Improve Safety**
2. **Utilising safety surveillance systems to improve outcomes**
3. **Improving outcomes for people through systematic learning.**

1. Streamlining Leadership and Governance to Improve Safety

What are we trying to achieve?

- Collective leadership responsibility for Patient Safety across HSC organisations
- Robust governance and assurance structures relating to Patient Safety issues across HSC
- Strong workforce capacity & capability in Patient safety & governance

How will we achieve it?

- Design an assurance framework for Safety issues and a reporting schedule to management committees and Boards to include information relating to Patient Safety such as SAIs, AIs, Complaints, Experience, KPIs, and the implementation of NICE Guidance, RQIA reports, NCEPOD Reports, Confidential enquiries.
- Establish a Patient Safety & Governance sub-committee, chaired by NED for Executive Boards which will provide a challenge function in respect of Patient Safety & Governance. .
- Establish a HSC Director Oversight structure with collective leadership responsibility for patient safety & risk to ensure maximum opportunities for learning are utilised.
- Co-ordinate an annual culture climate survey to understand attitudes towards patient safety and governance and develop a work plan as a result.
- Develop professional leadership in Patient Safety by providing capability opportunities through training and education in areas such as human factors, RCA, Improvement methodologies etc.

How will we know if anyone is better of?

- Short term, medium terms and long term measurement framework for this ambition is currently being developed

2. Utilising safety surveillance systems to improve outcomes

What are we trying to achieve?

- A regional safety surveillance system which enables the timely triangulation of intelligence and identification of risk from a range of sources.
- Increased staff capacity & capability to interpret information in order to anticipate and respond to risks about patient safety

How will we achieve it?

- Develop a regional analytics platform which will display an agreed metrics relating to patient safety issues such as SAIs, complaints, experience, regional KPI's information such as falls, pressure ulcers; and performance against a number of agreed areas.
- Create opportunities for staff to analyse and triangulate information to both pro-actively and re-actively respond to risks and common causes of harm.
- Facilitate the robust professional analysis of the data overtime to enable accurate conclusions to be drawn from the data and to support the narrative behind the data to ensure a holistic approach to data analysis.
- Facilitate the production of timely data information to Teams, Management Teams and Boards providing an assurance of oversight processes in operation.

How will we know if anyone is better of?

- Short term, medium terms and long term measurement framework for this ambition is currently being developed

3. Improving outcomes for people through systematic learning.

What are we trying to achieve?

- Measurable improvement in outcomes associated with the dissemination and implementation of regional learning
- Access to a suite of learning tools / techniques to support the translation of learning into a change in behaviour including the triangulation of information and integrated working. .
- Regional innovative platform to sharing learning and interact with the wider HSC in a systematic manner.

How will we achieve it?

- Development of a measurement framework including outcome, process and balance measures for the dissemination, implementation and associated behaviour change relating to learning received.
- Engage with HSC to understand various ways of learning and develop an improvement plan to continuously improve methods of learning.
- Design and deliver a bi-annual Patient Safety Improvement Programme focusing on areas of both pro-active and re-active causes of harm.

How will we know if anyone is better of?

- Short term, medium terms and long term measurement framework for this ambition is currently being developed

Next Steps:

1. **Design of framework and associated objectives / deliverables**
   - Work will continue over the coming months to further refine the 3 core components of the Safety Framework and develop a measurement framework associated with the objectives. This will be in consultation with HSC Trusts, SPPG, Patients, Clients and other relevant stakeholders.
   - A business case will be developed to strengthen capacity around Patient Safety work and support the further development of Safety framework within PHA / SPPG.
   - The regional framework will be designed and launched officially.

2. **Operationalisation of Framework**
   - Immediate steps are currently being progressed within PHA/SPPG to begin the operationalisation of the Safety Framework. It is envisaged that these will act as a pilot and thus their evaluation will inform the full implementation of the Framework across the HSC. Actions include:
     - Teams across PHA / SPPG are working to further enhance and streamline the governance / leadership structures around safety & quality.
     - Discussions are ongoing with data analytics team around the establishment of surveillance system, which has the potential to umbrella the current systems that currently being used to monitor data relating to patient safety.
     - A ‘Learning network has been established with engagement from a number of senior clinicians which will provide a platform to test new ways of developing, disseminating and measuring behaviour change relating to learning.
     - Continued roll out of new methods of learning including triangulation analysis papers on key patient safety topics, engagement with clinical networks, evaluation of ECHO programme and formal integration of Patient Safety issues into training programmes will continue to be tested over coming months.

The Regulation and Quality Improvement Authority

RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland

June 2022

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Health and Social Care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors who are either experienced practitioners or experts by experience. RQIA reports are submitted to the Department of Health (DoH) and are available on the RQIA website at www.rqia.org.uk.

Acknowledgements

RQIA wishes to thank all those who facilitated this review by participating in discussions, meetings, surveys and by providing relevant information.

Membership of the Expert Review Team

Maria Dineen	Managing Director of Consequence UK, Consultant to the National Patient Safety Agency 2001-2003, approved investigator - NHS England's serious incident framework and author of Six Steps to Root Cause Analysis.
Dr David Evans	Former Medical Director and Interim Chief Executive Northumbria Healthcare National Health Service Foundation Trust, England.
Dr Lourda Geoghegan	Former Director of Improvement and Medical Director, Regulation and Quality Improvement Authority (role in review ceased March 2020)
Emer Hopkins	Director of Hospital Services, Independent Healthcare, Audit and Reviews, RQIA (role in review commenced March 2020)
Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority.
Mrs Vivien Jess	Lay Representative and Independent Expert Advisor to the review
Mr Brian O'Hagan	Lay Representative and Independent Expert Advisor to the review
Dr Richard Wright	Former Medical Director of Southern Health and Social Care Trust and Professional Medical Advisor, Regulation and Quality Improvement Authority.

Table of Contents

Glossary of Terms

Belfast Trust	Belfast Health and Social Care Trust
CAMHS	Children and Adolescent Mental Health Services
CQC	Care Quality Commission
DoH	Department of Health
DRO	Designated Review Officer
HSC	Health and Social Care
HSCB	Health and Social Care Board
IHRD	Inquiry into Hyponatraemia-related Deaths
Multidisciplinary	Involving professionals from different disciplines who have different professional skills, expertise and experience.
NIAS	Northern Ireland Ambulance Service
Northern Trust	Northern Health and Social Care Trust
PCC	Patient Client Council
PHA	Public Health Agency
PPI	Personal and Public Involvement
RCA	Root Cause Analysis
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
SPPG	Strategic Performance and Planning Group (formerly Health and Social Care Board)
Western Trust	Western Health and Social Care Trust

Foreword

This Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland resulted from the independent Public Inquiry led by Justice O'Hara which investigated the deaths of five children in hospitals in Northern Ireland. After hearing evidence from a wide range of individuals and organisations, it concluded that deaths had been avoidable and that the culture of the health service at the time, arrangements in place to ensure the quality of services and behaviour of individuals had contributed to those unnecessary deaths.

A key finding of the Public Inquiry was that the internal investigations into the deaths and their surrounding circumstances were inadequate. They had failed to identify the underlying causes. It also found that, as guidance on fluid management on children became available, it was not disseminated and actioned effectively across the Health and Social Care (HSC) system.

The reality is that similar situations, where events leading to harm have been inadequately investigated and examples of recognised good practice have not been followed, have been, and are likely to be repeated in current practice.

Such inadequacies bring distress and suffering to the individuals affected and their loved ones; and the staff whose efforts to provide good and safe care are undermined.

Serious Adverse Incident (SAI) reviews are a fundamental part of how the whole system should learn from harm, and make improvements to Health and Social Care services in Northern Ireland.

This Review, commissioned by the Department of Health (DoH), in its response to the recommendations of the Inquiry, and undertaken by the RQIA, has assessed the effectiveness of the current SAI process.

It has been one of our most significant Reviews, which has benefited from engagement with a wide range of individuals, organisations and groups across the Health and Social Care system.

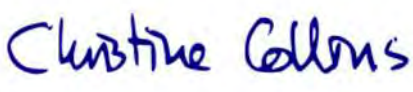
We would especially like to thank all families who contributed to the Review, as their experience of the reality from a patient and family perspective has been a key feature in shaping the Review's findings.

The Expert Review Team found that neither the SAI review process nor its implementation is sufficiently robust to consistently enable an understanding of what factors, both systems and people, have led to a patient or service user coming to harm.

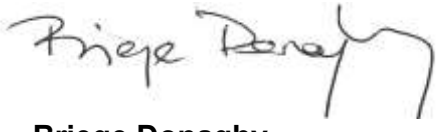
HSC leaders and managers must work to make sure that if something goes wrong, all staff are confident to speak up, through a competent and independent review process, knowing that doing so will help them keep their patients and service users safe and improve the quality of care they are able to deliver.

Patients and service users, and their loved ones and advocates, must be able to take part freely and fully in the process, so they find out what happened and can help make sure it won't happen again.

On behalf of RQIA, we hope that the recommendations in this Review, which have been produced with the assistance of a wide range of patients, service users, families, clinicians and managers from across HSC, will be accepted, implemented fully, and drive improvement in safety and quality throughout the system.



Christine Collins MBE
Chair



Briege Donaghy
Chief Executive

Executive Summary

Background and Context

Serious Adverse Incident (SAI) reviews are a fundamental component of how we learn from harm and subsequently make improvements to the systems for the delivery of safe patient care. Regional guidance for the reporting and follow-up of SAIs in Northern Ireland has been in place since 2004. However, over the last decade, the SAI process and its implementation has come under scrutiny both regionally and nationally. Concerns have been raised around the current procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs) in Northern Ireland (November 2016)[1] (here-after the SAI procedure). It has also been highlighted that there is a clear need for improvement in terms of how patients, their families and staff are engaged in reviews and how subsequent learning is derived and implemented. These issues are not unique to Northern Ireland or indeed the United Kingdom. Ensuring the effective implementation of SAI reviews and subsequent learning is a considerable undertaking. Not only does the procedure itself need to be robust, but its effective application necessitates an open and supportive learning culture with SAI reviewers who are trained in the necessary skill set to undertake effective SAI reviews.

In April 2018, the Regulation and Quality Improvement Authority (RQIA) was commissioned by the Department of Health (DoH) to examine the application and effectiveness of the SAI procedure. Terms of Reference for this review were approved by the Department of Health in October 2019 and fieldwork on this review concluded in January 2021. The time taken to complete and publish this review has been significantly impacted by the system response to Covid-19 Pandemic.

Terms of Reference

The terms of reference for this review, as agreed with the DoH, were as follows:

1) To review the systems/ processes in place for reporting and follow-up of Serious Adverse Incidents (SAIs) across the six Health and Social Care (HSC) Trusts, the HSCB and Public Health Agency in Northern Ireland, between 30 November 2016 and 31 March 2018.

2) To engage with families affected by SAIs reported between 30 November 2016 and 31 March 2018, to determine their level of involvement in the Serious Adverse Incident process.

3) To assess the process for the classification of the severity of SAIs and to determine whether incidents are appropriately classified through this process.

4) To assess the level of independence of the SAI reviews progressed and assess whether a multi-disciplinary systems-wide approach to reviews has been undertaken.

5) To assess the development and effectiveness of action plans and recommendations arising from SAIs reviews.

6) To assess whether appropriate learning has been identified from the SAIs and disseminated regionally, and whether the learning can deliver measurable and sustainable improvements in the quality and safety of care.

7) To determine current understanding of the role of respective organisations, including the Coroner, in the process for SAI reviews, and how this understanding compares to the published roles and responsibilities as outlined in the procedure for the Reporting and Follow up of Serious Adverse Incidents.

8) To assess the level of professional support provided to (i) staff who were delivering care at the time of the SAIs, as well as (ii) staff conducting the review of the SAIs.

9) To provide a report of the findings to the Department of Health, making recommendations for improvement as relevant to the overall response to SAIs, their assessment and review, and the learning arising through these processes.

Methodology

The Expert Review Team developed a methodology specific to this review incorporating extensive engagement with a range of key individuals and organisations and patients their relatives and representative groups. Focus Groups and individual interviews were undertaken. The engagement was supported by the development of a number of semi-structured questionnaires. An important aspect of this review was the undertaking of a rigorous assessment of 66 serious adverse incident reports from all HSC Trusts in Northern Ireland.

Findings

The Expert Review Team determined that the current SAI procedure and its implementation in Northern Ireland **does not** support:

- Fulfilment of the statutory duty of Personal Public Involvement as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.
- Reasonable application of the principles of effective SAI review practice.
- Confidence in the independence of chairs of SAI reviews at Level 2, or Level 3. Particularly in the case of Level 3 reviews, where the appointed chair is a former employee of an HSC Trust.
- Accountability of Health and Social Care organisations for:
    - decisions made regarding the level of review conducted
    - involvement and engagement with a patient and/or relatives
    - the quality of the review conducted and the acceptance of its findings and approval processes
    - evidencing that HSC Trust services have improved and are safer because of the reviews conducted
    - ensuring that issues requiring regional action to improve safety are appropriately identified and then escalated to the right people in the right organisations

- The formulation of evidence-based recommendations.
- The design of action plans that will enhance the safety and quality of healthcare provision across the region both in the short and longer term.
- The production of SAI review reports that are well-formulated, evidence-based and readable.

The Expert Review Team identified a number of reasons for this:

- The implementation of the SAI procedure focuses too heavily on process and non-attainable timescales instead of focusing on consistently conducting these reviews to a high standard.
- There was an absence of clear regional guidance on how to execute Personal Public Involvement duties and in relation to patient rights as part of an SAI review.
- There was no regional patient safety training strategy and curriculum.
- There were not clearly defined competencies required of lead investigating officers and SAI review panel chairs.
- There were not sufficient numbers of trained independent advocates for families and patients.
- There was a lack of effective training in how to execute an effective and meaningful SAI review.
- Furthermore, even where training had been delivered, the appointed chair or review leads, they did not always have sufficient authority to independently devise a review plan that fully delivers the required quality of review.
- There were also a large number of reviews identified as requiring an in-depth review but which did not require this, which was creating an unsustainable work pressure within the system.

The conclusion of the Expert Review Team is that current practice for reviewing and learning from SAIs in Northern Ireland is not achieving the intended purpose of the SAI procedure. Improving this situation will require both the SAI procedure and the system in which it operates to be re-designed.

Summary of Recommendations

The following recommendations are made to support the delivery of a new regional policy/procedure for reporting, investigating and learning from adverse events.

Number	Recommendation	Priority
1	The Department of Health should work collaboratively with patient and carer representatives, senior representatives of Trusts, the Strategic Performance and Planning Group, Public Health Agency and Regulation and Quality Improvement Authority to co-design a new regional procedure based on the concept of critical success factors. Central to this must be a focus on the involvement of patients and families in the review process.	**2**

2	Health and Social Care organisations should be required to evidence they are achieving these critical success factors to the Department of Health.	**3**
3	The Department of Health should implement an evidence-based approach for determining which adverse events require a structured, in-depth review. This should clearly outline that the level of SAI review is determined by significance of the incident and the level of potential deficit in care.	**3**
4	The Department of Health should ensure the new Regional procedure and its system of implementation is underpinned by 'just culture' principles and a clear evidence-based framework that delivers measurable and sustainable improvements.	**3**
5	The Department of Health should develop and implement a regional training curriculum and certification process for those participating in and leading SAI reviews.	**3**

Key Benefits

The Expert Review Team concluded that, should these recommendations be fully implemented and embraced by the Health and Social Care system in Northern Ireland, they would deliver the following key benefits:

- A clear regional framework which provides for learning from unexpected harm.
- Greater flexibility in the SAI review process, which is aligned to international best practice and allows a better opportunity for learning and safety improvement.
- A single, new report template and regional style guide that supports consistency across the region but is flexible enough to allow reviewers to add and remove sections as required.
- A lower number of in-depth Root Cause Analysis (RCA) reviews, where early case assessment shows that this level of review is not required or proportionate.
- Increased capacity within HSC to deliver structured, in-depth reviews, where early assessment indicates this is necessary.
- An appropriate amount of time to conduct a review well and involve patients and families in a way that is meaningful.
- A review process that does not cause further harm to patients, their families or staff.
- A culture of safety, openness and compassion.

1.0 Background and Context

1.1 Introduction

Health and Social Care services are used extensively across Northern Ireland daily, and most patients and their families are satisfied with their care. However, it is inevitable that some will not have a satisfactory experience while others may even experience harm. When harm occurs, there is a moral, ethical and professional duty on those involved in the delivery of care to review what happened.

When such an incident is identified, the process of reviewing an event in an effort to learn is known as an Adverse Incident (AI) review, and some will warrant a Serious Adverse Incident (SAI) review. The SAI review aims to:

- Determine if any element of the care delivery or treatment plan contributed to the harm and any underlying systemic reasons for this.
- Ensure that the necessary improvements are made to the standard of care delivered and to the underlying systems and processes that support patient safety.
- Facilitate the recovery of the patient and their family from the harming experience, so that reconciliation can occur, including continuing trust in the Health and Social Care services.

Fundamental to achieving these aims is a clear, regionally agreed approach to identifying, reporting, reviewing and learning from incidents of harm, including serious near-miss events or apparent near-miss events. Furthermore, this approach must be clearly articulated within policies and procedures.

Throughout this report, the term 'patient and family' is used to represent those that would fall under the category of patient, service user, carer, family, or family member. The Expert Review Team recognises that users of mental health and learning disability services are normally referred to as service users rather than patients.

1.2 Context

Regional guidance for the reporting and follow-up of SAIs has been in place in Northern Ireland since 2004. Over the last decade, the SAI process has come under scrutiny both regionally and nationally. Following the Public Inquiry into Mid-Staffordshire NHS Foundation Trust in 2014[2] the Chief Medical Officer in Northern Ireland wrote to HSC Trusts to remind them of their statutory duty in relation to the review and reporting of SAIs. This correspondence outlined a need for candour alongside meaningful engagement with patients and their families when incidents of harm have occurred.

The Donaldson Report in 2014[3] highlighted concerns around the reporting of adverse incidents, ineffective processes for review, lack of expertise amongst reviewers (particularly in relation to human factors) and a failure for learning to translate into improvements in systems and patient safety. Donaldson also outlined

a need for a 'just culture' for healthcare staff participating in SAI reviews, in addition to a need for candour and openness with patients and families.

In 2018, Justice O'Hara published his long-awaited inquiry report; Hyponatraemia-related Deaths (IHRD) in Northern Ireland[4]. It called for a statutory duty of candour and made a number of recommendations in relation to reporting, investigating and sharing of learning from SAIs, including a need to increase the involvement of families in these processes. This served to further highlight a need for a review of the regional procedure for SAI reviews in Northern Ireland.

In April 2018, the RQIA was commissioned by the Department of Health (DoH) to examine the effectiveness of the current procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs) (November 2016) and its implementation within Health and Social Care services and make recommendations for improvement. A final Terms of Reference for this work was agreed with the DoH in October 2019 and fieldwork on this review concluded in January 2021.

The review was conducted in phases, with interim reports submitted to DoH upon completion of each phase. This document is the culmination of this work and is an overall assessment of the effectiveness of the SAI procedure and its implementation across Health and Social Care in Northern Ireland

1.3 Overview of Regional SAI Procedure

The system for reporting adverse incidents was first introduced in Northern Ireland in 2004 by the former Department of Health, Social Services and Public Safety (DHSSPS), now known as the DoH. Reporting arrangements were transferred to the Health and Social Care Board (HSCB), now the Strategic Planning Performance Group (SPPG) within the DoH, in partnership with the Public Health Agency (PHA), in 2010. Updates to this procedure were implemented in 2010, 2013 and 2016.

The current version of the regional SAI procedure which was last updated in 2016, advises that SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

Incidents which meet the following criteria may be classified as an SAI.

- Serious injury to, or the unexpected/unexplained death of:
    - a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
    - a staff member in the course of their work
    - a member of the public whilst visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and/or member of the public.
- Unexpected or significant threat to provide service and/or maintain business continuity.

- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.
- Serious self-harm or serious assault (including homicide and sexual assaults)

    - on other service users,
    - on staff or
    - on members of the public.

- By a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including Children and Adolescent Mental Health Services (CAMHS), psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Serious incidents of public interest or concern relating to:

    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner.

Three levels of review are described in the regional procedure. The expectation in respect of each level is summarised below:

Level 1 Review: Significant Event Audit (SEA)

For Level 1 reviews, membership of the SEA review team should include all relevant professionals, yet be appropriate and proportionate to the type of incident and professional groups involved.

The review panel undertakes an SEA of the incident to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local or regional learning.

Level 2 Review: Root Cause Analysis (RCA)

For Level 2 reviews, the level of review undertaken will determine the degree of leadership, overview and strategic review required. A core review panel should be comprised of a minimum of three people of appropriate seniority and objectivity. Review panels should be multidisciplinary and have no conflict of interest with the incident concerned. The review should have a chairperson who is independent of the service area involved, while possessing relevant experience of the service area in general and of chairing reviews.

The chairperson should also not have been directly involved in the care or treatment of the individual or be responsible for the service area under review.

The review panel undertakes a RCA to a high level of detail, using appropriate analytical tools to assess what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning.

Level 3 Review: Independent Review

For Level 3 reviews, the same principles as Level 2 reviews apply; however, team membership must be agreed upon between the reporting organisation and the HSCB/ PHA (PHA) Designated Review Officer (DRO) prior to the review commencing.

The 2016 procedure states that: "The review panel undertakes an in-depth review of the incident, to a high level of detail, using appropriate analytical tools to assess: what happened; why it happened; what went wrong and what went well; what has changed or what needs to change; and identify any local and regional learning."

In 2016, the Regional SAI procedure was updated to guide SAI review panels in relation to providing patients and families with an opportunity to contribute to the SAI review.

The guidance outlined that:

- The level of involvement depended on the nature of the SAI and the patient and family's willingness to be involved.
- Teams involved in the review of SAIs should ensure sensitivity to the needs of the patient and family/carer involved.
- Teams should agree on appropriate communication arrangements with the patient and family/carer involved.

To support the involvement process, an SAI leaflet[5] was designed by the HSCB and PHA for organisations to give to patients and families prior to their initial discussion regarding the SAI which had occurred.

1.4 Patient and Family Involvement and Engagement

Health and Social Care services across Northern Ireland have a legal duty to involve service users and their carers. Personal and Public Involvement (PPI) is a legislative requirement for Health and Social Care organisations as set out in the Health and Social Services (Reform) Northern Ireland Act 2009[6].

The Act states that service users and carers must be involved in and consulted on:

- The planning of the provision of care.
- The development and consideration of proposals for changes in the way that care is provided.

- Decisions to be made by the body that has the responsibility for the provision of that care.
- The efficacy of that care.

PPI is the active and meaningful involvement of service users and carers in the planning, commissioning, delivery and evaluation of Health and Social Care (HSC) services, in ways that are relevant to them. It is the process of empowering and enabling those who use services and their carers to make their voices heard, ensuring that their knowledge, expertise and views are listened to.

Given this statutory duty, service user and family involvement were considered a pivotal aspect of this review. Throughout the review, the effectiveness and extent of patient and family engagement have been examined from the perspective of patients and families, frontline staff and managers.

2.0 Terms of Reference

The terms of reference for this review, as agreed with the Department of Health, were as follows:

1) To review the systems/ processes in place for reporting and follow-up of Serious Adverse Incidents (SAIs) across the six HSC Trusts, the HSCB and Public Health Agency in Northern Ireland, between 30 November 2016 and 31 March 2018.

2) To engage with families affected by SAIs reported between 30 November 2016 and 31 March 2018, to determine their level of involvement in the Serious Adverse Incident process.

3) To assess the process for the classification of the severity of SAIs and to determine whether incidents are appropriately classified through this process.

4) To assess the level of independence of the SAI reviews progressed and assess whether a multi-disciplinary systems-wide approach to reviews has been undertaken.

5) To assess the development and effectiveness of action plans and recommendations arising from SAIs reviews.

6) To assess whether appropriate learning has been identified from the SAIs and disseminated regionally, and whether the learning can deliver measurable and sustainable improvements in the quality and safety of care.

7) To determine current understanding of the role of respective organisations, including the Coroner, in the process for SAI reviews, and how this understanding compares to the published roles and responsibilities as outlined in the procedure for the Reporting and Follow up of Serious Adverse Incidents.

8) To assess the level of professional support provided to (i) staff who were delivering care at the time of the SAIs, as well as (ii) staff conducting the review of the SAIs.

9) To provide a report of the findings to the Department of Health, making recommendations for improvement as relevant to the overall response to SAIs, their assessment and review, and the learning arising through these processes.

3.0 Review Methodology

The review used a range of methodologies to ensure each term of reference was addressed. Each methodology aimed to optimise the quality of information sought by the expert panel to ensure a robust evidence-base for their recommendations.

The methods included:

1) The assessment of SAI review reports, by the Expert Review Team. The criteria for assessment as agreed with the Department of Health.

2) The design of a structured assessment questionnaire which was applied by the Expert Review Team to all SAI review reports submitted by the participating HSC Trusts.

3) Questionnaires issued to a range of Trust staff, from senior management to frontline practitioners, and SAI panel chairs, seeking their views of their involvement in the SAI review process.

4) Engagement of patients and families who had experienced healthcare-induced harm and the offer of face-to-face conversations to learn about their experiences and hear their views as to how these experiences could have been improved.

5) Focus groups involving staff involved in an SAI, as well as staff involved in the SAI review process.

6) Meetings with individuals and groups of staff in HSC organisations involved in SAI reviews.

7) Engagement with other relevant organisations.

It was intended that the effectiveness of implementation of SAI recommendations would be examined in specific detail by the Expert Review Team to explore further the arrangements within services to deliver on sustained and measurable improvements to patient safety. However due to the COVID-19 pandemic, this aspect of the methodology was unable to be performed in full, but was explored though other aspects of the methodology.
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3.1 The Identification and Selection of SAIs

For the aspect of this review SAIs selected had been conducted between 30 November 2016 and 31 March 2018 and fell within the following categories:

- Deaths of women and babies related to pregnancy and childbirth: maternal deaths, stillbirths and neonatal deaths. Serious illness of women and babies where this has been related to pregnancy and childbirth.
- Sepsis
- Choking on Food
- Never Events[1]
- Cases where private hospitals or private nursing homes feature in the care pathway.
- People with a learning disability who have died from a treatable physical condition.
- People with a learning disability in residential care.
- Primary Care
- Any other categories RQIA considered appropriate for inclusion the review.

The information relating to these SAIs was obtained from the HSCB. After validation, 54 SAIs were identified for inclusion. A total of 12 additional SAIs were subsequently selected, comprised of Level 2 and Level 3 reviews, resulting in a total of 66 SAIs being selected for expert review (Appendix A).

3.2 The Structured Assessment of SAI Reports

A structured assessment tool was developed and applied to each SAI report reviewed. The assessment captured the perspectives of members of the Expert Review Team who were:

- Experienced investigators.
- Clinicians.
- Lay and family representatives.

Two distinct types of structured assessment tools were developed, one for use by the lay members of the Expert Review Team and one for the technical assessment of the SAI reports by other Expert Review Team members. This approach ensured consistent and objective assessment of each SAI report.

Due to the differences in templates used and levels of review required, for Level 1 and Level 2 SAI reviews set out in the regional procedure, the core assessment tool, which applies to Level 2 SAIs, was modified to meet the requirements of a Level 1 SAI report.

[1] Never Events are serious, wholly preventable safety incidents that should not occur if the available preventative measures are implemented. They include things like wrong site surgery or foreign objects left in a person's body after an operation. The full scope of Never Events is detailed in the Care Quality Commission report, Learning from Never Events (July 2018).

To ensure a robust approach, members of the Expert Review Team with either a clinical qualification or extensive prior experience in the conduct of SAI review were grouped in pairs. This resulted in each pair reviewing a total of 33 SAI reports.

The lay members of the Expert Review Team reviewed all 66 SAI reports individually before comparing their assessments and discussing any differences of opinion. This resulted in three subgroups with two members of the Expert Review Team in each, assessing the SAI review reports.

Table 1 below shows the breakdown of trusts and reports allocated to each technical team.

Table 1: Breakdown of trusts and reports allocated to each technical team

Team	Organisation	Number of SAI reports for review
Team 1	Northern Trust	10
	South Eastern Trust	13
	Western Trust	10
Team 2	Belfast Trust	11
	Southern Trust	14
	NIAS	4
	Integrated Care Team, HSCB	4
TOTAL		**66**

Source: RQIA Structure Assessment Exercise

3.2.1 Quality Assurance of the Structured Assessments

The structured assessment tool developed by the Expert Review Team considered the extent to which the SAI report described:

- The incident under review and why it was being reviewed.
- The level of independence of the review panel members and the competencies and skills they had to conduct the review.
- The degree of patient and family engagement with the review process.
- The nature of the recommendations made and their relevance to improving patient safety.
- The robustness of the action plans constructed to deliver the recommendations and whether they would deliver a measurable and sustained improvement in quality and safety.

3.2.2 Technical Assessment

To ensure reliable and accurate assessments of the SAI reports, two quality assurance exercises were undertaken.

Firstly, for each of the three technical teams referenced above, an intra-team reliability exercise was undertaken. This required the assessors to submit a sample of four assessments to each other for a repeat assessment to ascertain the similarity or differences in assessment outcome. This process demonstrated a high level of consistency between the assessments. Where there were significant differences in the assessments, these were presented and discussed at a round table conversation between the technical assessors to reach consensus. A lay member of the Expert Review Team was included in this process.

The second quality assurance exercise was undertaken upon completion of the assessment of all SAI reports.

This involved a sample of four completed assessments being selected from each technical assessment team and reassessed by the other team. Following this, the technical assessment teams met to compare findings. There were few discrepancies between the teams which confirmed a high level of consistency. Any discrepancies were discussed, and a consensus position was reached.

3.2.3 Lay Assessment

The lay members of the Expert Review Team assessed all 66 SAI reports adopting the perspective of a family member who might receive these reports. To achieve a comparable process of quality assurance, each lay member assessed all 66 reports and subsequently met with their lay counterpart to discuss each report, including any differences in perspective.

As with the technical assessments, there were few discrepancies between the assessments conducted by the two lay members of the Expert Review Team, and any differences were resolved by discussion thereby reaching a consensus view.

3.2.4 Analysis of the SAI Report Assessments

Themes were extracted from SAI report assessments and collated to inform key findings. These findings informed engagement with the HSC organisations during subsequent phases of this review. During the review, emerging findings and key messages were shared with the Department of Health via interim reports.

3.3 How each Trust responds to Significant Unexpected Harm Events

Questionnaires were developed for and issued to each HSC Trust, the HSCB and the PHA. These were designed to gather information from each organisation about their respective approaches to SAI review and the related structures and processes in place, including the extent of patient and family involvement.

A thematic analysis of the responses received was subsequently undertaken.

3.4 Patient and Family Engagement

Initially, it was intended that the Expert Review Team would make direct contact with those patients and/or families affected by the 66 SAIs which were included in the structured review undertaken in the first phase of this review. Recognising the potential for further psychological impact, the Expert Review Team agreed the following patients and/or family members would not be contacted:

- Where there had been an expressed wish by the patient and family not to be contacted further or where there were issues of confidentiality.
- Families of cases who were subject to a coroner's investigation.
- Patients/families of cases which were subject to legal proceedings.
- Patients/families of those involved in significantly distressing SAIs (including suicide of a family member).

This resulted in 38 out of the 66 patients/families being contacted to seek their involvement in the review process. Of the invitations sent to each patient and family, only six responses were received. Following this, two decided not to be involved. This resulted in four out of 38 individuals contacted agreeing to become involved. Individuals subsequently met with RQIA staff members. This number was considered too few for the purposes of this review. As such a decision was made to supplement the engagement and further seek experiences via several additional routes, including approaching the Department of Health and the Patient Client Council (PCC) to supplement the experiences of those four initially contacted. Both organisations had previously engaged with patients/families who have had an experience of the SAI process following an incident of unexpected harm.

The PCC agreed to meet with the Expert Review Panel to share the views of patients/families with whom they had engaged. Communication with the Department of Health also resulted in three additional families agreeing to participate and share their experiences.

3.4.1 Additional information considered on engagement with patients and families

Experiences of patients and families involved in SAI reviews were also ascertained through engagement with other groups and work streams:

- In November 2019, the Inquiry into Hyponatraemia-related Deaths Implementation Programme (Work stream 5, Serious Adverse Incidents), held a workshop in conjunction with the PCC to engage with families on their experience of the region's SAI review process. The findings from the workshop were shared with RQIA and considered by the Expert Review Team.

- In October 2019, the PCC shared its Serious Adverse Incident Complaints A Thematic Review of Client Support Service Cases 2014-2018 report. It outlined the experiences of families who had been through the region's SAI review process and the findings were considered by the Expert Review Team.

- In December 2020, the Expert Review Team met with staff from Cause NI[2] who shared the experiences of families they had supported through the SAI review process and provided insight into how to achieve quality family engagement in the process.

These findings were articulated in the Expert Review Team's interim report on Patient and Family Engagement. .

3.5 Staff Engagement

As part of this review, the Expert Review Team engaged with those staff involved in the care of the 66 patients who were the subject of the SAI review reports involved in the structured assessment undertaken in the earlier phase of the review. Several methods of staff engagement were utilised:

- Focus group meetings using a café style approach.
- A private post box method.
- An online survey.
- One-to-one telephone interviews.

3.5.1. Focus Groups

Focus groups were held between 5 November and 21 November 2019. To accommodate the range of staff involved in the SAI process, each focus group had a different emphasis:

- Staff involved in the care of the patient who was harmed.
- Staff involved in the SAI review process.
- Staff involved in a named SAI review.

The focus groups focused on three primary areas:

- The experience of staff who had been involved in the SAI process.
- Their experience of engaging and involving patients/families in the SAI process.
- The views of staff in relation to how the SAI process could be improved.

Table 2 below shows the number of staff who attended each of the focus groups.

[2] Cause NI is an organisation which supports people with a mental health problem and their family members.

Table 2: Staff Engagement Focus Groups by Participation and Organisation
Source: Information recorded by RQIA during the focus groups

	Focus Group 1	Focus Group 2	Focus Group 3	
Organisation	Staff involved in an incident	Staff involved in reviewing an incident	Team involved in reviewing an incident	Total number of staff by organisation
Belfast Trust	5	12	4	21
Northern Trust	19	16	2	37
South Eastern Trust	14	15	4	33
Southern Trust	12	10	3	25
Western Trust	5	19	4	28
NIAS	2	8	n/a	10
Integrated Care	n/a	8	n/a	8
Total number of staff by focus group	**57**	**88**	**17**	**162**

3.5.2 Confidential Post-Box Feedback

At each staff focus group, a confidential post-box was provided to enable staff to share their experiences of the SAI process should they not be comfortable with speaking out in front of a group.

3.5.3 Online Survey

The third method to support staff engagement was via an online survey. All staff working within HSC Trusts were offered an opportunity to respond, provided they had experienced the SAI review process.

Overall, 201 staff completed the survey. However, 114 of those had not been involved in an SAI process, either as a member of a care team involved in an incident or as a member of the SAI review panel. Their responses were therefore not included in these analyses.

Of 87 respondents who had an experience of the SAI review process, 40 staff members had been involved in care and treatment related to an incident and 47 staff members had been part of the panel reviewing an incident.

3.5.4 Telephone Interview

All staff who attended the focus group meetings were also offered the opportunity to speak confidentially with a member of the Expert Review Team by telephone interview. Four staff members were subsequently interviewed.

3.6 Meetings with HSC Organisations

The Expert Review Team met with Senior Managers in each of the HSC Trusts. The meetings focused on the management and oversight of the SAI review process within the organisations and included a discussion on potential improvements to the SAI review process.

The Expert Review Team also met with the HSCB and PHA to discuss their regional responsibilities, their roles in oversight of the SAI review process and the role of the Designated Review Officer. This meeting also included a discussion on potential improvements to the SAI review process.

3.7 Engagement with other Organisations

The Expert Review Team met with representatives of the RQIA's Mental Health inspection team and the Coroners Service in NI, both of which were identified as having had frequent engagement with the SAI process. The purpose of this discussion was to gain an insight into their experience of the SAI process and what improvements they considered could be made.

A broad range of organisations are involved and impacted by the regional SAI review process. Engagement with these organisations focussed on those that had most frequently experienced the process. Other organisations, such as other regulatory bodies, trade unions, and the Police Service for Northern Ireland were provided with information about the review and asked if they would like to make a written submission regarding their views and opinions in relation to the current SAI process and their suggestions for change to the SAI process.

Of the organisations contacted, the following nine responded. These were; the British Medical Association, the Royal College of Nursing, the Eastern Local Medical Committee, the Pharmacy Forum, the Coroner's Service, the Northern Ireland Public Sector Alliance, the Northern Ireland Medical and Dental Training Agency, the Information Commissioners Office and the Health and Safety Executive Northern Ireland.

The full list of organisations contacted is outlined in Appendix B.

4.0 Findings

4.1 Overall findings of the Expert Review Panel

After full consideration of all the evidence gathered from each of the contributors to this review, the Expert Review Team was confident in their determination that the current regional policy for SAI review in Northern Ireland must change. It was clear that the current procedure and its implementation does not support:

- Fulfilment of the statutory duty of PPI as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009.
- Reasonable application of the principles of effective review practice.
- Confidence in the independence of Chairs of SAI reviews at Level 2, or Level 3 - particularly so for Level 3 reviews where the appointed chair is a former employee of an HSC Trust.
- Health and Social Care organisations embracing their accountability for:
    - decisions made regarding the level of review conducted
    - how they involve and engage with a patient and family
    - the quality of review conducted, acceptance of its findings and approval processes
    - demonstrating how HSC Trust services have improved and are safer because of the reviews conducted
    - ensuring that issues requiring regional attention to improve safety are escalated to the right people/organisations.
- The formulation of evidence-based recommendations.
- The design of action plans that will enhance the safety and quality of healthcare provision across the region both in the short and longer-term.
- Review reports that are well-formulated, evidence-based and readable.

The Expert Review Team identified a number of reasons for this:

- The implementation of the regional procedure focuses too heavily on process and non-attainable timescales instead of focusing on consistently delivering the practice of conducting high quality SAI reviews.
- There was an absence of clear regional guidance on PPI duties in relation to patient rights within the serious adverse incident process.
- There was no defined regional patient safety training strategy and curriculum.
- There were not defined competencies required of lead investigating officers and serious adverse incident panel chairs.
- There were insufficient numbers of trained independent advocates to support family involvement in the process.
- There was a regional lack of effective training in how to conduct a meaningful review. Furthermore, even where training had been delivered, the appointed chair or investigative leads did not have sufficient authority to independently devise a review plan that fully delivers the required quality of a review.

The evidence underpinning these findings was derived across a broad range of engagements and is detailed further in the following sections under three key themes.

1) Patient and family engagement.
2) Staff engagement.
3) The effectiveness of the procedure and approach for delivery of SAI reviews.

4.2 Patient and Family Engagement

A hallmark of success in any approach to the review and learning from incidents of unexpected and avoidable harm is the manner in which a health provider organisation engages with the patient and their family through the review process. The families who provided information to the Expert Review Team, the PCC and the lay members of the Expert Review Panel (who themselves have lived experience of healthcare induced harm) provided consistent reflections on how this aspect of SAI Reviews is delivered in Northern Ireland.

The Expert Review Team identified several of themes after listening to the views and experiences of patients and families:

- There was inconsistency in the practice of HSC Trusts in when and how they informed families about:
    - the incident
    - the decision to conduct an incident review process
    - the rights of patients and families to be engaged at all stages of the review, including shaping the terms of reference or lines of enquiry
    - sharing of the interim findings of the review process to allow commenting and feedback from the patient and family to be incorporated.

- There was inconsistency in the quality and frequency of communications with the patient and their family. This includes written correspondence as well as verbal communications. A common concern was the level of empathy, respect in the nature and tone of communications and levels of planning with the patient and their family about what mode of communication was best and with what frequency.
- Families reported there was not sufficient transparency about the process.
- There was a deficit in the availability of independent support or advocacy for patients and families.
- There were concerns about the timeliness and amount of information provided about the plan for the review process and its intended conclusion date.
- They described HSC organisations across the region were unable to apologise for the harm that had occurred. In their words, it was not enough to say, “sorry, we are at fault”. Rather, the apology should say: “Sorry this has happened to you. We will look after you and help you understand what happened”.

- They experienced an unwillingness to seek the testimony of the patient and family members as an integral component of the review process, thus diminishing the status of the patients and their families.
- Many stated that the interim findings of the review process were not shared with the patient or their family members so that they could contribute constructive comments and ensure their voice is appropriately represented and heard.
- There was not a sufficient level of openness and candour about what had happened and why. They described the shrouding of the SAI review findings in technical language which was not accessible and perceived it to be defensiveness.
- There were some who were concerned about potential 'cover-ups' and a lack of transparency in the process, as well as in the report subsequently written.
- Several described Chairs of the SAI review whose communication skills and ability to work constructively with a family were poor.
- Several were not confident in the independence of Chairs of the SAI review.

Of particular note was the view expressed by Cause NI, a charity that specialises in offering practical and emotional support to families whose loved ones have experienced harm as a result of serious mental illness or suicide. They considered that the current requirement within the SAI procedure, for the investigation of all deaths that have occurred as a result of mental illness (where the individual who dies was known to Mental Health Services in the preceding 12 months), was not the best approach. It was suggested SAI reviews would be most appropriate in those cases where it was suspected there were care deficits preceding the death.

The Expert Review Team reflected, that overall, the expressed views of patients of families in Northern Ireland regarding their experiences of involvement, were similar to findings of independent reviews and inquiries elsewhere in the UK, such as the Care Quality Commission (CQC) review, '*Learning, Candour and Accountability 2016*[7], the *Mid Staffordshire NHS Foundation Trust Inquiry* and *The Report of the Morecambe Bay Investigation.* It was therefore disappointing that in Northern Ireland, more progress had not been made in implementing best practice in how HSC organisations work with families after unexpected harm.

The Expert Review Team was impressed with the attitude of staff who expressed a willingness to have greater engagement and involvement with the patient and their family in the process. Most staff appreciated that patients and families are an important component of a successful approach to learning from harm. They reported feeling constrained by an overly bureaucratic process, which they perceived placed completion of arbitrary timescales and narrow performance targets above the requirement for meaningful involvement.

The most significant barriers to achieving meaningful involvement of patients and their families were described as:

- Uncertainty about what staff could and could not say to a family and what constitutes an acceptable level of disclosure.
- How to achieve realistic expectations with a patient and their family about what the SAI process can and cannot deliver.

- The time allowed for the delivery of the SAI process, and the time available to an SAI review panel chair, who would have additional managerial or frontline clinical duties and which is not conducive to meaningful patient and family engagement.
- The availability of dedicated support for patients and their families through the SAI process. Without support, it is difficult for Chairs of SAI reviews to also attend properly to the needs of the patient and family.
- Absence of constructive guidance on how to capture family involvement and engagement within the SAI review report, exacerbated by lack of space within the review report template to record the level of family involvement.
- Staff were concerned about legal issues and reported anxiety about how to describe the findings that then might result in a claim for damages. A small number of staff described instances where legal services have requested modifications to a report which diluted the findings of the SAI review panel.

The Expert Review Team is clear that concerns regarding future claims for damages must not interfere with conduct of an SAI review or with the integrity of the resulting report. It is wholly unacceptable that report authors could be asked by a manager or by legal services to dilute their findings. Furthermore, such action should have serious implications for health professionals who have breached their professional duty of candour.

However, there are good reasons for a legal services team to review an internal SAI review report document:

- To sense check the use of language.
- To test the strength of the evidence base underpinning the report's findings and conclusions.
- To determine a report's readability.

Feedback made to a report author in the context of the above must be considered and acted upon.

Across the HSC, it was not the cultural norm to share interim findings of an SAI review with a patient and their family. Enabling the patient and family to have a voice in the report, to comment on the report content, and to influence the content and tone of the final report appears not to be a primary consideration. Ineffective and insufficient patient and family engagement can cause further harm. Families report having experienced some of the following adverse effects:

- Increase in stress.
- Delay in starting the grieving process.
- Post-traumatic stress disorder.
- Loss of income.
- Feelings of anger.
- Loss of life enjoyment.

The Expert Review Team considered that, for many families, it is possible to avoid causing further harm if HSC organisations engage in a compassionate process. The

founders of the Harmed Patients Alliance[8], a campaign group founded to raise awareness of harmed patients and families, effectively communicate the kind of compassion families need following healthcare harm.

"In the aftermath of our loss, we needed healthcare to fully acknowledge and thoroughly understand our experience of what had happened to our children and the impact it had on us. We needed answers to all of the questions that we had, that were important to us, and we needed those regardless of whether anyone else felt our question relevant or important. We needed staff to be supported to give us honest accounts of their actions and their reflections. We needed a collaborative approach to reach a truthful and evidence-based explanation of events. We needed help and support to understand what all the processes were that were happening and how to engage with them. We needed the system to learn and to see meaningful change, but we also needed the system to help us heal, recover, and restore our trust. Meaningful engagement coming from a place of care could have provided that."

Harmed Patients Alliance

4.2.1 Working with patients and their families in a way that delivers a restorative process and maintains candour

The Expert Review Team determined that the Department of Health with associated stakeholders must describe the region's statement of intent regarding how patients and families are involved in the SAI review process and the core objectives in relation to patient and family involvement for which each HSC provider must evidence achievement.

Examples of objectives relating to patient and family involvement are:

- Families and patients are supported as active partners in the review process as much as they wish to be engaged, including the involvement of an appointed advocate.
- Patients/families experience a compassionate and empathetic approach, which is demonstrated by the nature and frequency of contact throughout the review process.
- The voice of the patient and family is heard, their testimony captured, and they have the same status as any professional contributing information to the review process.
- The patient and family has a named source of support, outside of the review panel. The role of this individual is clearly defined, including the basis authority to act as advocates in the best interests of the family.

- Questions asked by the patient and family are responded to fully, with honesty, integrity and candour.
- The patient and family are encouraged to contribute to the terms of reference for incidents identified as requiring in-depth review.
- Patients/families are taken through the interim findings of the review and are provided with enough time to read, comment on, and influence the content of the final report.

In the event of new information becoming available after the conclusion of an SAI review, or if there is a change in conclusion or material findings from such review, then this information must be shared with the patient/families as soon as possible.

How individual HSC organisations undertake to deliver the objectives should be for them to determine. However, what is required from all HSC organisations is clear evidence that they have achieved the objectives. In particular, they should provide evidence that patients and families are given the same opportunity for involvement in an SAI review as the staff and others involved in an incident. This evidence should be validated by patients and families who have experienced unexpected healthcare harm of the nature that warrants an SAI review. The Expert Review Team considered that a co-production model for development and further improvement of the SAI procedure, involving frontline staff and patients and their families, should be adopted going forward.

4.3 Staff Engagement (staff engaged in the care and management of the patient who experienced harm)

Every SAI review must involve the collection and analysis of a sufficient amount of information from multiple sources. This requires the active engagement of staff involved in the care and treatment of the harmed patient and the engagement of a wider sphere of individuals who have experience in the field and understand the system at work.

The purpose of the SAI review process is to:

- Find out what happened.
- Understand how and why it happened.
- Implement any appropriate early remedial actions to address any identified deficits in care.
- Identify areas for improvement in order to support the delivery of safe patient care.
- Implement appropriate improvements based on the findings of the SAI review.

In circumstances where patients have been harmed, it is understandable that frontline staff may feel vulnerable and experience emotional pain, as well as feelings of anger, shame, fear, sorrow or regret.

To enable HSC staff to fully inform the review process, they must feel safe to do so. They must also have confidence in both the competence the appointed review panel and feel secure that the information they provide will be used fairly.

What staff employed within Health and Social Care trusts across the region had to say

Comments about the SAI procedure and its implementation:

In the online survey completed by HSC staff:

- 89% (179) said they agreed, or strongly agreed, that SAI reviews were an essential activity for a learning organisation.
- 74% of respondents (149) said SAI reviews generated improvement for safety within their organisations.
- 64% (129) said they agreed or strongly agreed that they were aware of more than one improvement resulting from an SAI review.
- 61% (123) said outcomes from SAI reviews were regularly discussed at team or service meetings.

While the survey results cannot definitively conclude whether or not SAI reviews enabled the collection of quality information upon which to formulate evidence-based findings, face-to-face meetings conducted with staff in HSC organisations did, however, provide a useful insight into the experiences of staff involved in SAI reviews.

The information gathered at staff focus groups, for example, highlighted that the principle of a 'just culture' was not embedded across the region.

Staff consistently reported:

- Insufficient openness about the process and the standards of conduct expected of the SAI review panel members.
- Insufficient communication about the progress of an SAI review and why it was being conducted. The key lines of enquiry, progress, findings, and recommendations were frequently unknown by staff who had been involved in the care and treatment of the patient to which the SAI review related.
- The experience of the review felt like it was designed to apportion blame.
- Terms of reference for SAI reviews did not suggest they were grounded in a constructive or learning process.
- There was variable engagement in the process, with some staff unaware the SAI review was even being conducted, only to find out at a later point in time. Some staff described an over-emphasis on the collection of written submissions and a lack of detailed exploratory conversations being conducted by SAI review panels.
- Some staff described insufficient notice of, or information about, SAI panel meetings or interviews staff were asked to attend.
- Some staff did not have an opportunity to read the interim findings before these were finalised in the SAI report.

- Some staff said they were not able to respond to any criticisms made in the SAI report before it was signed off as completed.

Regarding the constitution of the SAI review panel, and how those panels operated, the following concerns were described by frontline staff who participated in this review:

- Concerns about the appropriateness of members of the panel in terms of technical and subject matter competency and insight.
- Concern about the lack of factual accuracy checking by review panels, both in terms of the sequence of events leading to the incident under review, but also regarding the accuracy of notes of face-to-face meeting. Staff said that this meant they were unable to correct the SAI review panel's misinterpretation of words spoken at interviews, or during panel meetings.
- Some staff described too narrow a field of focus by SAI review panels, with little consideration of the system within which frontline staff work. For example, workload, workplace design, task design, skill mix, staffing issues, team dynamics, and cultural factors, leadership and factors which may contribute to an incident.

Although negative experiences were reported, some staff reported a more positive experience and had been involved fully throughout the SAI review. These staff reported that they felt they had been involved throughout the SAI review, in terms of being kept up to date with progress of the SAI review and were able to contribute to the learning from the SAI review.

During discussions with the Expert Review Team, frontline staff reflected on the support mechanisms available to them in coming to terms with the SAI event and its subsequent review. Although we received many comments about a lack of support, a small number of staff did share positive experiences of being supported by both managers and colleagues. These staff highlighted that the people who had provided the support, had themselves been previously part of a SAI review. The overwhelming message from all focus groups across all Trusts was that staff had experiences of inadequate support as they went through the SAI process.
Frontline staff acknowledged that it was not the role of the chair of the SAI panel or the Trust staff member who oversees the review to provide appropriate support for staff as their role was to deliver an effective, unbiased review process. However, they did consider that better quality support ought to be forthcoming from:

- Their own line managers.
- Independent providers of psychological support.
- Their employer via staff supports and counselling services.

In several focus groups, the Expert Review Panel members were struck by the level of emotion expressed by staff who had participated in an SAI reviews. It was evident that these staff had not been through a supportive, reflective process of learning.

4.3.1 Achieving a way of working with staff that delivers a supportive, learning-orientated process within a 'Just Culture'.

The Expert Review Team determined that the Department of Health, working with appropriate stakeholders, must set out, in its strategic direction, its expectations for how staff in HSC organisations and those they report to are engaged and when participating in an SAI review. As with family engagement, the principles for effective staff engagement must be developed and defined before an effective process can be designed.

An example of a statement of success could be:

'*Staff are treated well, their voice is heard, and they actively contribute to the SAI review process.'*

The core objectives for HSC organisations which will ensure this is delivered could be:

1) Staff experience a compassionate and empathetic approach.
2) The voice of the staff involved in an incident is heard, including their experience of the incident, and the context in which it occurred.
3) Staff are well informed throughout the review process.
4) Staff are treated fairly and equitably, in line with the principle of a 'just culture', including having the opportunity to read any criticisms made about them and to respond.
5) Staff involved in the incident (and other key staff) are given the opportunity to read the interim findings of the SAI review panel and to provide feedback in relation to factual accuracy, tone, and style.
6) Staff involved in the incident and service in which the incident occurred are actively engaged in designing the action plan to deliver measurable and sustained improvement.

Again, individual HSC organisations should determine for themselves how to deliver these objectives but should be able to evidence achievement of the objectives. This evidence should be validated by staff that have experienced the SAI process. Perspectives of staff who have delivered the SAI process should also be gathered and evaluated. The Expert Review Team again advises that a cooperative approach be adopted for involving frontline staff, patients and their families in designing of these improvements.

4.4 Staff Engagement (staff with experience undertaking SAI reviews)

A robust SAI review requires staff delivering the process to have the right technical knowledge, along with a range of non-technical skills and attributes. At the time of this review there was no competency framework in place to ensure the required competencies to deliver the review process. It cannot be assumed individuals have these skills simply because of their professional background or seniority. Implementing an effective approach for SAI reviews will require upskilling of staff before it can be practised and evaluated.

For the implementation of the review procedure to be effective and for optimal learning to be achieved, a structured and feasible policy framework needs to be embedded alongside cultural change.

The consistent messages provided to the Expert Review Panel from staff engaged in the delivery of the SAI procedure and its implementation were:

- It was challenging to undertake the SAI reviews alongside their pre-existing professional duties. There was no protected time for this, nor any account taken of their day-to-day workloads or frontline patient care duties.
- There was insufficient supervision and mentorship by experienced reviewers who hold the necessary technical and non-technical skills and attributes.
- There was a lack of training in conducting SAI reviews and related methodologies.
- There were challenges in engaging with staff involved in the care giving, such as established off duty rotas, the need to provide a 6–8-week lead time to medical staff before meeting with them, challenges in locating agency and locum staff, and the delay between the incident occurring and the SAI review being commissioned.
- Communication with all relevant parties was described as a persistent challenge.
- The classification of an SAI, and how it was determined that an incident met Level 1 or Level 2 criteria, was difficult for staff to understand. There was not always full understanding that the current procedure directs reviews should be conducted at a level appropriate and proportionate to the complexity of the incident and significance of event under review rather, that the impact or outcome for the patient. Most staff considered that the criteria for classification were not clear.
- The current approach of imposed regional terms of reference does not support an effective review practice. Staff understood effective reviews require the right technical questions to be asked about the patient's care and treatment; this is not supported by the current process. When asked why the terms of reference were not changed to something more relevant, staff reported that they did not believe they had the authority to do so.
- The regional report template did not support the formulation of an evidence-based, well-structured or readable report. Participants reported that the design of the regional template made it difficult to reflect the level of an engagement that an SAI review panel may have achieved with the family. Overall, the template was considered to be not fit for purpose.
- Recommendations were a particular source of concern for participating staff, with many reporting their perspective that recommendations often did not get implemented due to a lack of resources. Staff also displayed some frustration members of review panels felt obliged to make recommendations even if they suspected that nothing would happen as a result.

In addition to the above, staff with experience in conducting SAI reviews provided insights into the review methodology of Root Cause Analysis (RCA) and the extent to which learning is implemented. The information provided by staff indicated that there is confusion about what constitutes an RCA method. The fact that many staff believed completion of the regional report template constituted a valid review and an

RCA is concerning. Staff did not demonstrate an informed understanding of what constituted a review and were not aware of the broad range of tools and approaches they could employ to deliver this. The tools that participating staff were aware of were simple chronology, the 'five-whys' technique, and the 'fishbone' diagram.

The Expert Review Team was left with an impression that HSC Trusts across Northern Ireland are using the language of RCA without an embedded understanding of what this means, or where RCA fits into a structured and auditable review. The regional guidance does not address this, nor does it provide practical advice on how to conduct a review to an acceptable standard.

The Expert Review Team could not be confident that across the HSC Trusts, consistent systems based learning was happening, and that changes were embedded or that there was a robust system in place for sharing learning beyond the investigating organisation. The issuing of regional learning letters by the HSCB was referred to, but most frontline staff were not aware of this and only two of those interviewed had ever seen a learning letter.

Staff with experience as an SAI reviewer understood why staff asked to provide information to the review panel may suspect the existence of a 'blame culture'. They considered that most of the staff they interviewed often appeared anxious about the process and were sometimes defensive when questioned. Some staff who had undertaken several SAI reviews considered that the level of anxiety among staff being interviewed had increased over time.

The Expert Review Team considers from their assessment of the 66 review reports that the language used in SAI review reports might also contribute to a sense of blame. For example, root causes of incidents were described as 'human error', which may unfairly suggest that an individual member of staff is responsible. This is further compounded by the lack of deconstruction of events from a systems perspective, meaning that the true root causes and contributory factors which underlie errors in care and treatment are not identified, placing an unreasonable weight of responsibility on frontline staff.

Staff acting as SAI reviewers on behalf of their employer also considered the way the media in Northern Ireland reported on incidents that had reached the public domain. Subsequent media interest and commentary fuelled their feeling of a blame-driven approach and culture, alongside concerns about medico-legal consequences.

As with staff involved in care delivery, those who had an experience of conducting SAI reviews also believed that there was a lack of constructive support. Staff asked to chair SAI review panels were particularly concerned. They considered that there was no account taken of the true time required to deliver the role well, or how the time required conflicted with their other professional responsibilities. Some staff reported having to write SAI reports in their own time and late into the night, which then impacted their wellbeing and concentration levels at work the next day.

The Expert Review Team considers this situation to be wholly unacceptable. If the objective is to learn and improve safety, the system cannot overload staff already working at full capacity. Failing to provide protected time to lead the SAI review

process infers that it lacks importance. In the rail, marine, and airline industries, where an incident merits careful analysis, only trained individuals with time to undertake the work are appointed to the task.

The lack of administrative assistance for review chairs was also cited by staff as evidence of lack of support. There is considerable administration associated with the conduct of an SAI review. The Expert Review Team considers that it is not appropriate for a frontline clinician, who has been asked to lead an SAI review process, to also be responsible for administering it.

4.4.1 How to ensure chairs and members of SAI review panels are equipped to deliver the job adequately and with enough time

The Expert Review Team considers that the first step in achieving a sustainable situation across the region is to review how decisions are made regarding the level of SAI review required. This should be informed by:

- The frequency by which the incident type occurs.
- Whether there is a safety review already ongoing to explore and address any safety issues.
- Whether the conduct of the review is likely to deliver more learning than has already been achieved by previous reviews.
- Whether there is a safety improvement plan already underway.

It is widely recognised that many individual reviews involving the same incident type often do not lead to tangible safety improvements. Therefore, the practice of defining the need for an SAI review on the basis of adverse patient outcomes should be discouraged and is not in line with the current guidance contained within the SAI procedure which states,

"SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event".

An approach that allows a sensible period of time for the early assessment of 'what happened', and consideration of early information gathered about the care and incident, might enable a more structured and evidence-based approach to deciding which cases require an in-depth systems analysis. Treating the review as a process, where reviewers and chairs can determine an evidenced-based stop point, might be more successful than a static approach which assumes that all incidents can be treated the same. One of the expert review panel members has supported several NHS Trust mental health teams to implement such an approach. As a result, mental health teams reported a reduction in the number of in-depth reviews, greater engagement from staff and a formalised process whereby the review is led by the team lead; now recognised to be an important aspect of the process.

A more flexible approach is required to enable families to understand the process and what it can deliver. For example, it can deliver learning and provide answers to questions but it cannot provide justice.

In terms of the time allocated to conduct an SAI review, it will always be necessary to stipulate timescales, but it is important that they are realistic. They must allow at least to six-months for complex cases, and it would be reasonable to require a structured project management approach that can be monitored and quality assured.

The second step is to define the core competencies required of:

- People acting as review leads and/or chairs of review panel.
- The subject advisors supporting the process.

Furthermore, a regional training curriculum and certification process must be agreed. All training providers across the region should meet the minimum content requirement in order to enable competency achievement. For such an approach to work well, all HSC Trusts and independent providers responsible for delivering training should be required to demonstrate their competency and knowledge in order to be approved as training providers. Requiring all training providers to apply to be on a regional register or preferred provider list would support the achievement of this.

Finally, to support the implementation of a training curriculum it was considered that a mentorship and coaching approach could also be adopted. A person independent of the HSC Trust in which the incident occurred could provide external support to the lead reviewer/chair. This has the added advantage of providing an independent quality assurance check of the process and its outcomes.

4.5 SAI Reports: The extent they demonstrated a reasonable standard of review and positive contribution to patient safety in Northern Ireland

As previously outlined in the methodology in section 3.0, the Expert Review Team reviewed 66 SAI reports as part of this review.

In undertaken the review of reports, it was evident to the Expert Review Team that having two separate report templates for Level 1 and Level 2 reviews is not working. The design of the templates also does not support staff to write up their findings in a way that delivers confidence in the standard of the review or in the appropriateness of the level of review undertaken. Furthermore, the templates are designed in a way that limits important information being included, such as the questions that have been asked by patients and family members.

Upon assessing the report of a significant adverse incident review, the expectation is that it demonstrates that an effective method has been used to underpin the review. Indicators of an effective methodology are:

- The methods, tools and techniques used by the SAI review panel are clearly stated and appropriate to the incident under examination.
- The evidence upon which findings and conclusions are based have been clearly triangulated.
- An appropriate range of subject advisers have been engaged in the review process

- The SAI review report outlines the key elements of the processes and procedures relevant to the expected standards of care and treatment.
- There is a clear account of:
    - what happened
    - where policy, process or procedural expectations were met
    - where there was a deviation from procedural expectations.
- Where deviation from procedural expectations is identified, there is an explanation of:
    - whether the deviations were reasonable and justified based on the presentation of the patient, their clinical needs at the time, and the unfolding situation
    - whether the deviations were not reasonable and therefore not justifiable.
- In the instance of a non-justifiable deviation from the expected standard of care, there should be an indication of whether this contributed to or caused the harm to the patient, and whether the deviation represents a breach in standards to such an extent as to pose an ongoing threat to the safety of another patient should it reoccur.
    - In all such instances, a report should outline a human factor and systems-based explanation of how and why the deviation(s) occurred.
- Recommendations should address the most significant factors identified which contributed to or directly caused the incident.

In addition to the above, all significant adverse incident reports should deliver the following:

- Clarity about the questions posed by the family. The answers to these questions should be included in the findings section of the report.
- A good standard of writing with correct use of grammar, punctuation, and syntax. There should be no abbreviations, unless already in common usage in Northern Ireland.
- A readable report written in non-technical language.

4.5.1 Expert Review Team Findings following review of 66 significant adverse incident reports, comprising Level 1 and Level 2 reviews

The Expert Review Team found that all HSC Trusts utilised the relevant regional templates for the Level 1 or Level 2 review reports. Therefore, the Expert Review Team's findings are as much a reflection of the design of the templates as the quality of the reports assessed.

Style and structure of the reports

The Expert Review Team considered the presentation of the review reports and there was consensus that both report templates would benefit from a basic front page that simply states the name of the reviewing organisation, the title of the report and the publication date. It was proposed that any demographic information required for regional collection purposes could be accommodated within an appendix.

In both the Level 1 and level 2 report templates, space is provided to record 'what happened'. Mostly, this was comprehensively completed. However, in many reports, the sequence of events was recorded in too much detail and at the expense of the detailed analysis expected in the findings section of both reports, accepting that the Level 1 report is intended to be more succinct than the Level 2 report.

In the Level 1 report, there is no 'findings' section but instead, a section titled 'why it happened'. This title is erroneous. It implies that 'why' is determinable and automatically infers that the incident was preventable. It does not promote a balanced, constructive, analytical process.

In the Level 2 reports, there was a 'findings' section, but this was not structured. There were no uniform subheadings to guide a report author about what they should be recording. For example:

- Evidence that shows that expected standards of care were delivered as intended.
- Evidence of deviations from the expected standards of care.

Some reports made statements of policy and procedural compliance but did not say what these were and did not present an evidence base for the reported levels of compliance.

Some review reports stated their findings in relation to human factors, such as team elements, education and training. However, in the majority of instances the Expert Review could not link these findings to a systematic analysis of these areas of concerns in keeping with the approach of the National patient Safety Agency.[9] This indicates that the review panel, the author of the SAI review report and those signing off the reports did not fully understand how to effectively implement a human factors approach.

Some reports reviewed by the Expert Review Team did outline deviations in the care and management of the patient but did not make clear the significance or seriousness of these in relation to the patient outcome. As stated above, rarely was this accompanied by any structured or evidence-based explanation regarding how and why these deviations occurred. As a result, there was a lack of outcome-focused recommendations within the reports reviewed.

In stating the above, the Expert Review Team is not inferring that staff who undertook the reviews or wrote the reports were failing to deliver what was required of them, rather, the lack of structure and quality of the reports is a consequence of:

- A lack of investment in those tasked with leading the reviews in terms of their knowledge, skill base and time required to do the job adequately.
- A report structure that is not fit for purpose (Level 1 and Level 2 templates).
- A lack of effective quality assurance of reports at senior management levels across HSC Trusts.
- A lack of empowerment in HSC Trusts to adopt a more comprehensive approach and a better style of report, based on the principles outlined in regional policy and guidance.
- A lack of an effective quality assurance process within each HSC organisation and at a regional level. There appears to be no reliable process through which reports are peer reviewed to ensure delivery of an acceptable standard of review, including outcome-focused recommendations. Nor are they quality assured with a view to ensuring that there is a standard of report writing suitable for sharing with patients and their families.

Expert Review Team findings in relation to specific indicators of a robust SAI review

These are the findings from the Expert Review Team's structured assessment of the 66 review reports.

Indicator 1: The methods, tools and techniques used by the review panel are clearly stated and appropriate to the incident under examination

The following list describes what was found to be commonly recorded in terms of the methodology and approach to reviewing SAIs:

- The patient's notes were reviewed.
- A tabular timeline established.
- Relevant staff were interviewed.
- Family was invited to participate in the review.

The above elements are not sufficient to be considered a methodology, nor do they provide clarity regarding the approach taken by the relevant review panel. As previously articulated in this report, the primary reason for this is a lack of understanding about what constitutes a fair and reasonable review, with a regional approach that is too limiting and not embracing a tool-kit method.

Indicator 2: The evidence upon which findings and conclusions are based has a clear triangulated evidence-base

None of the reports reviewed satisfied the Expert Review Team that there was a triangulated, and thus validated, evidence-base for what was written in the findings section of the reports. This represents an unacceptable situation. A credible review aims to establish what happened, how it happened and why it happened.

An SAI Review Panel Chair understands the importance of triangulating and validating information and understands the dangers of not delivering this standard of practice. The SAI reports reviewed demonstrated a region-wide lack of adherence to

defendable review practice. This is mostly due to a lack of training, an unclear competency framework and insufficient professional supervision.

Indicator 3: An appropriate range of subject advisers have been engaged in the process

Regarding the independence and appropriateness of subject advisers, in 93% of reports this was either unclear or absent. Regarding relevant experience of subject advisers, this was unclear in 45% of the reports reviewed. The lack of clarity was in part influenced by the design of the regional report template which did not require precision in the recording of this information.

Indicator 4: The key elements of processes and procedures relevant to the effective care and management of the patient's condition are recorded

This was missing from almost all reports reviewed. It is not a current requirement of the regional report template, and its absence underlines the lack of appreciation about what is necessary for a structured and credible review.

Each report should give a clear account of:

1) What happened.
2) Where policy/process/procedural expectations were delivered as expected.
3) Where there was deviation from policy/process/procedural expectations and an explanation for such deviations.

Although there was a clear account of what happened, few reports provided an analysis that enabled the reader to know where expectations were delivered, where they were not, and where the design of the process for care delivery and management was incomplete.

This is a significant shortcoming in the SAI protocol which does not require systems based analysis as part of its approach to conducting SAI reviews or within its regional report template.

Reports of reviews must determine:

- What was expected.
- Where the evidence supports that the standard of care was delivered as expected.
- Where the evidence shows deviation from what was expected.
- Where the evidence shows there was a pre-existing deficiency in the design of care and treatment requirements and associated systems and processes.

Where deviation from policy, process or procedural expectations is identified, there is an explanation of any or all of the following:

- Whether the deviations were reasonable and justifiable based on the presentation of the patient, their clinical needs at the time and the unfolding situation.

- Whether the deviations were not reasonable and therefore not justifiable.

Where deviations in care standards and the care and treatment delivered were identified, there was little evidence regarding the reasonableness of such deviations. It is accepted across all domains of clinical practice that sometimes it is necessary to do things differently than what is outlined in policy and procedure. Clinical professionals are trained to apply their clinical skills and to have a clear reason why a different approach in any given situation is right for the patient under their care. It is possible to make a correct decision at the time care is delivered to alter the normal plan and for this to be later contemplated as a contributor to an incident that occurred later. The rights and wrongs of these decisions must be carefully contemplated, alongside the application of principles such as the substitution test (that is, what would a similarly qualified group of professionals, providing care under the same/similar set of circumstances, reasonably have done). There was no evidence from the reports reviewed that these core principles have been applied.

The situation is uncomplicated if the review panel and the care team agree that an unjustifiable deviation occurred. The problem arises when there is a difference of opinion between the care team and the SAI review panel. In all such instances, the SAI review panel must apply the substitution test.

There was no indication in any of the reports reviewed as to whether the care teams had agreed or disagreed with the findings and conclusions of the SAI review panel.

Many report authors and SAI review panels tried to draw conclusions regarding contributory factors and causal factors. However, there was a lack of robustness in the evidence-base on which such important conclusions were being made. In some cases, where a finding of causality had been made, it was clear from the content of the report and the Expert Review Team's clinical knowledge that the conclusion of causality would not stand up to independent scrutiny. It is the lack of a robust evidence base for such conclusions that contributes to the widely-held view, supported by some members of staff during focus groups, that a culture of blame pervades reviews.

Regarding the human factors and systems-based analysis, report authors and the review panels clearly tried to undertake this analysis and present its outputs in the review report. However, based on most of the reports assessed by the Expert Review Team, there is a lack of understanding about how this needs to be approached, and how the findings need to be structured and presented. The design of the regional report template will have further compounded this.

Indicator 5: Recommendations to address the most significant influencing factors to the identified contributory and causal factors

The quantitative assessment of the 66 SAI reports reviewed by the Expert Review Team revealed:

- There was a lack of clarity about whether the report made recommendations. This was found in 14 (21%) of the SAI reports.

- Recommendations were only made in 26 (39%) of the SAI reports, but what they were trying to achieve was unclear.
- In terms of whether there was a correlation between the incident, the report content, and the recommendations, in 30 (45%) of the SAI reports this was clear, in 32 (48%) it was unclear, and in 4 (6%) it was difficult to make a judgement about this.
- In terms of the appropriateness of recommendations, in 22 (33%) of the SAI reports the recommendations seemed reasonable, but in 40 (61%) they did not. In 4 reports (6%) it was difficult to make a judgement about this.
- Regarding any correlation between recommendations and the subsequent action plan, this was clear in 29 (44%) of SAI reports while in 36 (55%) it was not. In 1 report (2%) it was difficult to make a judgement about this.

In no report was there evidence that a structured approach was taken to the formulation of recommendations. The regional guidance on SAIs does not describe any requirements for this and neither do the regional report templates.

An example of a structured approach to recommendations is:

- Clear identification of the intended recipient of the recommendation.
- A clear statement of what is required.
- A clear statement about what the recommendation should deliver.
- A clear statement of what risk the recommendation is meant to contain.
- A clear statement of the scope of the recommendation (local, regional).

Indicator 6: Regarding the non-technical aspects of SAI reports

SAI review reports should adhere to the following non-technical requirements:

- Clarity about the questions posed by the family and the answers to these questions.
- A good standard of writing, with the correct use of grammar, punctuation, and syntax, with no abbreviations, unless already in common usage within the population of Northern Ireland.
- A readable report, written in non-technical language.

Each of the reports was assessed in relation to these factors. Regarding the level of family engagement and understanding, it is the Expert Review Team's perspective that most SAI review reports did not deliver any evidence, or at least convincing evidence, of compliance with candour.

The standard of writing was variable as was the use and non-use of technical language.

Regarding the degree of satisfaction a patient and family might have with the report presented, the lay members of the Expert Review Team considered that they would be satisfied with 16 (24)% of SAI reports reviewed. They considered that they would not be satisfied with (23) 35% of the SAI reports and were unable to determine an opinion of their satisfaction with the remaining 27 (41%).

Regarding the inclusion of evidence that patient and/or family questions had been asked and responded to during the SAI review process, there was evidence in 15 (23%) of SAI reports reviewed that this had happened. In 44 (66%) of SAI reports, there was no such evidence, while in 7 (11%) of SAI reports it was unclear.

Regarding readability and comprehension of SAI review reports, the lay members of the Expert Review Panel considered most reports 89 of 132[3], (67%) as easy to read in terms of structure and flow, but this dropped to 26 of 66 (39%) in terms of ease of comprehension of report contents.

Wider Consideration from Structured Assessment of 66 SAIs

On consideration of the implications of the overall findings of the structured assessment of the 66 SAI review reports, the Expert Review Team considered the necessary steps to ensure SAI reviews and their reports are of good quality, readable, respond to family questions and provide evidence an acceptable standard of review.

They agreed on a number of general issues that need to be addressed regarding the procedure and its implementation, if the overall standard and credibility of the SAI report, which sets out the findings, conclusions and recommendations of the significant adverse incident review process, are to improve. These include:

- A regional framework that makes clear what the approach to learning from unexpected and unintended harm is intended to deliver; that is, what are its measurable markers of success.
- A regional approach to SAI reviews that delivers recognised international good practice in the science of review.
- A reasonable amount of time to conduct an effective review and include the patient and family in the process in an empathetic, meaningful, and respectful way.
- A single, new report template and regional style guide that enables a consistent approach to SAI reviews across the region but is flexible enough to allow SAI review report writers to remove and add sections to the template.

There is no single activity that will achieve the above. The Expert Review Team wish to make clear that re-writing the regional standards will not achieve the standard of practice that harmed patients and their families are rightfully demanding of this specialist field across the HSC. This is a standard of practice that is comparable to other industries where the activity of reviewing and learning from unexpected harming incidents deliver the core components necessary for an evidence-based review, undertaken by investigators who are skilled for the job, so the right lessons are learned and the right safety improvements are implemented.

[3] The denominator in this indicator is 132 as there was not consensus. 132 reviews were undertaken 2 of each 66 reports. One by each lay reviewer.

It is the Expert Review Team's assertion that there must be a comprehensive recalibration of the approach to the requirement for, and delivery of, SAI reviews across Northern Ireland.
A new approach must achieve:

- Greater flexibility in an approach that focuses on the opportunity for learning and safety improvement.
- A lower number of in-depth reviews. Where early assessment indicates that this depth of review is necessary, there should then be capability and capacity in the system to do this well.
- A process by which individuals and/or organisations who want the opportunity to deliver 'Investigating Well' training to HSC staff, are asked to undertake an assessment process so that it can be determined that they have the right knowledge and skills to deliver such training. This would preferably then lead to a regional register of preferred providers from which individual HSC Trusts can source training.
- A register of individuals and organisations who are authorised and have been assessed as competent to lead the review of unexpected harm events that meet the threshold for an in-depth fully independent review - for example, mental health homicide, removal of a body part in error, in-patient suicide.

Northern Ireland is in the envious position of having only six HSC Trusts. This provides an opportunity to reset the compass in a way that is not possible in regions with larger populations. Achieving this reset and designing a fit-for-purpose approach to reviewing and learning from SAIs will require unified and cooperative work across all involved organisations. Furthermore, it will require frontline senior clinicians to be prepared to provide straightforward, peer-to-peer assessment, reflection and feedback to colleagues in neighbouring Trusts about the care and treatment provided to patients when the outcome constitutes unexpected and unintended healthcare harm. This is a core element of professionalism and clinicians of all disciplines need to meet this challenge head-on. It should not be the case that trusted independent clinical opinion has always to be sought from outside of Northern Ireland.

5.0 Conclusion

The work undertaken for this review has, alongside other related projects, determined that the SAI procedure and its implementation across Northern Ireland is not working as intended.

It frequently fails to:

- Answer patient and family questions.
- Determine where safety breaches have occurred.
- Achieve a systemic understanding of those safety breaches.
- Design recommendations and action plans to reduce the opportunity for the same or similar safety breaches in future.

Patients and their families are not fully enabled to engage with the process as partners and their questions are not always sought. They do not always receive open, honest and straightforward answers to their questions. The witness testimonies of patients and families are not routinely collected and, when they are, they are not treated as they should be; that is, as evidence in the same way staff testimonies are treated. The current situation is not tenable and must change.

Frontline staff, who come to work to help and support patients to achieve the best quality of health they can, consider the current process to be blame-orientated and not learning-orientated. It does not embrace the basic principles of a credible review process, a reasonable expectation of fair treatment, or the right to know of any criticism that is to be made and its relevant evidence-base. Staff are most frequently engaged as passive recipients to the process, which is not a good platform for learning and positive change.

The SAI review reports largely do not evidence a defendable approach to the review and identification of learning arising from unexpected patient harm. There are several contributory factors, including:

- Staff asked to lead the reviews are mostly asked to do this on top of pre-existing work commitments, including frontline patient care duties.
- The level of training provided to staff that are tasked with leading SAI reviews is insufficient and is not informed by regionally agreed competencies or a core patient safety training strategy or curriculum.
- The regional timescales allowed for undertaking a complex review, including meaningful engagement with a patient and their family, are unrealistic and lead to a bureaucratic process.
- The regional report templates are not designed to support the delivery of a quality, evidence-based report.

It is worth noting that since this review was commissioned, a number of Public Inquiries, patient recall and lookback exercises have been initiated in Northern Ireland. The Expert Review Team considers that such lengthy inquiries and large-scale pieces of work could be avoided by a robust system for deriving and implementing learning from SAIs. Ineffective systems and processes for review

and identification of learning emerging from SAIs, not only damage public confidence and trust in the SAI process, but also adversely impact on the trust of patients, their families and the public in the healthcare system as a whole.

There is now an important opportunity to achieve better for patients, for staff and for Health and Social Care services across the region. It is patently evident that continuing as we have been is not an option. The Expert Review Team has made five recommendations that, if implemented, should transform the current approach to learning from and preventing recurrence of harm within Health and Social Care in Northern Ireland. The RQIA look forward to working in partnership with DoH, PHA, HSC Trusts, patients, families and carers to deliver on a new and improved regional system for optimising the learning from adverse incidents which occur in Health and Social Care services and ensuring every opportunity is seized to improve the safety of Health and Social Care services.

6.0 Recommendations

The following recommendations are intended to deliver a new regional policy for reporting, investigating and learning from adverse events.

Recommendation 1:

The Department of Health should work collaboratively with patient and carer representatives, senior representatives of Trusts, the Strategic Performance and Planning Group, Public Health Agency and Regulation and Quality Improvement Authority to co-design a new regional procedure based on the concept of critical success factors. Central to this must be a focus on the involvement of patients and families in the review process.

Recommendation 2:

Health and Social Care organisations should be required to evidence they are achieving these critical success factors to the Department of Health.

Critical success factors

Appendix D provides an example of the critical success factors the Department of Health may wish to use to commence the work of redesigning the region's approach to learning from SAIs.

An example of a critical success factor and its core objectives:

- Families and patients are supported as active partners in the review process as much as they wish to be involved, including the involvement of an appointed advocate.
- Patients/families experience a compassionate and empathetic approach, which includes the method and frequency of contact throughout the review process.
- The voice of the patient and family is heard, their testimony is captured and they have the same status as any professional contributing information to the review process.
- The patient and family have a named source of support outside of the review panel. The role of this individual is clearly defined, including their authority to act in the best interest of the family.
- Questions asked by the patient and family are responded to fully, with honesty and integrity.
- The patient and family are encouraged to contribute to and influence the terms of reference for incidents identified as requiring in-depth.
- Patients/families are taken through the interim findings of the review and they are provided with enough time to enable them to read, comment on and influence the content of the final report.

How individual HSC organisations deliver these objectives is for them to determine. However, what must be required from all HSC organisations is evidence of achievement and an equal opportunity to be involved. This must be validated by patients and families who have experienced unexpected healthcare harm of a nature that warrants a dedicated review.

The Expert Review Team recommends that a co-production model, involving frontline staff, patients and their families, be adopted regionally to shape any way forward.

Implementing this recommendation will achieve:

Meaningful involvement of patients and families as partners in the SAI review process. This should incorporate a restorative process delivered within a culture of learning and improvement. The incident of harm and its resulting impact is one which the patient and their family must manage and live with. Therefore, it is essential that the patient and their family are at the centre of the review process if their trust in the Health and Social Care service concerned is to be retained.

This recommendation should address the risk of:

Further loss of public confidence in the systems of learning from healthcare harm and, importantly, risk of unnecessary harm to patients/families.

Recommendation 3:

The Department of Health should implement an evidence-based approach for determining which adverse events require a structured, in-depth review. This should clearly outline that the level of SAI review is determined by significance of the incident and the level of potential deficit in care.

What is required:

RQIA has found throughout its inspection and review work, widespread practice, where adverse outcome for the patient often drives the requirement for a Level 2 or Level 3 review. This practice must change. Not all unexpected harm, irreversible harm, and unexpected deaths are attributed to mistakes in the care or treatment provided.

Clear guidance is necessary which includes the implementation of a system of early, structured case assessment, taking place within one to two weeks of the incident occurring. This will deliver a greater degree of clarity regarding the degree of variance from expected care and treatment standards, and, on this basis, a proportionate decision can be made regarding the subsequent level of review required.

The Expert Review Team suggests:

- In all cases where there is concern that an identified variance may have contributed to the outcome for the patient, an in-depth examination of those variances is required.
- Where a serious breach in the expected standards of safe care is identified, an in-depth examination is warranted – even if the variance itself is not considered to have contributed to the patient's outcome.
- Where the incident represents issues known to have been previously examined individually, that consideration is given to conducting a structured, in-depth, whole system review rather than repeating another individual incident review which, by its nature, is unlikely to include systems-based learning and improvement.

In all the above suggestions, it is expected that there will be involvement and engagement with the harmed patient and their family.

Other considerations that should be incorporated into a decision-making process:

- It should be considered whether a further Level 2 or Level 3 review will achieve more learning than has already been achieved by a previous review.
- It should be considered whether a safety improvement plan, regarding issues relevant to this SAI, is already underway. If yes, then the value of an individual incident review should be determined. Consideration must be given to incorporating this case into the pre-existing safety improvement project.

Implementing this recommendation will achieve an approach that:

- Is proportionate.
- Makes appropriate use of public funds.
- Allows review panels to focus in-depth reviews on those cases where there is the greatest opportunity for learning and improvement.
- Enables the relevant clinical teams and service managers to retain ownership of incidents that do not reach the threshold for a level 2 or 3 review. This ensures recognition of the skill, competence and integrity of staff that are entrusted with the delivery of safe patient care.

In summation, this recommendation should address the risk of perpetuating a situation where the volume of level 2 reviews required exceeds the capacity and capability to deliver to a credible standard. The resulting proportionality will also support measurable improvements in safety and quality. This will also serve to address the risk of prolonging the dissatisfaction with the process that has been expressed by patients, their families, and frontline staff.

Recommendation 4:

The Department of Health should ensure the new Regional procedure and its system of implementation is underpinned by 'just culture' principles and a clear evidence-based framework that delivers measurable and sustainable improvements.

Recommendation 5:

The Department of Health should develop and implement a regional training curriculum and certification process for those participating in and leading SAI reviews.

What is required:

There are several issues that must be addressed if the overall standard of how serious incidents are reviewed and learnt from is to improve. These include:

- A regional framework that makes clear the key factors for success[4], against which each Trust/DoH (SPPG) is performance managed.
- A regional approach that delivers international good practice in the science of review. The development of a standard operating procedure that focuses on the practice of investigating rather than performance targets would support this.
- A process that embraces a just and fair culture where staff are supported through a constructive learning process and not scapegoated should deficiencies in systems or processes be found.
- A quality assurance system that makes explicit the accountability of senior managers within each Trust/DoH (SPPG) organisation, alongside a mechanism for holding them to account for SAIs signed-off as acceptable.
- A regional training curriculum, competency framework, certification or accreditation process and mentorship programme.
- Investigators of SAIs must demonstrate that they have the competencies to do so and have completed a programme of training in line with regional curriculum requirements.
- Educators/trainers and mentors must demonstrate that they have the right knowledge and competencies. Furthermore, they must complete an assessment process in order to be included on a region-wide approved provider register. Only providers on this register can provide review training to Trusts/DoH (SPPG).
- A fair and reasonable amount of time to conduct a credible review must be provided. This must include time to engage and involve the family/patient in an empathetic, meaningful and respectful way.
- A single new report template and regional style guide must be designed. This must facilitate a consistent approach to report formulation and presentation, with enough flexibility to allow a report writer to adapt it to meet the needs of the review conducted.

[4] That is the critical success factors and the core objectives for each success factor are agreed, and adopted by all Trusts and HSCB.

A new approach must achieve:

- Greater flexibility in approach, that focuses on the opportunity for learning and safety improvement.
- A lower number of in-depth RCA reviews. However, where early assessment indicates that this depth of review is necessary, there must then be the capability and capacity in the system to do this well.

Implementing this recommendation will achieve:

An approach to learning from harm that HSC staff and the public can have confidence in, in terms of:

- Learning lessons.
- Measurable safety improvement.
- Transparency.
- Alignment with the core principles and hallmarks of a robust review process.
- Restoration and reconciliation.

This recommendation should address the risk of:

A system of learning that is overwhelmed by too many reviews, few of which lead to measurable improvements in safety or learning of any significance. This will enable the HSC Trusts to develop a flexible and innovative approach to learning from harm; one which engages the patient and their family in the process and mitigates the risk of perpetual mistrust.

There is no single activity that will achieve the above recommendations. There must be a comprehensive recalibration of the approach to the requirement for, and delivery of, SAI reviews across the region.

Appendix A: SAIs by Category and by HSC Organisation

	SAI Level	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NIAS	Primary Care	Total
Maternity related	Level 1	2	5	3	0	4	0	0	14
	Level 2	0	0	1	1	0	0	0	2
Sepsis	Level 1	1	0	2	0	0	0	0	3
	Level 2	0	0	0	1	0	0	0	1
Choking	Level 1	0	0	1	0	0	0	0	1
	Level 2		1	0	0	0	0	0	1
Never Event	Level 1	1	0	3	0	1	0	0	5
Reference to Private Hospital/Nursing Home	Level 1	1	1	0	0	1	1	0	4
Person with a learning disability who died from a treatable condition	Level 1	0	0	0	0	0	0	0	0
Primary Care	Level 1	0	0	0	0	0	0	4	4
Reference to a person with a learning disability in Residential Care	Level 2	0	0	0	1	0	0	0	1
Other Level 1 SAIs	Level 1	0	0	1	0	0	3	0	4
Other Level 2 SAIs	Level 2	5	3	2	11	4	0	0	25
Other Level 3 SAIs	Level 3	1	0	0	0	0	0	0	1
Total SAIs reports to be assessed		**11**	**10**	**13**	**14**	**10**	**4**	**4**	**66**

Source: Information provided by HSCB and HSC Trusts. Categories suggested by DoH

Appendix B: Other Organisations that were offered the Opportunity to Input Into this Review

Organisation
Medicines & Healthcare products Regulatory Agency (MHRA)
Northern Ireland Adverse Incident Centre (NIAIC)
Health and Safety Executive Northern Ireland (HSENI)
Police Service for Northern Ireland (PSNI)
Safeguarding Board for Northern Ireland (SBNI)
Northern Ireland Adult Safeguarding Partnership (NIASP)
Information Commissioner Office (ICO)
British Medical Association (BMA)
General Medical Council (GMC)
General Dental Council (GDC)
Northern Ireland Medical and Dental Training Agency (NIMDTA)
Pharmaceutical Society Northern Ireland (PSNI)
Northern Ireland Social Care Council (NISCC)
Royal College of Nursing (RCN)
Nursing and Midwifery Council (NMC)
Health Care Professional Council (HCPC)
Northern Local Medical Committee (NLMC)
Eastern Local Medical Committee (ELMC)
Southern Local Medical Committee (SLMC)
Western Local Medical Committee (WLMC)
UNISON
Unite the Union
Northern Ireland Public Sector Alliance (NIPSA)

Appendix C: Improvements Suggested by Staff

During the engagement process, staff were asked to share any suggestions they felt would improve the SAI review process or patient and family engagement. Staff suggestions were used to formulate the following suggested improvements.

Suggested improvements to the SAI process

Classification of incidents

- The identification of incidents requiring an in-depth review must be driven by a structured assessment, which identifies:
    - a significant learning opportunity
    - the presence of significant care lapses, or care concerns
    - the depth and range of family questions

  Eliminating the determination for an in-depth review based on incident type and/or patient outcome alone can minimise the number of reviews with little impact on improving safety.
- Incidents involving suicide should not automatically be classified within the SAI process.

Timescales for Conducting SAI reviews

- Overwhelmingly, HSC staff consider that the timescales for conducting SAI reviews need to allow greater flexibility and take account of the complexity and the needs of the patient and family.
- A structured timescale approach that outlines the importance of capturing factual accounts and situational context within the first 48 hours post-incident, and early capture of information from families followed by a realistic period to allow an initial assessment of the information before determining what subsequent review is required, along with its depth and approach.

Terms of Reference

- The terms of reference for SAI reviews should be specific to the incident and referred to as key lines of enquiry to reflect a more learning-based approach.
- Terms of reference must include patient and family questions, where the patient and family have questions.
- The practice of pre-determined terms of reference that are used for all SAIs should desist as it provides no meaningful structure for the review process.

Staff Involvement

- Staff said that to achieve a ‘just culture’ and optimal learning they needed to be more involved in the process, specifically:
    - Their team leaders need to be involved in decisions over what to review, at what depth, and why

- Involved staff need an early invitation to capture a full account of what had happened and the situational context of the day, shift, or relevant period
- There needs to be a shift away from only reviewing documents to engaging involved staff in conversation about what had happened
- More group learning approaches could be utilised, such as after-action review
- Providing feedback on a high quality draft of the review report, that their comments are listened to and taken account of by the review panel
- In formulating recommendations
- In contributing to the design of action plans
- In participating in a post review learning event.

Communication with Staff

- Staff involved in an incident should receive notification that an SAI has been requested and be provided with a copy of the agreed terms of reference or key lines of enquiry, as well as information about who is conducting the review.
- Staff involved in an SAI ought to expect their team leader to receive update reports regarding the progress of the review so that the whole team is informed about this.
- Several staff thought a website or shared area should be established to keep those staff involved in an incident up to date on the progress of the SAI review while maintaining confidentiality.

SAI Review

- Currently, the SAI process is perceived as a negative review that does not support a 'just culture'. It must be mandated that the aspects of care that met or exceeded care standards, as well as those aspects that could have been improved, are reported on. This includes interventions that may have mitigated the impact of the incident.

SAI Review Panel

- Where it is identified that there were, or may have been significant care lapses, staff considered a dedicated SAI review panel from outside the Trust was required. This includes the lead reviewer and the subject advisors/field experts. Staff considered that such a team needed to be appointed by an external agency such as the HSCB/PHA.
- There should be a set of competencies, skills and knowledge required of the chair of an SAI review panel/lead reviewer, and the subject advisors/field experts asked to work with this individual.

Independence

Staff recognised that achieving complete independence was not feasible. However, they considered that:

- The lead reviewer/chair should not come from the service involved in the incident.
- Mentorship should be available for lead reviewers/chairs to support them in maintaining objectivity and impartiality.
- Ideally, a non-clinician with the right investigatory skills and competencies should chair the SAI review panels.
- A lay person or trained family advocate should be included in the SAI review panels. This would support meeting family needs and writing a report that is understandable by a non-technician.
- Optimal use of interventions such as web-conferencing and remote web-based interviews could be utilised to support involvement of independent technicians without the excessive cost often associated with this.

Staff Support

- Staff involved in an incident must be given protected time to prepare and attend interviews or meetings during the SAI review.
- Staff involved in an incident must be given the opportunity for pastoral/psychological support to deal with traumatic incidents.
- A rapid team debrief post incident must become normal practice.
- All SAI teams must include an administrator to support its smooth delivery and to ensure that the time of frontline, professionally qualified staff is used appropriately.
- Corporate teams responsible for patient safety must have the necessary competencies required to provide support and mentorship to SAI leads/chairs.
- Staff asked to lead SAIs must have received a minimum of two days training, plus mentorship and coaching support so that they can lead the process competently.
- Staff required to conduct the initial reviews of incidents before a decision is made to progress to SAIs need to know how to conduct a structured review, and what information is required to do this competently.

Advocacy

- Northern Ireland needs to engage with patient advocacy organisations to develop a system where lay people can become accredited advocates for families following patient safety incidents.
- Publicly funded independent advocacy should be available for patients/families that require this and where there are concerns about the adequacy of care and/or treatment offered.

Recommendations

- Staff need protected time to participate/lead in Quality Improvement Action plans emerging from SAI reviews.
- Multidisciplinary staff should be brought together to help develop outcome-focused recommendations. This should not be the sole domain of the SAI review panel.

- Recommendations from SAI reviews should be benchmarked against core criteria, and the teams and services involved in the incident must be invited to comment on the appropriateness of the recommendations made.
- When contemplating whether a recommendation is or is not accepted and how it is treated, due consideration must be given to pre-existing safety and quality improvement projects already underway or planned.
- Recommendations from SAI reviews need to be outcome-focused and drive action plans that deliver measurable and sustainable improvements in the quality and safety of care.

Learning

- There must be more formal processes for disseminating learning from SAI reviews. The Oxford Model developed in the 1990's and successfully utilised by Mersey Care NHS Trust is an example of this.
- Each Trust must be required to demonstrate not only what it has learnt but how it has improved. This will drive disseminated learning.
- RQIA and other regional bodies must show how the learning within individual Trusts is captured and used for learning across Northern Ireland.

SAI Review Reports

- Feedback from all key staff involved should be considered in the finalisation of an SAI review report. This assures factual accuracy and greater engagement by frontline professionals.
- A meeting with all staff associated with the incident, and who provided information to the SAI review panel, should be conducted to enable findings, conclusions and recommendations to be discussed and agreed.
- The SAI review report template should be revised to include a section that allows greater articulation of patient and family engagement.

Action Plans

- How action plans are developed must be in line with good practice, rather than copying and pasting recommendations into an action plan template. This does not deliver sustainable or measurable change.

General

- The practice of retrospective recordkeeping in the 72 hours post incident needs to be enabled. Where this is not possible for whatever reason, accounts of involvement must be collected.
- SAI reviews should focus less on assigning blame and scapegoating, and instead embrace the principles of a ‘just culture’ and justifiable accountability.
- The SAI process should be reviewed to examine how best to review future incidents in a more proportionate way.

Suggested improvements for patient and family engagement

Information for Patients/Families

- Patients/families should be better informed of the SAI review process. For example, there could be better quality information leaflets available, or a video or podcast explaining the process on the DoH or RQIA's website.
- The SAI process must be explained to patients/families before the process commences so they can have realistic expectations.

Communication with Patients/Families

- There must be clear standards of how a patient and family should be communicated with during the SAI process, with patients/families asked for formal feedback at the end of the process via a questionnaire or online survey tool. This should also accommodate requests for anonymity.
- The terms of reference/key lines of enquiry must be shared with patients/families prior to an SAI review commencing, and these must include the patient and family questions alongside technical clinical/process-based questions.

Patient and Family Engagement

- Trusts must demonstrate their commitment to the SAI process and to the patients/families affected by SAIs by ensuring senior management are actively involved in communications with families. This is particularly important at the start and end of the process.
- Staff must receive training from experienced advocates and families who have experienced the SAI review process so they know how to achieve and maintain positive engagement with a family.

Appendix D: Examples of Critical Success Factors

The factors listed below are examples of critical success factors (CSF), previously developed by an HSC organisation in the UK and provided to this review by Maria Dineen, member of the Expert Review Team. This list is not intended to serve as a definitive list; rather, its purpose is to provide an initial starting point for a wider conversation about what the critical success factors could look like in Northern Ireland.

Critical Success Factor 1:

We consistently value and engage meaningfully with patients and their families through the entire review (including complaints) process.

The core objectives for this CSF are proposed as:

- Patients/families experience a compassionate and empathetic approach.
- The voice of the patient and family is heard.
- The patient and family are well informed throughout the process.
- Questions asked are responded to with honesty and integrity.
- Patients/families are provided with the opportunity to contribute to and /or influence the terms of reference for incidents identified as requiring in-depth review.
- Patients/families are taken through the draft review report, and provided enough time to enable them to read, comment on and influence the content of the final report.

Critical Success Factor 2:

We consistently value and engage meaningfully with staff throughout the entire review (including complaints) process

The core objectives for this CSF are proposed as:

- Staff experiences a compassionate and empathetic approach.
- The voice of the staff involved in an incident is heard. This includes their experience of 'the day', and the 'context' in which the incident occurred.
- Staff involved are well informed throughout the review process.
- Staff are treated fairly and equitably, in line with NHS Improvements Just Culture Guidance.
- Staff involved in the incident, and other key staff informants to the review, are facilitated in reading the draft report and providing feedback on it relating to factual accuracy, tone and style.
- Staff involved in the incident and service(s) in which the incident occurred are actively engaged in designing the action plan to deliver measurable and meaningful improvement.

Critical Success Factor 3:

We will consistently show that measurable improvements in standards, safety and quality occurs, is sustained, and known about by staff.

The core objectives for this CSF are proposed as:

- There is a corporate action planning/lessons learnt group that acts as a repository for those issues identified in one division, but which have wider implications for other services / divisions within the Trust. A central approach will ensure these issues are assessed and addressed corporately.
- Within each division the safety governance group, lessons learnt and recommendations arising from reviews are a standing agenda item.
- Recommendations are targeted towards i) the local team ii) the local service/division and iii) corporate wide. Further they are mostly addressing systems improvement and not individual practice.
- There is an action planning method/approach that facilitates engagement of staff involved in service delivery and sets out clearly the range of activities required to deliver the intent of the recommendation.
- All action plans include how success is to be measured and at what frequency to assure sustainability.
- Recommendations are formulated to make clear their intent (i.e. what needs to be achieved if they are accepted and implemented).
- Staff are aware of the improvements implemented in their service and division as a consequence of reviews conducted, and more widely across the organisation.

Critical Success Factor 4:

Incidents will be reviewed proportionately i.e.: right level, right depth, and right breadth of review according to the volume and magnitude of errors (if any).

The core objectives for this CSF are proposed as:

- The Trust has an achievable and defined method/process through which harming incidents that meet the threshold for Duty of Candour (i.e. moderate harm and above) are assessed to determine the depth of review required and with what degree of independence.
- The Trust has a clear categorisation system for incidents that meet the threshold for Duty of Candour (and above) so that there is clarity between those that occurred despite good care, and those that were caused by mistakes in care delivery. (E.g. Category A means care and treatment was appropriate, and category D means there were several lapses in care and treatment that may have contributed to the outcome).
- The Trust assigns the review of cases where there may have been a contribution to the harm because of mistake to a case reviewer who has the right competencies to lead and deliver a more complex review.

- Terms of reference for reviews are bespoke and make clear the relevant technical questions that must be asked and answered, alongside any family questions that have been posed.
- The Trust has a review framework, and approach, that allows a range of methods and tools to be employed to meet the discrete requirements of each review.
- The Trust has in place a process to enable early preservation of information including memory capture, so that the assessment of incidents and any subsequent review is well informed and can be explored to the right depth and breadth.

Critical Success Factor 5:

Reviews are conducted using appropriate methods and tools, and in line with good project management principles, assuring delivery within an agreed and realistic timescale.

The core objectives for this CSF are proposed as:

- The Trust will have enough staff trained to undertake the case screening element of the review journey within 10 working days of incident occurrence.
- The Trust will have enough staff trained to a higher level of knowledge and competency to delivery those reviews that are categorised C or D (i.e. care/ management a bit 'hit or miss' or serious lapses are identified).
- The Trust will commit to a stepped review process including clear boundaries for the review arising from carefully formulated terms of reference that make clear the necessary technical questions as well as including family questions.
- Staff asked to act in a case screening or lead reviewer/case reviewer capacity will have the necessary adjustments made to their pre-existing diary commitments so that they have a fair amount of dedicated time to deliver the review project.
- Specialist advisors will be allocated to the appointed case reviewer in a timely manner so that avoidable delays do not occur.
- The Trust will ensure for all category C and D reviews that there is reasonable administrative support provided to the case investigator so that working practices are as efficient as possible. (Category C and D - i.e. care/ management a bit 'hit or miss' or serious lapses are identified).

Critical Success Factor 6:

Review reports are consistently produced and meet the following standards:

- Well written.
- Understandable by a non-technician.
- Reasoned (i.e. evidence and not opinion orientated).
- Clear findings, conclusions and recommendations.
- Answer all family questions where it is possible to do so.
- Accessible.
- Validated.

The core objectives for this CSF are proposed as:

- The Trust has a practical approach to proof reading reports that includes insights from:
    - a technical advisor
    - a lay person
    - someone who has good grammar, and spelling
    - someone who is good at formatting documents, using 'smart report' technology.

- The Trust has a well-designed report template that includes:
    - acknowledgements
    - contents list
    - an executive summary
    - introduction (case over view and context of care, as well as outcome and reasons for the review)
    - a family section
    - a findings section (what was delivered to a reasonable standard, what could have been improved, any significant or serious lapses in care standards.)
    - what has changed / improved since the incident
    - what additional lessons learnt arose from this review
    - conclusions
    - recommendations
    - appendices

- Both the patient / family and the staff involved are provided with the opportunity to read and comment on the report when in good draft format. Their comments are listened to and incorporated into the final report document as far as it is possible to do so. Where it is not, they are advised of this and why not.
- Review reports are written empathetically and compassionately.
- Review reports are written in plain language so they understandable by all readers.
- Staff required to write review reports have a mentor who can support the development of their writing and presentation skills.

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[2] Francis, R, The Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013). Available at: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry Cited June 2022

[3] Sir Liam Donaldson, 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). Available at: https://www.health-ni.gov.uk/publications/right-time-right-place Cited June 2022

[4] The Report of the Inquiry into Hyponatremia related Deaths, Justice O'Hara (January 2018). Available at: http://www.ihrdni.org/ Cited June 2022

[5] HSCB, PHA. Information Leaflet – What I Need to Know About a Serious Adverse Incident for Service Users/Family Members/Carers. Available at: https://hscboard.hscni.net/download/PUBLICATIONS/QUALITY%20AND%20SAFETY/sai_learning_reports/English-Communication-with-the-Service-User-Family-and-Carers-following-a-Serious-Adverse-Incident.pdf Cited June 2022

[6] Health and Social Care (Reform) Act (Northern Ireland), 2009. Available at: https://www.legislation.gov.uk/nia/2009/1/contents Cited June 2022

[7] CQC, Learning Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (December 2016). Available at: https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf Cited June 2022

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[9] Systems Analysis Of Clinical Incidents The London Protocol, Sally Taylor-Adams & Charles Vincent, Imperial College London. Available at: SYSTEMS ANALYSIS OF CLINICAL INCIDENTS (imperial.ac.uk) Cited June 2022

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street,
Belfast
BT1 4LS

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Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews

HSCB/PHA

Serious Adverse Incidents

HSCB/ PHA role in procedure

Anne Kane and Denise Boulter

Health and Social Care Board

Public Health Agency

Aims

To provide an overview of the following:

- **What is an SAI**
- **What is the purpose of an SAI**
- **Levels of review**

- **Family engagement**
- **Learning from SAI's**

SAI procedure

- Governed by the HSCB through the governance team under Director of Performance Management and Service Improvement
- Collaboration with both Quality and Safety nursing and medical teams and governance teams
- Professional oversight by the Director of Nursing, Director of Public Health, Director of Social Care and Director of Integrated care

SAI'S

- When things do go wrong in health and social care, it is important that we identify this, explain what has happened to those affected, and learn lessons to reduce the possibility of it happening again. We do this through the Serious Adverse Incident (SAI) process.
- The Health and Social Care Board in conjunction with the Public Health Agency are responsible for the report and follow-up of SAIs. There is a regional procedure which should be followed by health and social care organisations when an SAI occurs.

Key Aim from SAI Process

- Improve patient safety
- Reduce the risk of recurrence
- Find out;

WHAT HAPPENED?

WHY DID IT HAPPEN?

WHAT CAN WE LEARN TO STOP IT HAPPENING AGAIN?

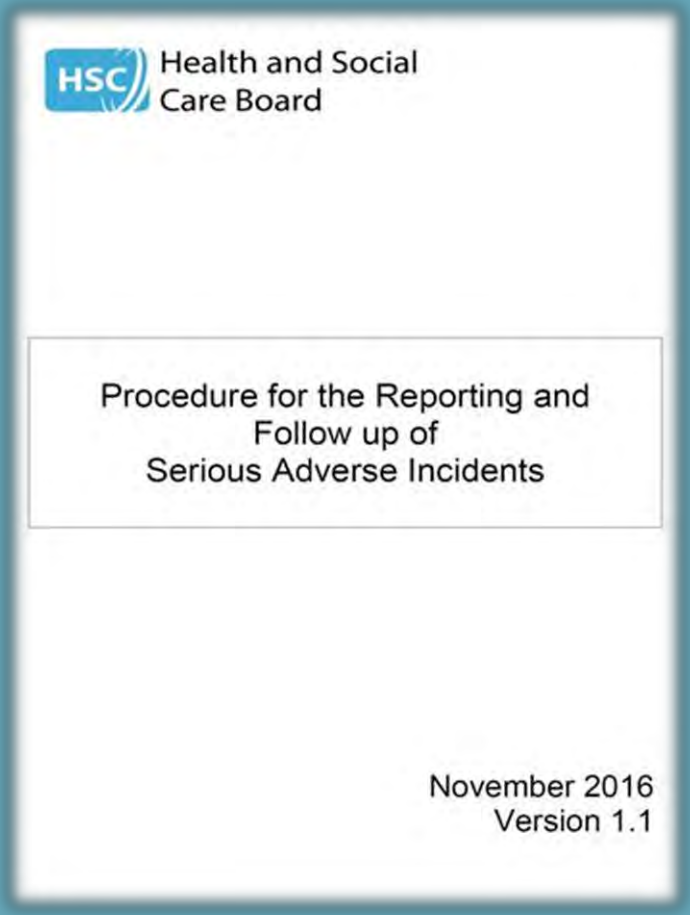
What is an SAI?

- A **serious adverse incident** is defined as any event or circumstance that led or could have led to **serious** unintended or unexpected harm, loss or damage to patients

SAI Procedure

- From 1 May 2010 responsibility for the management of SAIs transferred from DoH to HSCB (*working jointly with PHA and collaboratively with RQIA*)

- Revisions
  - October 2013
  - Current procedure operational from November 2016



Reporting SAIs

- When an SAI occurs, it will be reported by the health and social care organisation to the Health and Social Care Board. All those affected by the SAI should also be informed of the incident.
- An SAI review will be initiated by the reporting organisation, and an SAI panel will be established.

- Three levels of review may take place, depending on the nature, type and impact of the incident.

Level of review	Application	Product/Outcome	Owner	Timescales
Level 1 **Concise internal investigation**	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.	Concise/compact review report which includes the essentials of a credible investigation utilising the Serious Event Audit review template. Learning summary to be sent to HSCB/PHA for review by the DRO. All internal investigation should be supported by a clear review management plan.	Chief Executive in the organisation where the incident occurred, providing principles for objectivity are upheld. They are responsible for quality of review, local actions to support learning and identification of regional learning to HSCB/PHA.	Internal investigations, whether concise or comprehensive, must be completed within 60 working days of the incident being reported to the HSCB/PHA.

Level of review	Application	Product/Outcome	Owner
Level 2 **Comprehensive internal review (this includes those with an independent element or full independent panels).**	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.	Comprehensive review report including all elements of a credible review	Chief Executive in the organisation where the incident occurred, providing principles for objectivity are upheld. Providers may wish to commission an independent review or involve independent members as part of the review team to add a level of external scrutiny/objectivity.

Level of review	Application	Product/Outcome	Owner
Level 3 Independent review.	MAHI - STM - 308 - 564 Required where the incident is complex or involving multiple organisations. In situations of homicide Required where the integrity of the investigation is likely to be challenged. Where it will 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.	Comprehensive review report including all elements of a credible independent review	The review panel chair and all members of the team must be independent of the provider. Chief Executive in the organisation where the incident occurred will identify a lead Director who will be responsible for supporting the independent review and addressing any urgent issues identified. That Chief Executive is responsible for taking forward any actions identified to prevent the incident recurring. HSCB/PHA is responsible for addressing regional learning.

External Timescales

Submission of	Timeframe
Terms of Reference	within 4 weeks following date of notification.
SEA / RCA Review Reports	Level 1 Learning Summary – 8 weeks Level 2 RCA Report – 12 weeks Level 3 RCA Report – To be agreed by DRO at outset
Escalation of SEA to RCA	If outcome of SEA Level 1 determines a RCA Level 2/3 Review is required. Timescale to be agreed by DRO.
RQIA Comments (*where relevant*)	3 weeks
DRO Queries	Level 1 Learning Summary (by exception) – within 2 weeks Level 2 and 3 RCA Report– within 3 weeks
Engagement Checklists	An engagement checklist should accompany all summary/review reports.

Journey of a SAI

- SAI submitted via SAI Mailbox
- Issued to DRO other relevant professionals including Governance lead
- DRO may respond to immediate action
- Daily SAI report issued to professional directors
- Multi-professional Weekly SAI Review Group
  - SAIs, Interface Incidents & Early Alerts
  - Consider
    - Escalation of SAI
    - Reporting of SAIs from Early Alerts/Interface incidents
    - Immediate action / queries not already taken by DRO
  - DATIX update DRO/Governance lead informed
- Timescales for level 3 SAIs to be agreed by DRO
- TOR level 2/3 submitted via SAI Mailbox – issued to DRO/Governance Lead
- Approved within 3 weeks by DRO / SAI professional group
- SAI review report submitted – issued to DRO
- Listed by Governance lead for next available SAI professional group

Journey of a SAI con/t MAHI - STM - 308 - 567

- Discussed by group
  - Level 1
    - Learning / Engagement checklist
  - Level 2 & 3
    - Learning / Robustness of report / Engagement Checklist
  - Closed with learning/without learning
  - Query – back to Trust – followed up by Governance lead / Trust SAI Performance Meetings
  - Listed for next meeting
- Closed with learning
  - Learning letter, Reminder of Best Practice, Professional letter – DRO involvement
  - Newsletter article – DRO involvement
  - Referral to other group / network
  - SAI Event
  - Thematic Review – DRO involvement
- Assurances on letters
  - 3 levels – SQAT process
    - No Assurance
    - Assurance added to audit programme – DRO involvement
    - Assurance on actions – DRO involvement

Interface incidents

- According to the “Procedure for the reporting and follow up of SAI’s” Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility.
- In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form. The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Interface incidents

- Can cause considerable email traffic
- Trusts need to provide robust response to why they believe is not an SAI
- 39 reported in 2020/21- 17 converted to SAI's
- Communication between Trusts before notification?

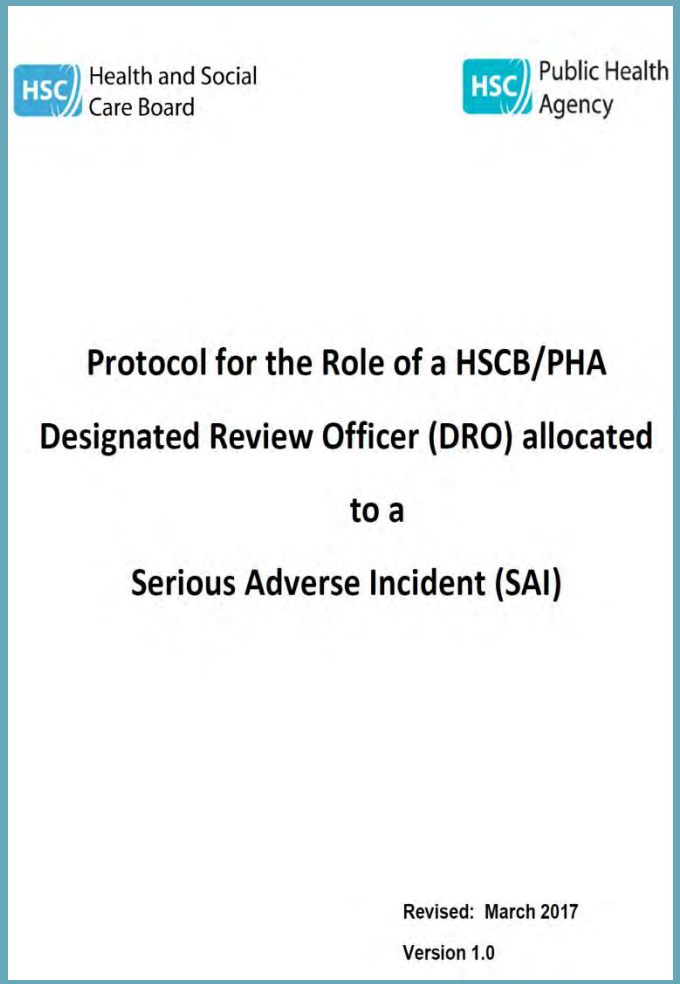
What is important for us in an SAI

- Notification which gives enough detail of what happened to generate an SAI
- Strong identifiable team membership and terms of reference
- Good achievable value added recommendations

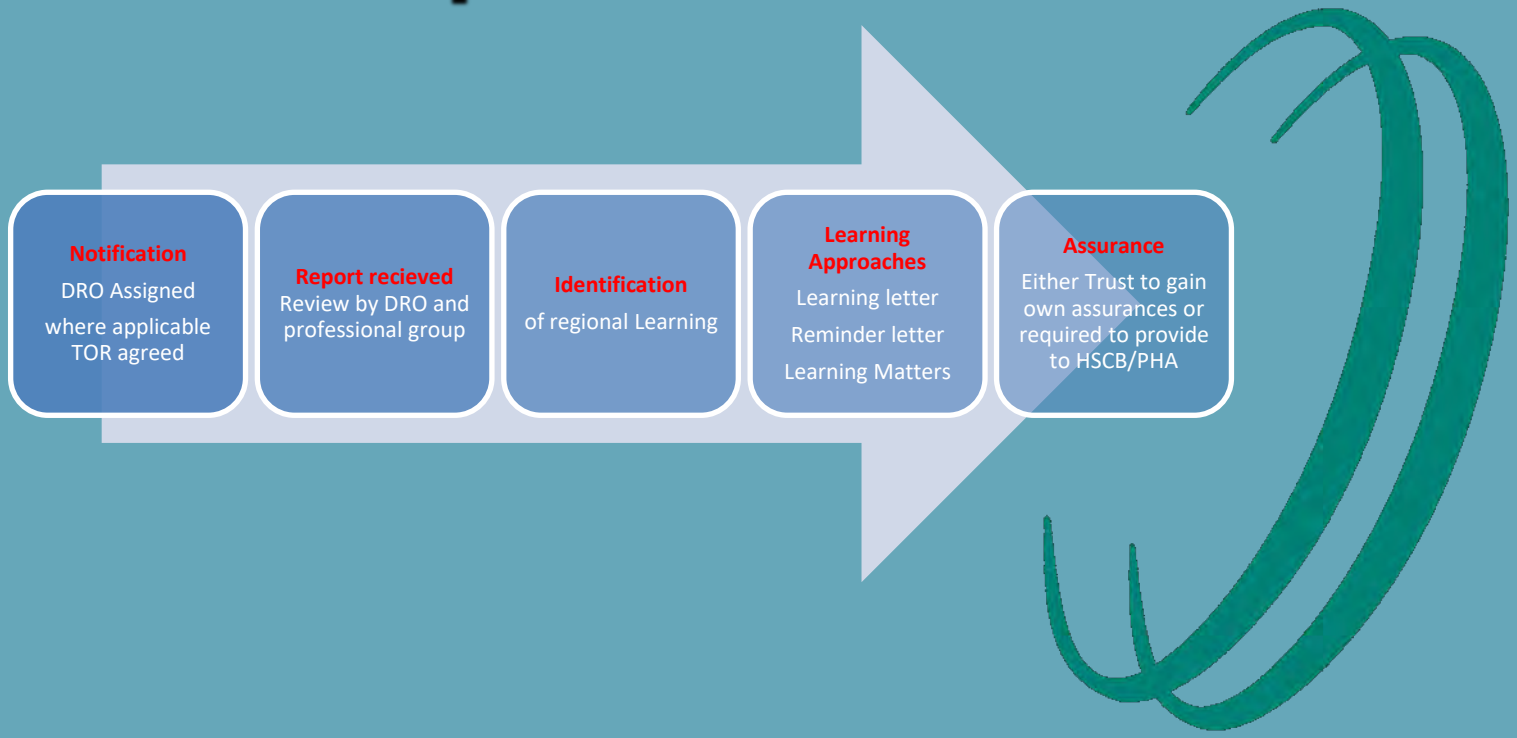
HSCB/PHA Safety and Quality Structure

Role of a DRO

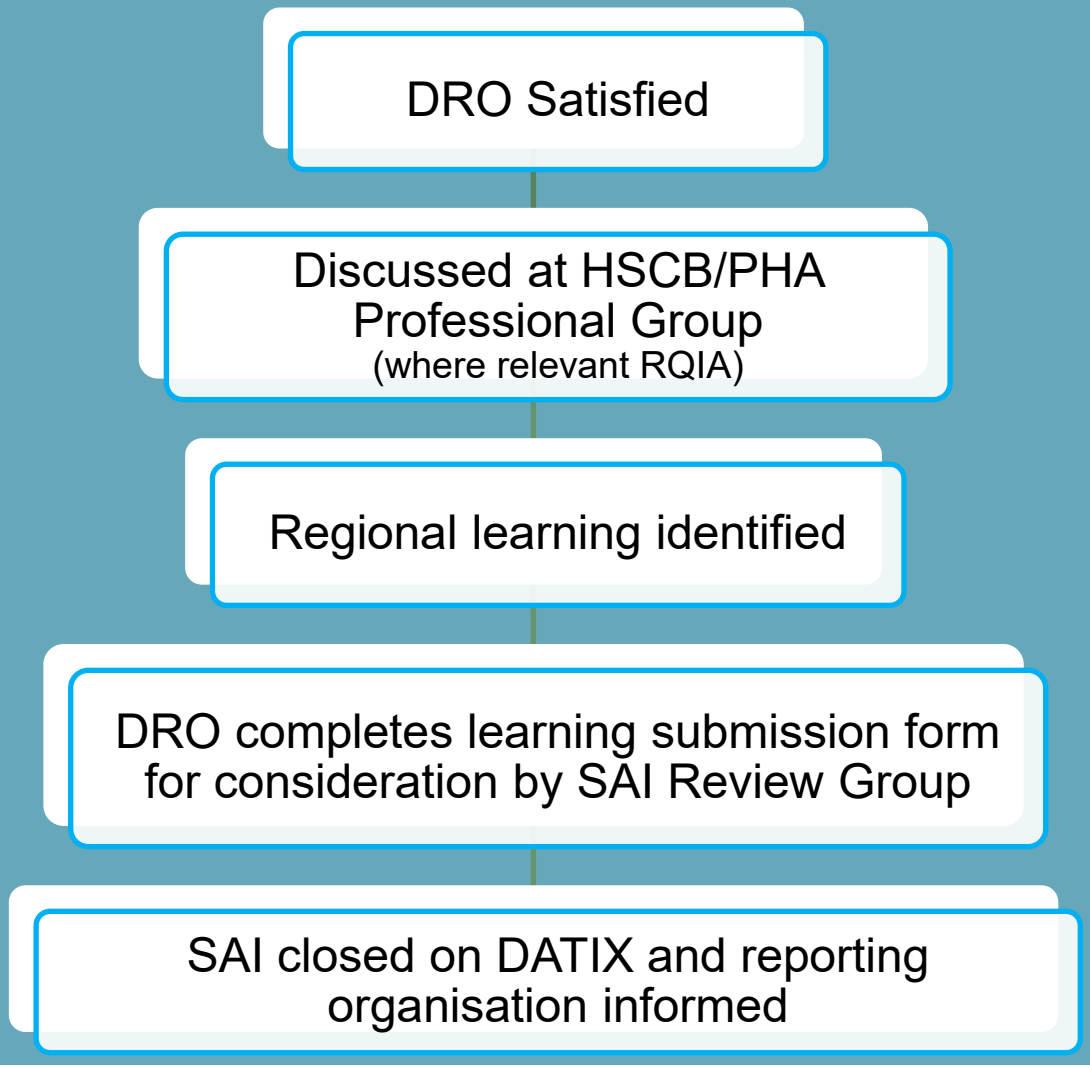
- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where a DRO believes the SAI review is not being undertaken at the appropriate level
- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;
- reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);
- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 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.
- HSCB do not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.



Overview of key stages of process

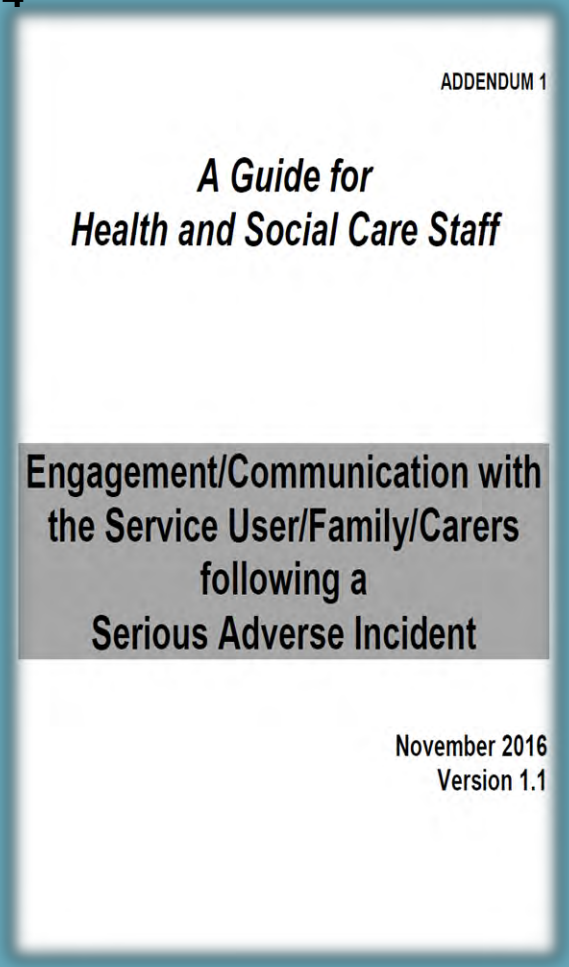


SAI Review Report Received



Open & Transparent

- Direction of DoH
  - Guidance for HSC organisations when involving service users/families throughout the SAI process – January 2015
- Incorporated into the 2016 procedure – Addendum 1

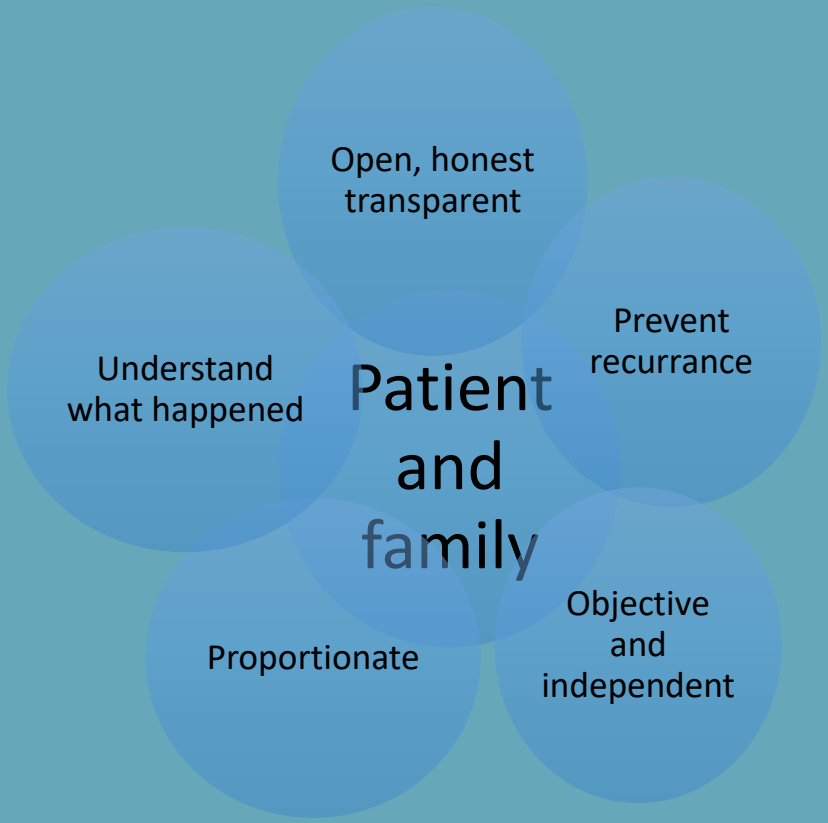

ADDENDUM 1

A Guide for
Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

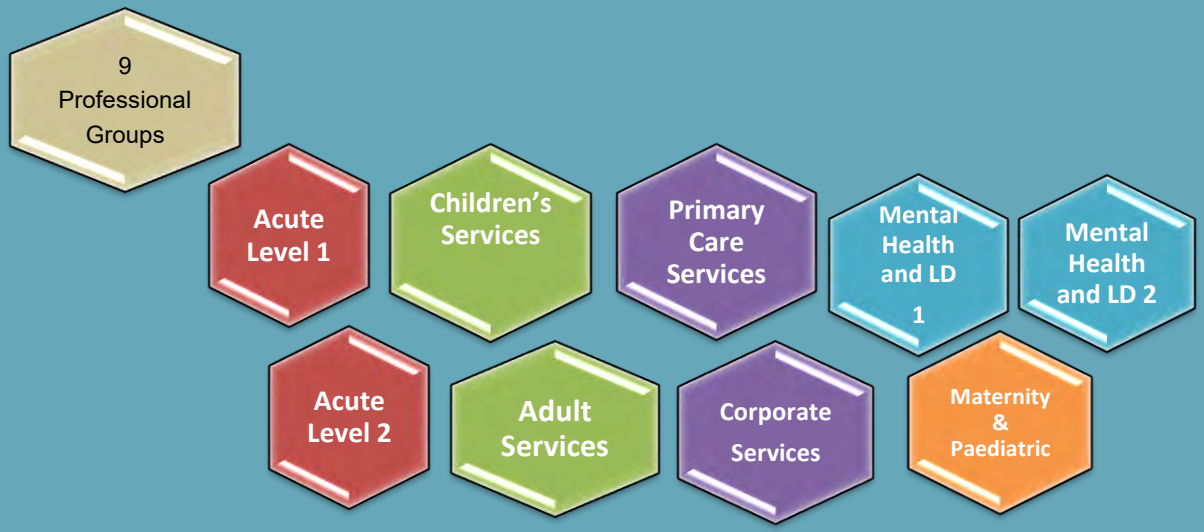
Patient/ Family at centre



What next when report received?

- Reviewed by DRO
- Discussed at professional group for programme of care
- Any issues communicated back to HSCT
- Regional learning identified
- Preparation and dissemination of learning

Professional groups



Shared learning

- The key aim of SAI review is to do things better and reduce the risk of incident recurrence across health and social care. The dissemination of learning following an SAI is central to achieving this and to ensuring shared lessons are embedded in practice and the safety and quality of care provided.

Confidentiality

- It is vital throughout this process that confidentiality is preserved, whilst at the same time ensuring that opportunities to improve services are shared throughout the wider health care system. Therefore, as part of our process to improve quality, we may share the anonymised content of the SAI report with other health and social care organisations.

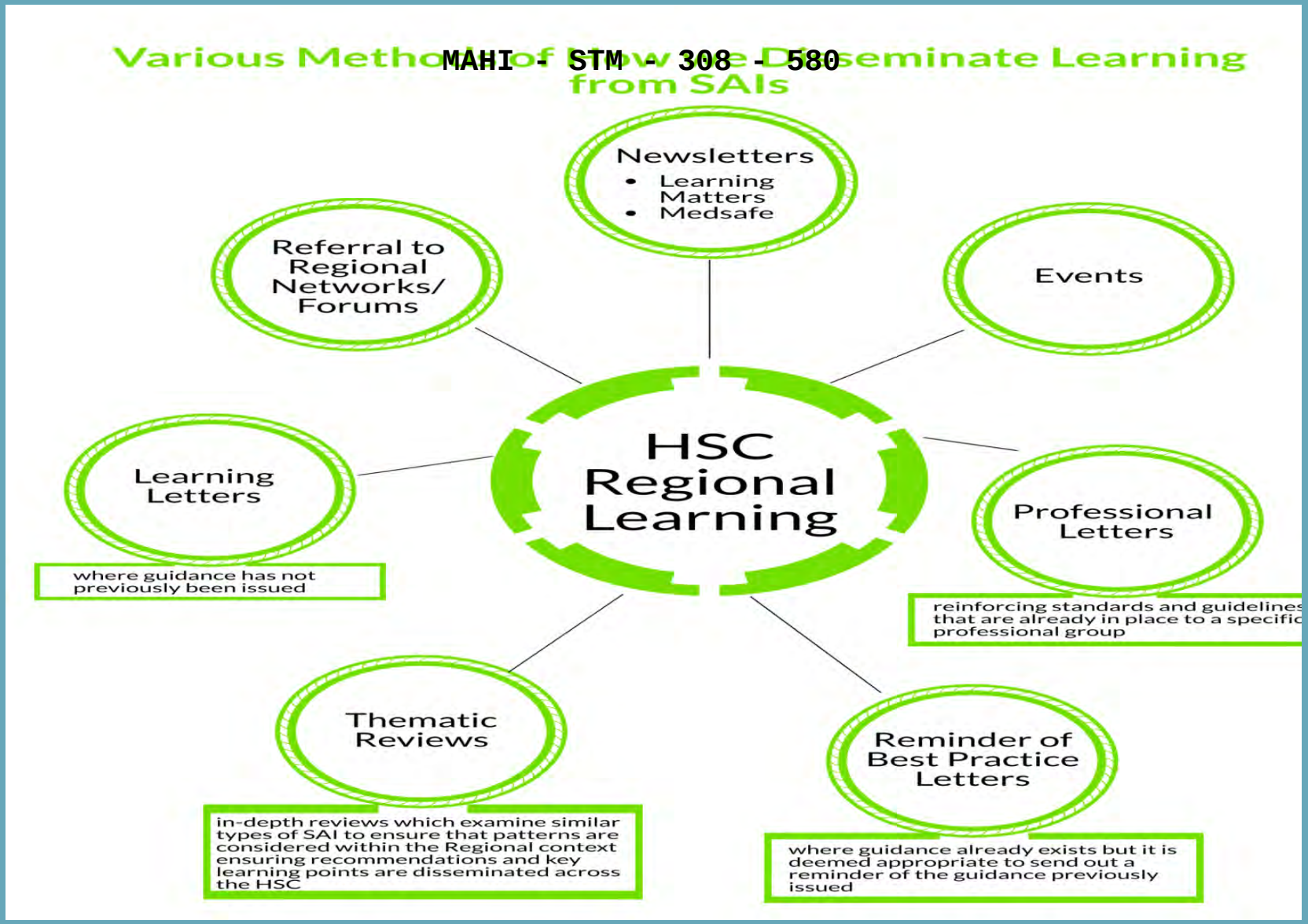
Approval of Regional Learning

Decided by DRO/ professional groups

Referred to Quality, Safety and Experience (QSE) group or Safety Quality Alerts Team (SQAT)

Learning approach agreed depending on the type of learning identified.

Urgent/immediate learning identified the DRO will take forward in conjunction with the relevant HSCB/PHA professional Director


Various Methods of How We Disseminate Learning from SAIs
Newsletters
Learning Matters
Medsafe
Referral to Regional Networks/ Forums
Events
HSC Regional Learning
Learning Letters
where guidance has not previously been issued
Professional Letters
reinforcing standards and guidelines that are already in place to a specific professional group
Thematic Reviews
in-depth reviews which examine similar types of SAI to ensure that patterns are considered within the Regional context ensuring recommendations and key learning points are disseminated across the HSC
Reminder of Best Practice Letters
where guidance already exists but it is deemed appropriate to send out a reminder of the guidance previously issued

Regional SAI Learning Approaches

Disseminate	Implement/Embed	Inform Others
• Learning/Reminders of Best Practice • Learning Matters Newsletter • Medicine Safety Matters Newsletter • GMS Newsletter	• Within organisations • Through existing work stream or established group • Establish a task and finish group	• Commission or organise training event or workshop

Thank you

SAFETY AND QUALITY LEARNING LETTER

Subject	**[Insert title]**
HSCB ref number	**[For Alerts Office use Only]**
Programme of care	**[Insert programme/s of care the letter is applicable to]**

LEARNING SOURCE **[Indicate learning source by inserting ✓ as appropriate]**			
SAI/Early Alert/Adverse incident		Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

Below is an example of some points to be included in a Learning Letter regarding summary of event, which should be anonymised

- Provide brief background to the event(s) leading to the issue of the learning letter for regional learning i.e. SAI Report(s) / Complaint(s) / Audit or other review / Coroner's inquest / or other.

- Provide brief detail on the main factors which contributed to the incident(s).

For your referral examples of previously issued Learning Letters can be accessed on the HSCB intranet via the following link

http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html

TRANSFERABLE LEARNING

Below is an example of some points to be included in a Learning Letter regarding transferrable learning:

- Identify the range of staff to take note of the transferrable learning.
- Provide transferrable learning points for each staff group to take note of the transferrable learning.

ACTION REQUIRED

Below is an example of some points to be included in a Learning Letter regarding Action Required:

- Identify what organisations are required to take action.
- Identify what actions are to be undertaken by each organisation.

For example:

(1) Ask for confirmation that the letter has been disseminated to the staff groups named in the Transferable Learning Section, and other relevant staff and state a timescale for this i.e. immediate.

(2) Detail any assurances required by the organisation.

(3) Detail a response date to be returned to the Central Co-ordination Office Alerts In-Box at alerts@hscb.hscni.net
i.e. please confirm by {Insert date} to alerts@hscni.net that actions have been completed.

Date issued		
Signed:		
Issued by		

MAHI - STM - 308 - 585

RE: **[Insert title] – Distribution List – [insert ✓ as appropriate]**

	To – for Action	Copy	PHA	To – for Action	Copy
HSC Trusts			CEX		
CEXs			Acting Director of Public Health		
First point of contact			Interim Director of Nursing, Midwifery and AHPs		
			Director of HSCQI		
NIAS			AD Service Development, Safety and Quality		
CEX			PHA Duty Room		
First point of contact			AD Health Protection		
			AD Screening and Professional Standards		
RQIA			AD Health Improvement		
CEX			ADs Nursing		
Director of Quality Improvement			AD Allied Health Professionals		
Director of Quality Assurance			Clinical Director Safety Forum		
NIMDTA			**HSCB**		
CEX / PG Dean			CEX		
QUB			Director of Integrated Care		
Dean of Medical School			Director of Social Services		
Head of Nursing School			Director of Commissioning		
Head of Social Work School			Alerts Office		
Head of Pharmacy School			Interim Director of PMSI		
Head of Dentistry School			**Primary Care (through HSCB Integrated Care)**		
UU			GPs		
Head of Nursing School			Community Pharmacists		
Head of Social Work School			Dentists		
Head of Pharmacy School			GP Out-of-hours services		
Head of School of Health Sciences (AHP Lead)			Dispensing GPs		
Open University					
Head of Nursing Branch			**BSO**		
			Chief Executive		
Clinical Education Centre					
NIPEC			**DoH**		
NICPLD			CMO office		
NI Medicines Governance Team Leader for Secondary Care			CNO office		
NI Social Care Council			CPO office		
Safeguarding Board NI			CSSO office		
NICE Implementation Facilitator			CDO office		
Coroners Service for Northern Ireland			Safety, Quality and Standards Office		

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	**[Insert title]**
HSCB reference number	**[For Alerts Office use only]**
Programme of care	[Insert programme/s of care the letter is applicable to]

LEARNING SOURCE **[Indicate learning source by inserting ✓ as appropriate]**			
SAI/Early Alert/Adverse incident		Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

Below is an example of some points to be included in a Reminder Letter regarding the summary of event, which should be anonymised

- Provide brief background to the event(s) leading to the issue of the reminder letter for regional learning i.e. SAI Report(s) / Complaint(s) / Audit or other review / Coroner's inquest / or other.
- Provide brief detail on the main factors which contributed to the incident(s).

For your referral examples of previously issued Reminder Letters can be accessed on the HSCB intranet via the following link

http://insight.hscb.hscni.net/safety/safety-and-quality-best-practice-reminder-letters/

REQUIREMENTS UNDER CURRENT GUIDANCE

Below is an example of some points to be included in a Reminder Letter regarding requirements under current guidance:

- Identify the range of staff to take note of the current guidance.
- Provide points on current guidance for each staff group to take note of.

ACTION REQUIRED

Below is an example of some points to be included in a Reminder Letter regarding Action Required:

- Identify what organisations are required to take action.
- Identify what actions are to be undertaken by each organisation.
  For example:

  (1) Ask for confirmation that the letter has been disseminated to the staff groups named in the '**Requirements Under Current Guidance'** Section, and other relevant staff.
  (2) Detail any assurances required by the organisation.
  (3) Detail a response date to be returned to the Alerts Office at alerts@hscb.hscni.net i.e. please confirm by {Insert date} to alerts@hscni.net that actions have been completed.

Date issued			
Signed:			
Issued by			

MAHI - STM - 308 - 588

RE: [Insert title] – Distribution List – [insert ✓ as appropriate]

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
First point of contact			Acting Director of Public Health		
			Interim Director of Nursing, Midwifery and AHPs		
NIAS			Director of HSCQI		
CEX			AD Service Development, Safety and Quality		
First point of contact			PHA Duty Room		
			AD Health Protection		
RQIA			AD Screening and Professional Standards		
CEX			AD Health Improvement		
Director of Quality Improvement			ADs Nursing		
Director of Quality Assurance			AD Allied Health Professionals		
			Clinical Director Safety Forum		
NIMDTA					
CEX / PG Dean			**HSCB**		
QUB			CEX		
Dean of Medical School			Director of Integrated Care		
Head of Nursing School			Director of Social Services		
Head of Social Work School			Director of Commissioning		
Head of Pharmacy School			Alerts Office		
Head of Dentistry School			Interim Director of PMSI		
UU					
Head of Nursing School			**Primary Care (through Integrated Care)**		
Head of Social Work School			GPs		
Head of Pharmacy School			Community Pharmacists		
Head of School of Health Sciences (AHP Lead)			Dentists		
Open University			Dispensing GPs		
Head of Nursing Branch			**BSO**		
			Chief Executive		
Clinical Education Centre					
NIPEC			**DoH**		
NICPLD			CMO office		
NI Medicines Governance Team Leader for Secondary Care			CNO office		
NI Social Care Council			CPO office		
Safeguarding Board NI			CSSO office		
NICE Implementation Facilitator			CDO office		
Coroners Service for Northern Ireland			Safety, Quality and Standards Office		

Welcome to Learning Matters
Special Edition 15
January 2021

LEARNING MATTERS

Reducing the risk of oxygen tubing being connected to air flowmeters

Introduction

Severe harm or death can occur if medical air is accidentally administered to patients instead of oxygen. There has been a **significant increase** in the number of incidents reported regionally, where the patient has been inadvertently connected to medical air rather than oxygen. Nine serious adverse incidents (SAIs) have been reported by HSC Trusts since April 2020.

Unintentional connection of a patient requiring oxygen to an air flowmeter has been classified as a **Never Event** since 2018. This applies when a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter (NHS Improvement, 2018).

NHS Improvement Patient Safety Alert

In 2016, NHS Improvement issued a Patient Safety Alert (PSA) ***Reducing the risk of oxygen tubing being connected to air flowmeters*** available here: https://tinyurl.com/air-oxygen

Reminders of the above letter were reissued to HSC Trusts in June and December 2020, due to the regional rise in SAIs/Never Events related to oxygen tubing being connected to air flowmeters

Impact of the COVID-19 pandemic on the rise in SAIs/Never Events

During the COVID-19 pandemic there has been an increase in the number of patients requiring oxygen and along with staff redeployment, these may be key **contributory factors** that have led to the notable rise in SAIs/Never Events across HSC Trusts from April 2020. It is therefore vitally important that all staff, including those redeployed due to COVID-19 are fully inducted into the ward environment and made aware of the NHS Improvement PSA **Reducing the risk of oxygen tubing being connected to air flowmeters.**

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LEARNING MATTERS

Health and Social Care

QUALITY 2020

Learning from SAIs/Never Events

In one of the reported SAIs/Never Events, the moveable flowmeter flap fitted to air flowmeters, which aims to provide an additional visual cue was in place, however it **did not** prevent the error occurring and the patient was inadvertently connected to air instead of oxygen. It is therefore important to recognise that the visual moveable flap is an error-reducing solution **rather than** an error-proofing solution **(see figure 1).**

Differentiating medical air outlets from oxygen outlets

As below in Figure 2, medical air outlets and oxygen outlets are located beside each other but the outlet connections are different. Air flowmeters are coloured black and oxygen flowmeters are coloured white in the UK and Europe to differentiate them (HSIB, 2019)

Figure 3 provides detail of the various components of a flowmeter

Figure 1
AIR FLOWMETER WITH MOVEABLE FLAP

Figure 2
OXYGEN AND AIR FLOWMETERS

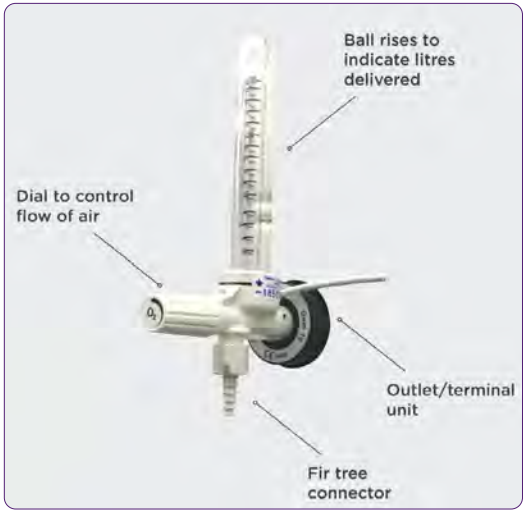

Figure 3
COMPONENTS OF A FLOWMETER

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LEARNING MATTERS

Equipment Design

As seen in figures 2, 3 and 4, air and oxygen flowmeters have identical universal fir tree connectors, meaning medical gas tubing can fit on either, which is an additional equipment design issue that makes it easy for error to occur.

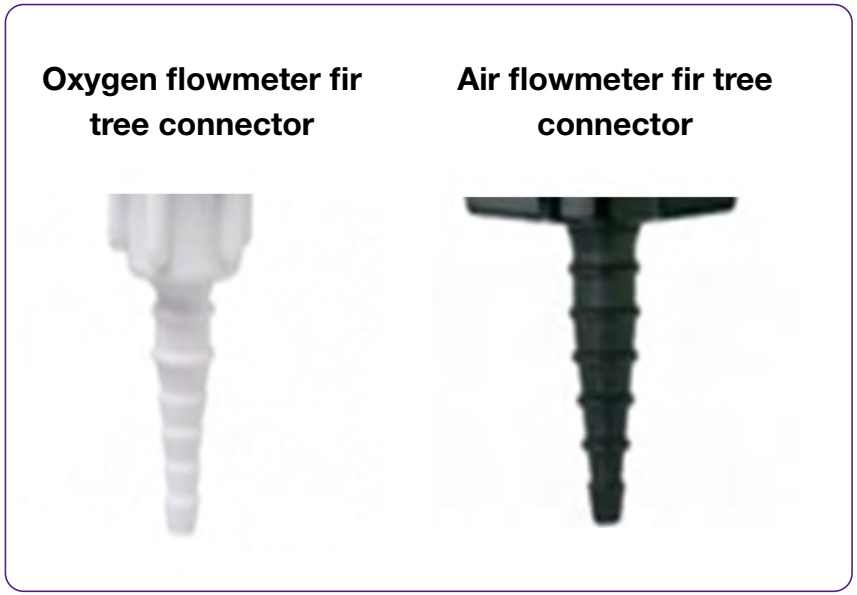

Figure 4
FIR TREE CONNECTORS – OXYGEN AND AIR

Barrier methods to reduce potential for error

Three distinct barriers to error have been recommended by the National Patient Safety Agency and British Thoracic Society (BTS).

1. **Medical air terminal units (wall outlets) are covered with designated caps in areas where there is no need for medical air.** (Figure 5)
   Medical air outlets were traditionally built into most clinical areas for the delivery of nebulised treatment but not all areas need them (e.g. they never have patients who need nebulisers, or they have access to electrically driven compressors or ultrasonic nebulisers).

2. **Medical air flowmeters are removed from terminal units (wall outlets) and stored in an allocated place when not in active use.**
   Removing unnecessary equipment is a more effective method of reducing human error than adding labels or warnings alone.

3. **Air flowmeters are fitted with a labelled, movable flap.** (Figure 1)
   The lettering on the flap is larger and more visible than on the flowmeter itself and this flap has to be lifted to attach a tube. This acts as a further barrier to unintended connection if staff occasionally forget to remove medical air flowmeters after a period of active use. This will provide visual and tactile prompts but may not be sufficient to prevent all errors.

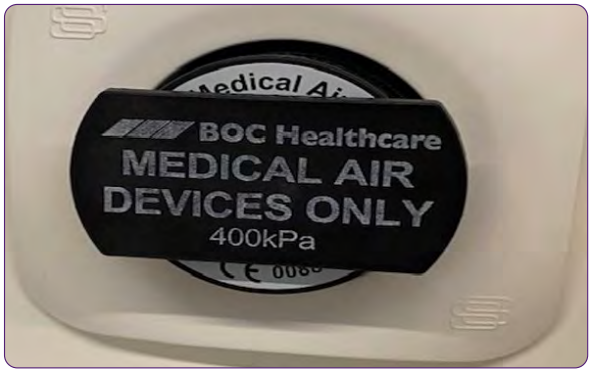

Figure 5
DESIGNATED MEDICAL AIR DEVICES ONLY CAP

LEARNING MATTERS

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HSC Health and Social Care

QUALITY 2020

KEY LEARNING

- The three barrier methods described above should ALL be in place in ALL relevant clinical areas
- Oxygen and medical air and use of barrier methods should be included in safety briefings and staff huddles
- Oxygen and medical air safety, including Medical Gases Safety training should be included in induction and training programmes for relevant staff working in clinical areas, including those who have been redeployed during the COVID 19 pandemic
- Failure of oxygen saturation levels to respond to treatment/therapy may indicate that insufficient oxygen has been given, the patient has deteriorated clinically or that there is a problem with the oxygen delivery system (HSIB, 2019)

Useful Resources:

NHS Improvement Patient Safety Alert Reducing the risk of oxygen tubing being connected to air flowmeters, 2016 and Supporting information.

https://www.england.nhs.uk/publication/patient-safety-alert-reducing-risk-oxygen-tubing-being-connected-air-flowmeters/

These resources include a short video animation.
https://youtu.be/17HkUck0bzQ

Healthcare Safety Investigation I2018/017, Feb 2019
https://www.hsib.org.uk/investigations-cases/piped-supply-medical-air-and-oxygen/

References

1. Department of Health (2018) HSC Revised Never Events List https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-36-18.pdf
2. Healthcare Safety Investigation Branch (2019) Piped Supply of Medical Air and Oxygen. Healthcare Safety Investigation I2018/017 https://www.hsib.org.uk/documents/89/hsib_report___piped_supply_medical_air_oxygen.pdf
3. NHS Improvement (2016) Patient Safety Alert: Reducing the risk of oxygen tubing being connected to air flowmeters https://tinyurl.com/air-oxygen

Editorial team:
Jackie McCall, Denise Boulter, Anne-Marie Phillips, Angela Carrington, Eugene Doherty

MUCKAMORE ABBEY HOSPITAL HSC ACTION PLAN

June 2021

INTRODUCTION

The independent Serious Adverse Incident (SAI) review report into safeguarding at Muckamore made for stark reading. It exposed not only significant failings in the care we provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities. In short, it told us that, while we have achieved much through Bamford, there is much more we need to do.

This is our response, and sets out exactly what we now must do. It recognises that the events at Muckamore have caused much distress for the patients receiving treatment in the hospital and their families and carers, and has also damaged wider public confidence in how the HSC system provides care, treatment and support to people with a learning disability and their families. The measures set out in this document are intended to address the issues that the SAI report highlighted, but also to provide wider assurance to society that the HSC system is working together in a co-ordinated way to make life better for people with a learning disability.

As the Permanent Secretary made clear when he met with all HSC Chief Executives in January this year, we must effect lasting change, with reference to every single recommendation in the SAI report. It is right that this report acts as our barometer, and the success of our efforts should be measured against it.

This document therefore sets out what we are doing and plan to do in response to its call to action. Specifically, it reiterates the overarching recommendation of the report endorsed by the Permanent Secretary that Muckamore must return to being a hospital not a residential facility. This will require a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs.

This timeline will be monitored closely by the Muckamore Departmental Assurance Group, which will include representation from the HSCB, PHA, RQIA, the 5 Trusts, professional representatives, specialist accommodation providers, appropriate academic expertise and importantly the families of patients, which will also ensure the team in Muckamore and the wider community services have the necessary support and resources in place to achieve these goals. A first but critical step will be to develop and deliver enhanced services in the community to source, support and sustain people in the places where they live. This will be the key role of the Regional Learning Disability Operational Delivery Group led by the Health and Social Care Board.

However, this document also recognises that more actions will follow as we progress the co-production of a new service model for learning disability as part of our transformation agenda. When developed, this will bring with it a new set of actions to consult on and implement.

We are also conscious that the police investigation into the unacceptable events at Muckamore Abbey Hospital is still ongoing. We await the outcome of that investigation and will be ready to take any additional actions to ensure that lessons are learned and put into practice across the full spectrum of learning disability services in Northern Ireland.

In this context this plan should be considered a live document which will be subject to ongoing review and development to drive further and emerging improvements to current practice.

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INDEX

RAG Rating	
Completed	
Work in progress	
Progress required	

SECTION A

COMPLETED ACTIONS

Permanent Secretary commitments						
PS1		**HSCB / PHA**	**A3**	By **March 2021**, complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes.	**Acute Care Review**	
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**DOH**	**A4**	By 31 **August 2019**, establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming	**Governance**	

				Minister) that the resettlements commitments and recommendations of the SAI report are met (see full governance structures associated with this plan at **Annex A**).		
PS1		**DoH/DoJ**	**A9**	By **31 December 2019,** provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.	**Governance**	
PS1		**HSCB/HSC Trusts**	**A10**	By **30 December 2020**, review current forensic LD services, identify and address service development needs to support people in community settings.	**Service Model**	
SAI Independent Review Panel recommendations						
R1.	Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities	**HSCB/PHA**	**A11**	By **December 2020,** deliver a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time, in the right place;	**Service Model**	

R.2	and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course. An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully			along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on implementation. **Postscript-April 2021** We Matter' Learning Disability Service Model, a High Level Consultation Summary, live Strategic Delivery Plan and an Equality Screening (which is currently under way) will be submitted to DoH on 14th May.		

	addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.					
	Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables	**HSCB/HSC Trusts**	**A15**	By **30 June 2020** review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex needs.	**Accommodation**	

	existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.					
		HSCTS	**A16**	By **31 December 2019** address security of tenure of people with a learning disability living in supported housing.	**Accommodation**	
		HSCTs	**A17**	By **31 March 2020** complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD.	**Accommodation**	
SAI Patients families recommendations						

R4.	Families and advocates should be allowed open access to wards and living areas.	**Belfast, Southern and Western Trusts.**	**A19**	Co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey).	**Service Model** **(Assessment & Treatment)**	
R5.	There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	**Belfast, Southern and Western Trusts.**	**A20**	By **30 June 2020,** carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.	**Service Model** **(Assessment & Treatment)**	
R6.	The use of seclusion ceases.	**DOH**	**A22**	By **March 2021,** develop a co-produced and publish regional seclusion and restraint policy/guidance**.**	**Governance** **(Mental Health Action Plan)**	
R8.	People with learning disabilities and their families are acknowledged to have a	**Belfast Trust**	**A24**	By **31 December 2019,** review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are	**Service Model**	

	critical and ongoing role in designing individualised support services for their relatives.			fully involved, taking account of lessons emerging from Independent Review into Dunmurry Manor.		
R11.	Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	**Belfast Trust**	**A27**	By **31 October 2019,** provide an information booklet to families on the complaints process.	**Governance**	
R12.	Families receive regular progress updates about what is happening as a result of the review.	**Belfast Trust**	**A28**	By **31 October 2019,** a schedule of Trust meetings with families will be produced and circulated to families.	**Governance**	
SAI Senior Trust staff recommendations						
R16.	A shared narrative is set out.	**HSCB/ PHA/HSC Trusts**	**A33**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set	**Service Model**	

				out the road map for regional adult learning disability services in the future.		
R18.	The transformation required in learning disability services must be values driven and well led.	**HSCB/ PHA/HSC Trusts**	**A35**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with people with learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.	**Service Model**	
R19.	The purpose of all our services is clear.	**HSCB/ PHA/HSC Trusts**	**A36**	By **December 2020,** the LD Service Model Transformation project will inform the development of a regionally consistent model for community and acute services and will provide clarity around purpose.	**Service Model**	
R23.	Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	**HSCB/ PHA/HSC Trusts**	**A42**	By **December 2020** the LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning disability, carers, and families. The future model for LD	**Service Model**	

				services will be designed around their aspirations, and will ensure effective structures are in place on an ongoing basis to fully operationalise this commitment.		
R24.	Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.	**DoH/HSCB/ PHA/HSC Trusts**	**A43**	By **December 2020,** all parts of the HSC will have been involved in the development of the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent, whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.	**Service Model**	
LG4	The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the	**HSCB/PHA**	**A47**	This was taken to HSCB/PHA Quality, Safety and Experience meeting on 3/2/21.QSE were asked to discuss potential mechanism to seek Trust assurances. It was agreed that this will be listed for discussion at the quality, safety and experience meeting with Trusts.		

	Trust Board.					
LG5	Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.	**HSCB/PHA**	**A48**	This work has been actioned by HSCB and is progressing and is being led by the Governance Lead in HSCB.		

SECTION B

RESETTLEMENT

Permanent Secretary commitments						
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**HSC Trusts**	**A1**	By **30 November 2019** carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing contingency plans for their patients, including updated discharge plans for each individual assessed as medically fit for discharge, with a target date for the individuals' discharge, a timeline to deliver appropriate high quality placements matching each individual's assessed needs and identifying any barriers to discharge. **June 2021 update** New community development opportunities have been identified within the NHSCT – placements to be made	**Resettlement**	

				available across Trusts.		
PS1		**HSCB/HSC Trusts**	**A2**	By **30 November 2019** develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge. **Linked to A1.** **June 2021 update** Work is continuing as per April 2021 update: The Regional Learning Disability Operational Delivery Group (RLDODG) continues to meet to consider obstacles to resettlement. The dash board provides the updated situation, and a summary of the current Resettlement status of the remaining MAH in-patients, including indicative timescales, was collated by each Trust and presented to MDAG in April 2021(paper MDAG/07/21	**Resettlement**	

				refers). All Trusts have updated resettlement plans and shared with HSCB.		
noPS1		**DoH/HSCB/HSC Trusts**	**A7**	By **30 September 2020,** in conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability. **June 2021 update** Work is continuing as per April 2021 update: Trusts continue work to scope potential new developments and attract new independent sector providers. The RLDODG continues to meet on a monthly basis to progress solutions. This is complemented by the work	**Resettlement**	

				completed in the Regional Housing Needs assessment and a Regional Procurement task and finish Group to procure enhanced domiciliary care services for those with complex needs. This work is ongoing and will be until resettlement is completed.		

SECTION C

WORKFORCE

Permanent Secretary commitments						
PS1		**DOH/HSCB/HSC Trusts**	**A5**	By **30 September 2021,** develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care e.g. Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by June 2022 deliver training to an agreed cohort of staff. **June 2021 update** Comments have been received and considered re the redraft of the Community Based Assessment and Treatment (CAT) for People with a learning disability and Complex Needs approach. The document is	**Workforce**	

				currently being revised. Further work is in progress.		
SAI Hospital Staff Recommendations						
R13.	An enhanced role for specialist nursing staff is set out.	**Belfast Trust**	**A29**	By **30 June 2020,** develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work. **June 2021 update** Delivering Care Work is ongoing.	**Workforce**	
		DOH	**A30**	By **June 2021,** complete a review of Learning Disability Nursing. **June 2021 update** Stakeholder events have been ongoing over the past three months and are almost complete. The review has been impacted by both pandemic related pressures and a change in review team capacity therefore it will not be possible	**Workforce**	Rating moved from amber to red.

				to have the review completed by the end of June 2021. Subject to capacity within the review team, it is anticipated that this review will be completed by early Autumn 2021.		
R20.	All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing.	**DoH**	**A37**	By **September 2021,** develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services. **June 2021 update** Work is continuing to establish a working group with an agreed ToR by September 2021 to progress the development of an evidence based workforce plan for LD services.	**Workforce**	

SECTION D

TRANSFORMATION: [SERVICE MODEL; ACUTE CARE REVIEW; ASSESSMENT & TREATMENT]

Permanent Secretary commitments						
PS1		**HSCB/PHA**	**A6**	By **31 March 2022,** commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent review of acute inpatient care. **June 2021 update** Comments have been received and considered re the redraft of the Community Based Assessment and Treatment (CAT) for People with a learning disability and Complex Needs approach. The document is currently being revised. Further work is in progress.	**Assessment & Treatment**	

PS1		**HSCB/HSC Trusts**	**A8**	By **March 2021,** in the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher tariff placements which specifies what staff and service requirements justify a higher tariff. June 2021 This action has now been remitted to HSCB having previously been allocated to DoH. HSCB MHLD, Older People and Adult Services are currently scoping this issue with Trusts to identify frameworks currently in place that could form the basis of a regional approach.	**Service Model**	
SAI Patients families recommendations						
R6.	The use of seclusion ceases.	**Belfast, Southern and Western Trusts.**	**A21**	By **31 January 2021,** complete an urgent review of seclusion policy and practice in MAH (and Lakeview and Dorsey), to inform wider consideration of regional	**Service Model** **(Assessment & Treatment)**	

				policy, and share outcomes with families. **June 2021 update** The Policy has now been updated incorporating the comments and feedback from the Equality Team. Legal advice was sought from DLS regarding the frequency of medical reviews which was reduced with approval by RQIA due to staffing challenges during Covid-19, the advice given was that the process should revert back to the level of checks pre-Covid-19. The policy is now being amended to reflect this. The BHSCT policy will be presented at the next Standards and Guidelines committee in August for sign off.		

SAI Senior Trust staff recommendations						
		HSCB/ PHA/HSC Trusts	**A38**	By **March 2022,** deliver community and home treatment services support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in the community where possible and only in hospital when indicated/necessary. **June 2021 update** Comments have been received and considered re the redraft of the Community Based Assessment and Treatment (CAT) for People with a learning disability and Complex Needs approach. The document is currently being revised. Further work is in progress	**Service Model** **(Assessment & Treatment)**	
R21.	The default "Friday afternoon and weekend admissions" to	**HSCB/PHA/ HSC Trusts**	**A39**	By **31 December 2019** support HSC Trusts to complete a regional review of admissions criteria and develop a regional	**Service Model** **(Assessment &**	

R22.	Muckamore Abbey Hospital have to stop. Time limited and timely Assessment and Treatment become the norm.			bed management protocol for learning disability services **June 2021 update** This needs to complement current work within Adult Mental Health Services and is dependent on the appointment of a bed manager. HSCB have reviewed the demand for this post and some discussion is required during MDAG meeting regarding ongoing need and whether there is potential for funding to be secured.	**Treatment)**	
		HSCB/HSC Trusts	**A40**	By **30 November 2019**, appoint a regional bed manager for all 3 current in-patient units. **June 2021 update** HSCB have reviewed the demand for this post and some discussion is required during MDAG meeting regarding ongoing need and whether there is potential for funding to be	**Service Model** **(Assessment & Treatment)**	

				secured.		
		HSCB/PHA/ HSC Trusts	**A41**	By **March 2022,** taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation. This should include community based assessment and treatment, clear thresholds for hospital admission and timely, supported discharge from hospital. (See Permanent Secretary commitments). **June 2021 update** Comments have been received and considered re the redraft of the Community Based Assessment and Treatment (CAT) for People with a learning disability and Complex Needs	**Service Model** **(Assessment & Treatment)**	

				approach. The document is currently being revised. Further work is in progress		

SECTION E

CHILDREN AND YOUNG PEOPLE

SAI Hospital Staff Recommendations						
		HSCB/PHA/ HSC Trusts	**A12**	By **March 2021** develop a regionally consistent pathway for children transitioning from Children's to Adult services, including: • People with learning disability and complex health needs. • People with Leaning disability and social care needs. • People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours. **June 2021 update** A training programme to support Building Better Futures is being planned. Transition is part of the Disability framework developed	**Children and Young People**	

				by HSCB with the 5 Trusts.		
		HSCB/PHA/ HSC Trusts	**A13**	By **31 December 2020** finalise and develop a costed implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services required to support them into adulthood. **June 2021 update** In view of the 1 year budget, potential progress will need to be reviewed.	**Children and Young People**	
		HSCB/PHA/ HSC Trusts	**A14**	By **31 December 2020** review the needs of children with learning disability that are currently being admitted to Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional review of children's residential services.	**Children and Young People**	

				June 2021 update The Disability Framework has been developed with the Trusts and is being presented to CSIB on Friday 18 June for final agreement. The Framework includes an action on developing a wider range of placements and developing a community model.		

SECTION F

GOVERNANCE

SAI Patients Families Recommendations						
R3	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	**Belfast Trust**	**A18**	Appoint a carers consultant and co-produce a communications strategy with parents and carers. **Completed** **June 2021 update** Interviews were held in May 2021 and an offer of appointment was made and accepted. The appointee will take up post following completion of employment checks.		
R9.	The Hospital's CCTV recordings are retained for at least 12 months.	**Belfast Trust**	**A25**	By **31 October 2019,** liaise with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation.	**Governance**	Rating moved from red to green

				June 2021 update CCTV footage is being retained via the current system therefore this action is complete. The Trust will continue to ensure that its CCTV system will deliver on this requirement going forward.		
R10.	Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	**Belfast Trust**	**A26**	By **30 November 2019** develop an information paper and share with families and staff. June 2021 update This is being taken forward via a carer contract which has been developed in conjunction with families on site. A further leaflet and advice is also under production by the ASG lead.	**Governance**	
R17.	Commissioners specify what "collective commissioning" means.	**HSCB**	**A34**	By **March 2021,** HSCB to write to BHSCT outlining the current position and status of commissioning for HSC	**Governance**	Rating moved from red to green

				Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor. **June 2021 update** Letter issued on 22 April 2021. This action can be closed off and changed to green.		

SECTION G

SAFEGUARDING

SAI Patients families recommendations						
R7. **R.14**	The perception that people with learning disabilities are unreliable witnesses has to change. Responses to safeguarding incidents and allegations are proportionate and timely.	**Belfast Trust**	**A23/A31**	By **30 June 2020,** complete a review of Adult Safeguarding culture and practices at MAH, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **June 2021 update (ASG Team provided)** CPEA recommendations included a major adult protection change programme in N. Ireland and consideration of an Adult Protection Bill. This work is being led by the DoH with the introduction of a new Adult Protection structure	**Safeguarding**	

				in N. Ireland. The Adult Protection Transformation Board, chaired by the Chief Social Work Officer, has been established and BHSCT are represented on this Board. The Transformation Board meets monthly. An Interim Adult Protection Board (IAPB) was established in February 2021 and an IAPB update is now a standing item on the Transformation Board agenda. DoH undertook a public consultation to inform the development of the Adult Protection Bill. The purpose of the new legislation is to introduce additional protection to strengthen and underpin the adult protection process. The consultation was open for 16 weeks (17 December 2020 to 8 April 2021). Analysis of the		

				responses to the consultation is currently ongoing. The intention is to bring the draft Bill forward early in the next mandate. The BHSCT will be guided by the Transformation Board and the IAPB regarding the priority actions to be taken forward.		
		HSCB	**A32**	By **December 2021,** carry out a review of regional Adult Safeguarding documentation, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **June 2021 update** The Interim Adult Protection Board has established a Procedures working group that will, in the first instance, review Joint Protocol procedures and	**Safeguarding**	

				documentation. Outcomes from the DOH current review of Adult Safeguarding policy will inform the group's future work-plan in relation to revised procedures/documentation.		

SECTION H

Leadership And Governance Review Recommendations						
LG1	The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.	**DOH**	**A44**	By March 2022, complete a review of the accountability arrangements for DSF. The HSCB are developing an outcomes based reporting template which will be the first stage of this process. In preparation for the Social Care Directorate moving into the Department following the closure of the HSCB in 2022, a review of the accountability arrangements for DSF will be undertaken.		
LG2	The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and	**DOH**	**A45**	The Department has carried out a fundamental review of the 2003 Order and the existing regulatory framework and has developed a new draft regulatory policy that includes the principles of regulation, along with the broad scope of services to be regulated and the		

	inspecting all hospital provision.			proposal that the regulator should have wider powers of enforcement etc. This work has been the first phase of the process and we intend to consult on the draft policy before moving on to phase 2, which will include the risk assessment of each provider type and consider the appropriate regulatory approach, including the range of enforcement and sanctions. Phase 2 will result in a clear regulatory framework and legislation and this framework will reflect Departmental Policy. A Departmental Reference group was established to enable relevant policy areas to be involved in the development of the draft regulatory policy in Phase 1 and to shape the regulatory framework in Phase 2. Minister approved the draft policy for consultation earlier this		

				year but the impact of Covid-19 and the subsequent refocus of Departmental priorities has meant that this work was paused in October, before the consultation was launched.		
LG3	The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.	**DOH**	**A46**	By June 2021, develop in partnership with patients, relatives and carers a plan for the future configuration of services to be delivered on the Muckamore Abbey Hospital site, including appropriate management arrangements.		
LG6	Specific care sensitive indicators should be	**HSCB/PHA**	**A49**	June 2021 update		

	developed for inpatient learning disability services and community care environments.			A meeting was held with Deputy CNO and Divisional Nurse to identify links to Nursing KPIs. The PHA MH/LD Nursing Team is to work with HSCB to develop MDT care sensitive indicators as part of the LDSM Health and Wellbeing key ambition as part of the delivery plan for LDSM.		
LG7	The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.	**Belfast Trust**	**A50**	By January 2021, complete disciplinary action in respect of first 7 individuals whose cases have been forwarded by PSNI to PPS. Action against a further 9 individuals will commence when PSNI confirm their cases have been forwarded to PPS. **June 2021 update** The Trust continue to progress Disciplinary action in line with employment law regulations.		Rating moved from amber to red.
LG8	The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is	**Belfast Trust**	**A51**	A Co-Director for Learning Disability services was appointed in June 2020. The dedicated Divisional Nurse post remains and a dedicated		

	recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.			Service Manager and two permanent dedicated Assistant Service Managers for the hospital have been appointed. Substantive appointments at Band 7 and Band 6 Ward Manager and Deputy Ward Manager level are being progressed. The Interim Director for Learning Disability Services will review the existing managerial arrangements as part of the Chief Executive's overall review of Directorate and Divisional structures which will take place in 2021.		
LG9	Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or	**Belfast Trust**	**A52**	By March 2021, complete a review of advocacy services. The Trust is engaging with representatives of Families Involved Northern Ireland (FINI) to develop Terms of Reference for a review of its advocacy arrangements. **June 2021 update** The Trust is progressing the identification of independent		Rating moved from amber to red.

	carers.			reviewers to complete this review using the Terms of Reference per April update.		
LG10	The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.	**Belfast Trust**	**A53**	The Trust have engaged with Mr B and written to him in an attempt to address his outstanding concerns. The resolution of these concerns is ongoing at this time and while every effort will be made to progress the investigation into the outstanding issues of concern, it is not at this stage possible to provide a definitive completion date. **June 2021 update** The Trust continues to engage with Mr B. regarding his complaint.		
LG11	In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.	**Belfast Trust**	**A54**	CCTV is currently used to inform and amend staff practice. Contemporaneous CCTV footage is independently viewed and the accounts of this footage, which reflects good practice and highlights any		

				areas for concern, are shared with staff. Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site. These questionnaires specifically asked for views on the proposed extension of the use of CCTV into areas such as training and practice development. Feedback from the questionnaires will inform next steps. **June 2021 update** Cross site discussions with staff and Trade Union colleagues are under way to address feedback from the questionnaires which highlight a number of questions and concerns from staff.		
LG12	The size and scale of the Trust means that	**Belfast Trust**	**A55**	The Trust Chief Executive is responsible for holding Trust Directors to account for		

	Directors have a significant degree of autonomy; the Trust should hold Directors to account.			achievement against their objectives, which are set on an annual basis and reviewed monthly (these are modified as issues arise). Directorate and Divisional management priorities, which are set, reviewed and reported on quarterly, are also in place as a framework for accountability. This is being supported by a developing quality management system (QMS) which will provide a comprehensive overview of the performance of the Directorates and Divisions across a range of agreed metrics. The transparency of performance articulated via the quality management system will facilitate the Trust Board to provide ongoing challenge throughout the year, rather than being responsive to issues escalated to it.		

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	15 April 2021
Title of paper	Annual Quality Report
Reference	PHA/03/04/21
Prepared by	Denise Boulter
Lead Director	Rodney Morton
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to approve the 2019/20 Annual Quality Report.

2 Background Information

Under PHA's Corporate Objective 4, "All health and wellbeing services should be safe and high quality", there is a target that produce an Annual Quality Report as part of its work in overseeing the implementation of the Quality 2020 Strategy.

There is a requirement from the DoH that the PHA in conjunction with the HSCB produce an Annual Quality Report outlining our commitment to improving quality.

3 Key Issues

This is the PHA and HSCB's seventh Annual Quality Report. It is a requirement from DoH that each organisation produce this report. It has grown from strength to strength each year. It contains a range of topics included from all Directorates which have been identified by relevant Directors which demonstrates from both a corporate and directorate point of view the length and breadth of our commitment to improving quality.

The report has been written under the following 5 strategic goals:

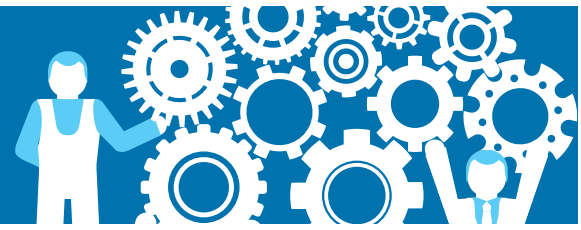
- Transforming the Culture
- Strengthening the workforce
- Measuring improvement

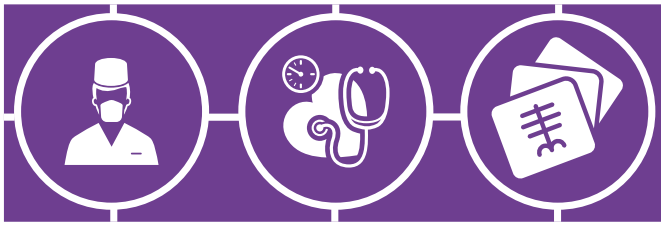
- Raising the standards
- Integrating the care

4 Next Steps

Following approval by the respective boards, the Annual Quality Report will be published on the HSCB and PHA websites.

Health and Social Care Board and Public Health Agency





Annual Quality Report
April 2019- September 2020

Health and Social Care Board

Public Health Agency

Foreword

Welcome to the seventh Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA). As Chief Executives we are pleased to share this report which outlines how we have improved the quality of health and social care services in line with our commitments set out in the Q2020 Strategy. Given the pressures created by Covid-19 completion of the annual report was deferred. This report covers the extended period April 2019 to September 2020.

The timeframe covered has been difficult for all of us but particularly for those impacted by COVID-19 and the report helpfully draws out how we have developed innovative solutions at pace to meet the significant challenges faced.

It is within this very challenging operating context the work undertaken to improve the quality, safety and experience of those who use Health and Social Care services is all the more remarkable.

We believe the report demonstrates not only how far we have come, but also our continued collective drive to achieving the vision of Quality 2020 against a background of increasing demands and unprecedented challenges. Looking to the future we are committed to delivering the highest standard of services, designed and implemented in partnership with those who use and work in our services.

In closing we would like to thank all Health and Social Care Staff for their commitment and dedication throughout the pandemic, we owe you a debt of gratitude.

Olive MacLeod
Chief Executive, PHA

Sharon Gallagher
Chief Executive, HSCB

Contents

Theme one

Transforming the culture

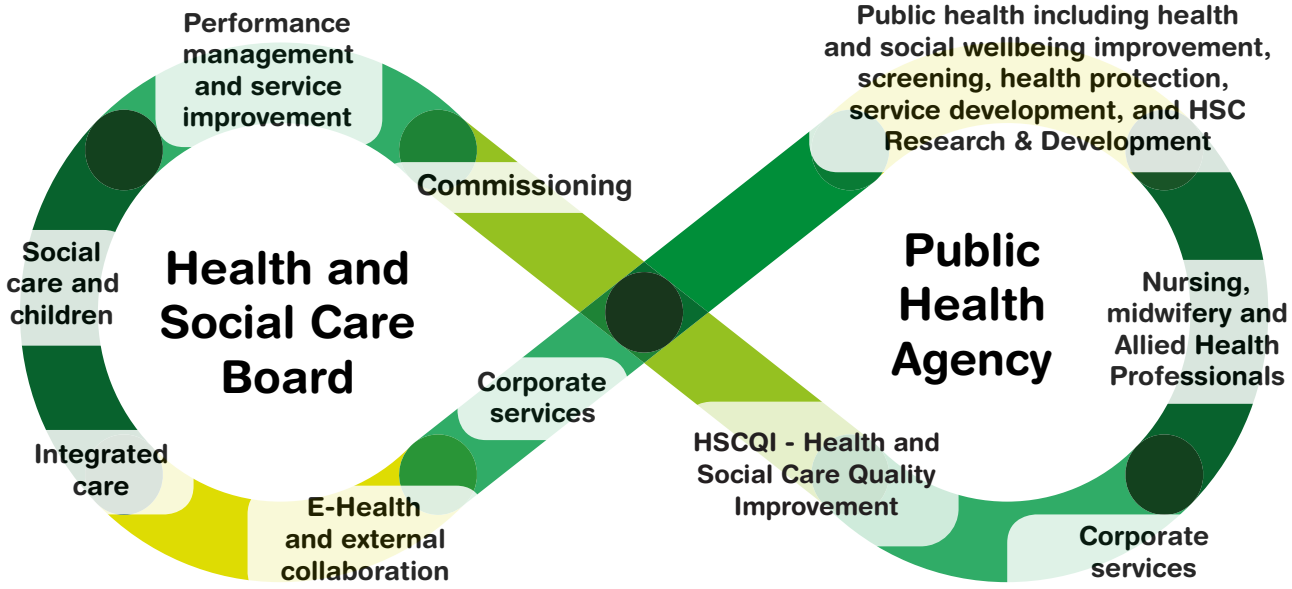
Transforming the culture

1.1 Introduction

The HSCB and PHA both recognise that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, and transparent and, in particular, patient and client focused. Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff and, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

1.2 Overview of HSCB & PHA

The HSCB and PHA are considered arm's-length bodies within HSC. Ensuring that services are safe, high quality, effective and meet people's needs is a core function of both the organisations, an objective which is outlined within each organisations corporate governance assurance framework. They continue to work collaboratively and focus on improving the quality of services delivered.

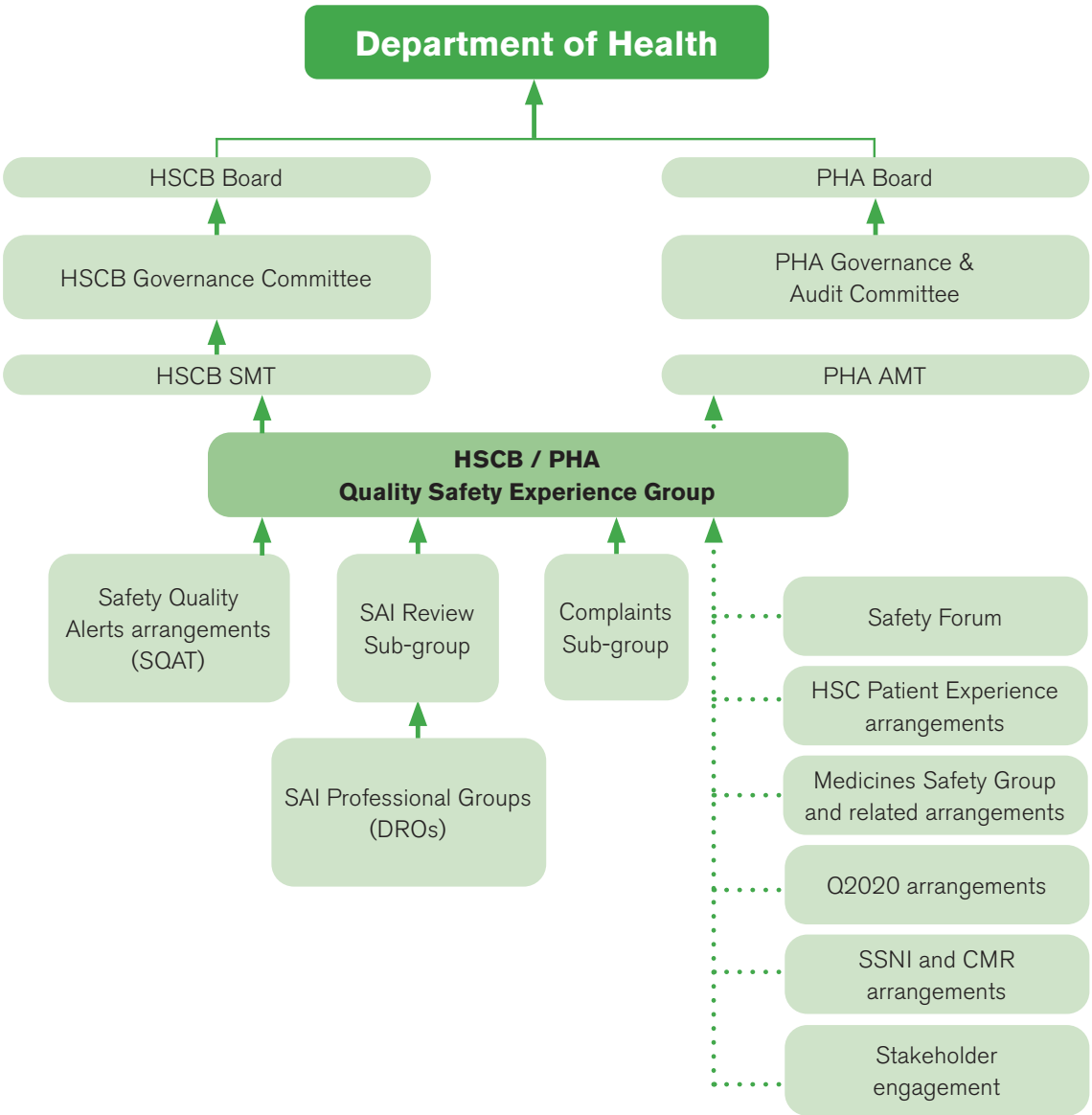


For further information relating to the HSCB and PHA's role, governance structure and the work that we do is available at:
http://www.hscboard.hscni.net/
http://www.publichealth.hscni.net/

1.3 Leadership and quality governance

Safety & quality governance

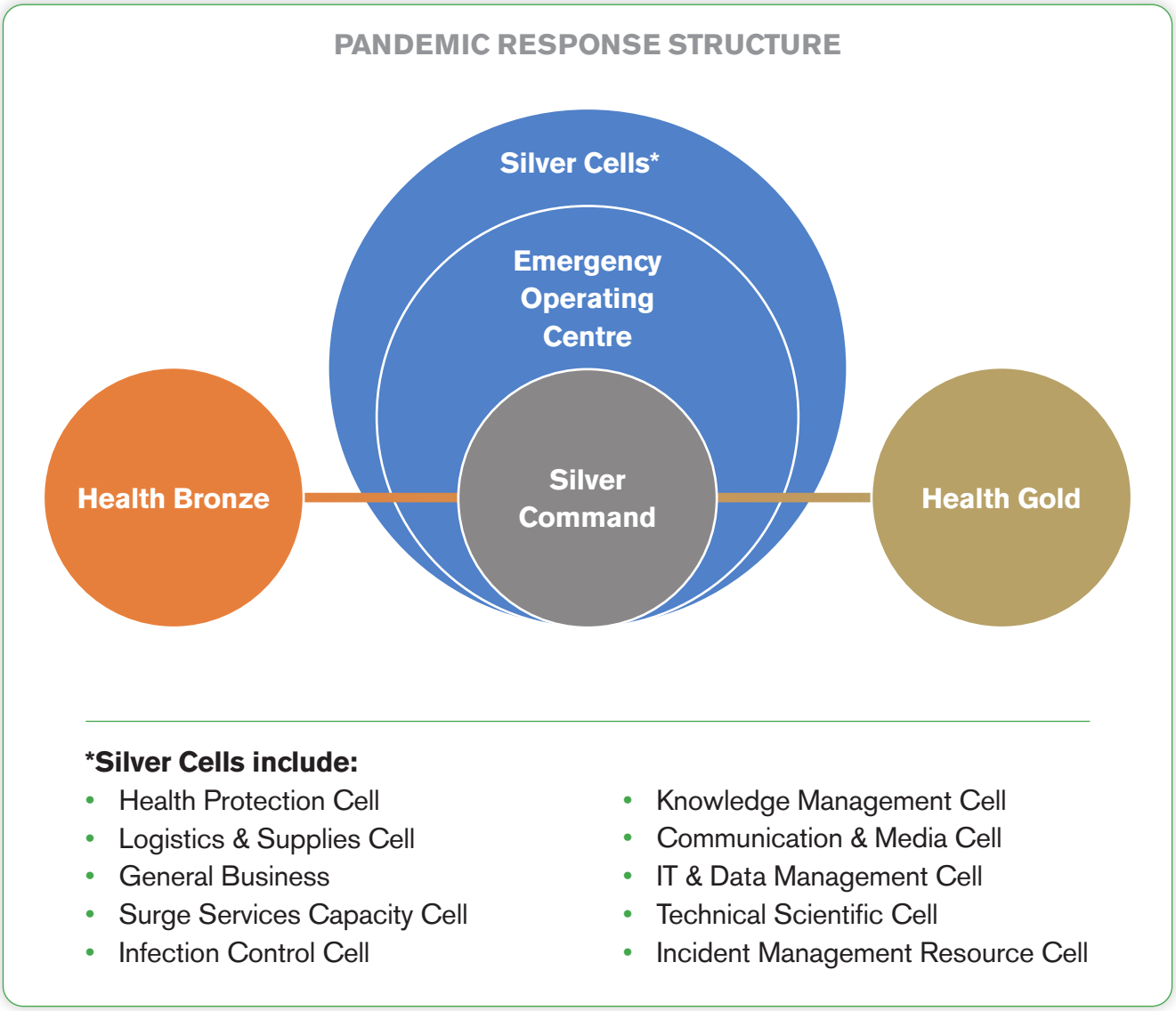
There are a number of core groups which oversee and provide governance on the quality of services commissioned or delivered by HSCB and PHA, outlined within the diagram. The **Quality, Safety and Experience (QSE) Group** provides an overarching structure whereby the HSCB and PHA can monitor and report on safety, effectiveness and the patient client experience to the respective Boards and committees. A range of groups; such as the Safety Quality Alerts Team, Regional Complaints Group, Serious Adverse Incident (SAI) Group, Designated Review Officer (DRO) professional groups and patient experience team, report to and support the work of QSE.



Transforming the culture

Leadership & governance in response to COVID-19

In February 2020 the HSCB and PHA put in place a structure to support the COVID-19 pandemic response based on the bronze, silver and gold approach



***Silver Cells include:**

- Health Protection Cell
- Logistics & Supplies Cell
- General Business
- Surge Services Capacity Cell
- Infection Control Cell
- Knowledge Management Cell
- Communication & Media Cell
- IT & Data Management Cell
- Technical Scientific Cell
- Incident Management Resource Cell

Transforming the culture

Further information:
Dr Aideen Keaney
Director HSCQI
Aideen.keaney@hscni.net

Joint PHA/HSCB Senior Management Team "Huddle"

During the Covid-19 emergency response the HSCQI Improvement Hub supported the PHA and HSCB joint emergency response to the COVID 19 pandemic by leading on the implementation of a joint PHA/HSCB Senior Management Team morning "Huddle". Using a QI approach, a "huddle" occurred on 18 mornings over the 10 week period (18th March 2020 – 18 May 2020). QI methodologies used included the Model for Improvement, Plan-Do-Study-Act cycles, Appreciative Inquiry and elements of Lean.

What is a "Huddle"?

Team Huddles are short meetings where each team member shares their key priorities for the day and important updates. These meetings keep team members informed of important information, help hold people accountable, and allow for sharing of collective information. Huddles are a key activity within Lean (Toyota Production System).

The approach

This "Huddle" approach was applied to the implementation of a joint PHA/HSCB Senior Management Team meeting in order to improve communication and action planning during the COVID-19 emergency pandemic response. Results demonstrated good participation from each of 15 PHA/HSCB silver supporting cells*. The "Huddle" allowed a structured approach to the communication of large volumes of activity contained in the action plans for each cell during a 40-50 minute morning meeting. Teamwork and communication between cells was demonstrated by the sharing of actions.

Feedback from appreciative inquiry to date has shown the usefulness of cell structures and the opportunities offered through a "Huddle" to see the "big picture", to work collaboratively within and across teams, directorates and organisations, thereby breaking down traditional organisational and professional boundaries.

This initiative demonstrates how, by using a Quality Improvement (QI) methodology, it was possible to implement a new meeting structure, one that many of the participants had never heard of nor participated in before. Applying a QI approach to this change enabled senior leaders from across both organisations to implement and adopt a new meeting format. This demonstrates the effectiveness of QI as an approach to leading and implementing change. During this 10 week period staff roles within both organisations continually evolved and the traditional stand up huddle approach had to be modified in order to take into account of social distancing and remote working.

The use of a QI approach to the implementation of a Huddle meeting during the emergency response of the COVID 19 pandemic is an approach which could be used to re-instate similar Huddle meetings as required in the future.

*Cells that support Silver Response within the Gold Silver Bronze emergency response.

A number of cells were established each with their own area of focus to support a response to the rapid moving environment relating to the emergence of the pandemic. An example of some of the work arising from the cell includes:

Transforming the culture

Infection Prevention Control (IPC) Cell

One of the main roles of the PHA / HSCB was a focus on infection prevention and control as COVID-19 began to spread in Northern Ireland. The work of the IPC cell involves overseeing the coordination of infection prevention and control across the HSC systems, Primary Care, including services provided by community, voluntary and independent sectors care providers. The Regional IPC Cell also has a link in the National IPC Cell. This cell is made up of representatives from across the Four Nations and it provides an opportunity to help shape and influence national guidance.

Personal protection equipment (PPE) helps protect those working in health and social care sectors. PPE covers a number of products which includes masks, visors and eye protectors, aprons and gowns. The UK government and devolved administrations have published clear guidance on appropriate PPE for health and social care workers. This has been written and reviewed by all four UK public health bodies and informed by NHS infection prevention control experts.

- Since the beginning of the COVID-19 pandemic in March 2020, over 261m PPE items have been procured to support HSC, including care homes. A Product Review Protocol has been developed between Infection Prevention and Control Leads (PHA and HSCTs), BSO and MOIC to assess all new PPE items to ensure they are suitable for use in healthcare settings.

During 2020, communication has been vital and regular meetings have taken place to discuss any IPC issues. These have included weekly Lead IPC Nurse Forum and Regional IPC cell meetings in which a wide range of IPC issues from across the region are discussed and resolved. An Outreach IPC Programme for Care Homes was also established and facilitated through HSCTs including the distribution of PPE.

In an effort to ensure regional consistency regarding the use and decontamination of reusable Respiratory Protection Equipment (RPE), a task and finish group has been established. The task and finish group is currently working on the development of a regional data specification with BSO.
An Expert Working Group has also been established to develop an implementation plan

Transforming the culture

for the PHE's COVID-19: "Guidance for the remobilisation of services within health and care settings which could potentially be linked to surge plans." This work continues and part of Northern Ireland's implementation plan may be informed by work being carried out in other regions.

The IPC Cell commissioned a 10,000 more Voices Survey of staff experience of PPE which closed at the end of September 2020. The report will be used to inform the approach to IPC policy and practice across Northern Ireland. A number of engagement meetings have also been undertaken with Trade Union colleagues to discuss important issues such as the IPC Product Review Group, fit testing, decontamination of PPE and FFP3 masks.

The impact of the IPC cell has been to improve early intervention in relation to the procurement and use of appropriate PPE which ensures safer systems of IPC throughout the pandemic.

261 million items
of PPE procured

250 items
reviewed through product review protocol

780 responses
to 10,000 Voices survey

"From the beginning of the pandemic, Integrated Care have found the advice and support coming from the IPC Cell invaluable. Without it there would be no formal link to any Infection Prevention Control team for Primary Care, Optometry, Dental and Pharmacy colleagues. The advice insured consistency across the region allowing colleagues on the frontline to feel safe and supported in appropriate PPE and ensuring their working environment was COVID secure."

Dr Gillian Clarke, GP Advisor, HSCB

Transforming the culture

Development of HSCQI Network March 2019 – September 2020

In early April 2019, the Department of Health formally launched the Health and Social Care Quality Improvement (HSCQI) body for Northern Ireland, expanding in scope and ambition on its predecessor organisation the HSC Safety Forum.

HSCQI is a network of improvers working across many areas of health and social care in Northern Ireland. HSCQI seeks to influence and be influenced by the HSCQI Leadership Alliance consisting of senior leaders in health and social care including the Chief Professional Officers, Chief Executives, Primary care leads and service user representation.

HSCQI aims to model the values and attributes the HSC aspires to, particularly enacting collective leadership, working together and openness in a patient and client-focused way. In particular, HSCQI has been tasked with developing and maturing an understanding of a learning system. The US based Institute of Medicine defines a learning system as a model where '*Science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience.*'

With a mandate from the HSCQI Leadership Alliance in the early part of summer 2020, a scoping exercise to identify 2-3 priorities to be applied to a learning system in the COVID-19 context were sought. Three areas were identified by members of the HSCQI network

Picture 1 – a blended approach to the scoping exercise for the learning system using ZOOM and in person approach to share, learn and develop together.

from across Northern Ireland: Virtual Visiting, Virtual Consultations and Staff Psychological Wellbeing and Safety. All three were regarded as important and providing purposeful value to the HSC both during the pandemic and as we sought to align to HSC rebuild and resilience efforts. Key examples of learning within these themes are being shared system wide through on-going project ECHO sessions.

In September 2020, the HSCQI Network were preparing to present their findings and examples in the three arenas to Minister Swann in early October with the intention to seek a mandate to work together as a network to mature a learning system that supports the HSC ambition to '*build back better*'.

The establishment of the HSCQI network has had the impact of improving collaboration across the HSC to promote safer systems throughout the COVID-19 pandemic. One outcome has been the virtual visiting platform which has improved the citizen experience when physical visiting is not available.

Transforming the culture

1.4 Learning

Learning from Serious Adverse Incidents (SAIs)

The key aim of the SAI process is to improve patient and client safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole. For the majority of SAIs reported, local learning will be identified and actioned by the reporting organisation. However as the HSCB/PHA has a role in reviewing all SAIs, they may also identify regional learning for dissemination across the wider HSC, through a number of mechanisms.

During the reporting period 329 SAIs were closed by the HSCB/PHA following review. The following methods of regional learning were approved to be taken forward in relation to the SAIs closed in 2019/20:

- **36** **Reminders of Best Practice Guidance Letters**
- **6** **Professional Letters**
- **5** **Learning Letters**
- **30** **Newsletter Articles were identified**
- **18** **Were referred to other specialist groups**
- **1** **Featured at the Regional SAI and Complaints Learning Event**

POC	Level 1	Level 2	Level 3	Total
Acute Services	117	24	1	142
Maternity and Child Health	12	3	0	15
Family and Childcare (inc CAMHS)	12	4	0	16
Elderly	11	1	0	12
Mental Health	88	20	2	110
Learning Disability	3	0	0	3
Physical Disability and Sensory Impairment	2	0	0	2
Primary Health and Adult Community (includes GP's)	23	2	0	25
Corporate Business / Other	4	0	0	4
Total	**272**	**54**	**3**	**329**

Transforming the culture

Listed below are two examples of regional learning issued in 2020:

- **WHO Surgical Checklist**

This first case relates to two incidents involving wrong site surgery. The first resulted in the amputation of the wrong toe. This happened following an ill patient causing disruption to the theatre list and another surgeon, who arrived after the initial checks were completed, carrying out the procedure rather than the planned surgeon. In the second incident, surgery was commenced on the wrong ear before this was recognised and the correct surgery undertaken. The report identified that the patient was boarded for surgery without stating the side for surgery. The patient was pre-assessed but not consented at the pre-assessment clinic and side for surgery was not clarified. The patient was then added to the theatre list without a side being identified, the wrong side was marked on the ward and the consent form was not completed. It should be noted that neither of these cases followed the entirety of the WHO Surgical Safety Checklist. As a result, a Reminder of Best Practice Guidance letter was issued to the wider HSC. The PHA and HSCB worked with Trusts to ensure:

- The letter was brought to the attention of relevant staff and shared at all safety briefings/huddles.
- Trusts reviewed and, as necessary, amended their systems to ensure that they reflect the Requirements Under Current Guidance section of the letter.

- **Correct administration of medicines**

In this case oral medication was administered intravenously to a patient in error. This medication was a controlled drug.

As a result a Reminder of Best Practice Guidance letter was issued to the wider HSC. Trusts were asked to:

- Disseminate the letter to all relevant staff.
- Ensure all clinical areas have the correct equipment available to ensure safe administration of medication.

The letter was also disseminated to all relevant independent sector providers and all relevant doctors in training.

For further information on learning from SAIs please see following link **http://www.hscboard.hscni.net/publications/sai-learning-reports/**

Transforming the culture

Learning from complaints

The HSCB and PHA review complaints received from HSCTs, family practitioners (FPS) and those received directly by the HSCB and PHA. For the majority of complaints, local learning will be identified and actioned by the reporting organisation. In some instances, the HSCB/PHA may also identify regional learning.

Setting the context during 2019/20:

- **HSCTs received 6105 complaints.**
- **HSCB received 140 complaints regarding Family Practitioner Services.**
- **HSCB acted as 'honest broker' in 70 complaints regarding Family Practitioner Services*.**

The top three categories of complaints are:

1. Treatment and care (1399 complaints)

2. Staff attitude and behaviour (1021 complaints)

3. Communication (948 complaints)

*Of note this year is a significant increase in the number of complaints where the HSCB has acted in the role of 'honest broker', which is in an intermediary capacity between the patient and the FPS practice, in an effort to resolve the complaint, or at least reach an understanding or agreed position on the issues.

Areas of concern, patterns and trends from complaints are shared with relevant professional groups. This ensures that issues raised by complaints inform key areas of work on the quality of patient experience and safety including thematic reviews and strategy and policy development.

Transforming the culture

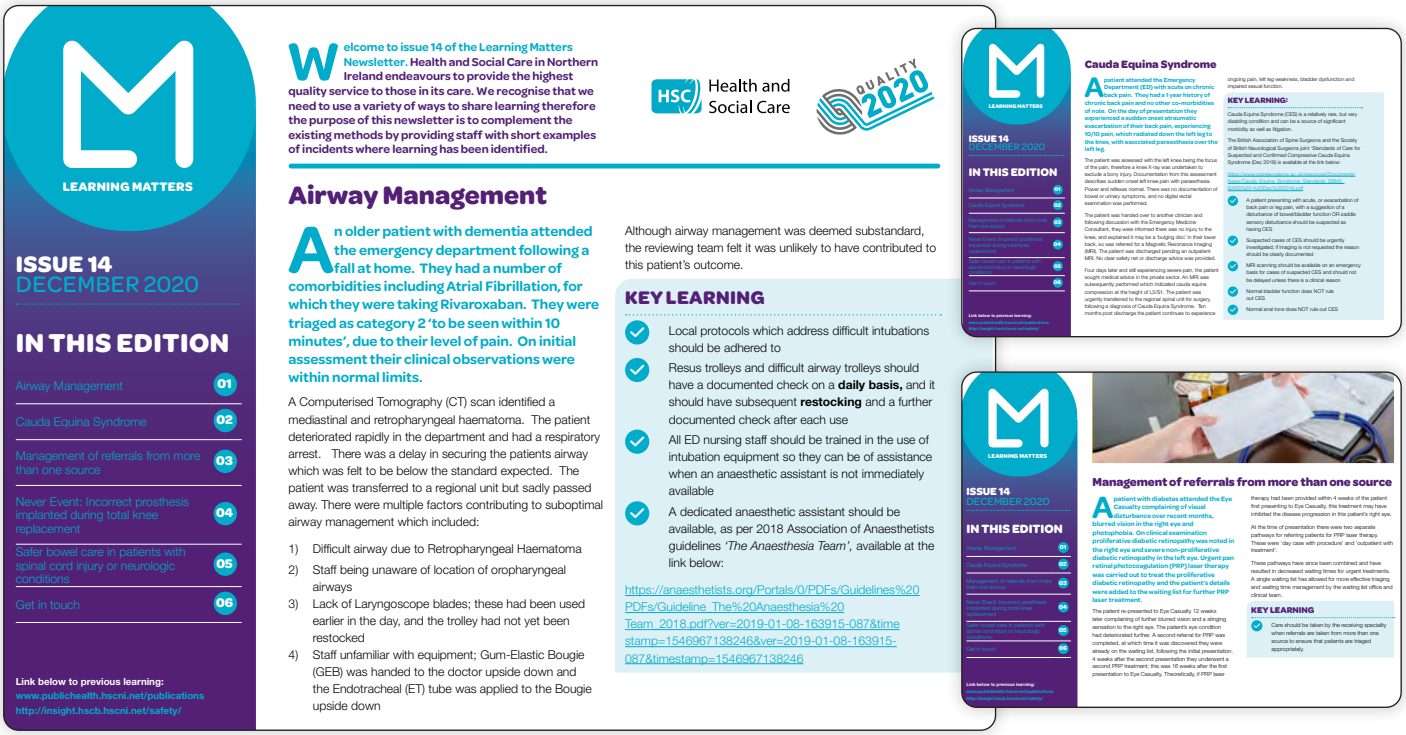
An example of learning from complaints: Cauda Equina Syndrome

A patient attended the ED with acute chronic back pain. She had a one year history of chronic back pain and no other co-morbidities of note. On the day of presentation she experienced a sudden onset atraumatic exacerbation of her back pain, experiencing 10/10 pain, which radiated down the left leg to the knee, with associated paraesthesia over the left leg.

The patient was assessed with the left knee being the focus of the pain, therefore a knee X-ray was undertaken to exclude a bony injury. Documentation from this assessment describes sudden onset left knee pain with paraesthesia. The patient's power and reflexes were normal. There was no documentation of bowel or urinary symptoms, and no PR was performed.

The patient was handed over to another clinician and following discussion with the Emergency Medicine Consultant, she was informed that there was no injury to her knee, and explained to her that it may be a 'bulging disc' in her lower back. She was referred for an MRI scan. The patient was discharged pending an outpatient MRI. No clear safety net or discharge advice was provided.

Four days later and still experiencing severe pain, the patient sought medical advice in the private sector. An MRI was subsequently performed which indicated spinal cord compression at the height of L5/S1. The patient was urgently transferred to the RVH for spinal surgery following a diagnosis of Cauda Equina Syndrome. Ten months post discharge the patient continues to experience ongoing pain, left leg weakness, bladder dysfunction and impaired sexual function.



LEARNING MATTERS

ISSUE 14
DECEMBER 2020

IN THIS EDITION

Link below to previous learning:
www.publichealth.hscni.net/publications
http://insight.hscb.hscni.net/safety/

Welcome to issue 14 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Airway Management

An older patient with dementia attended the emergency department following a fall at home. They had a number of comorbidities including Atrial Fibrillation, for which they were taking Rivaroxaban. They were triaged as category 2 'to be seen within 10 minutes', due to their level of pain. On initial assessment their clinical observations were within normal limits.

A Computerised Tomography (CT) scan identified a mediastinal and retropharyngeal haematoma. The patient deteriorated rapidly in the department and had a respiratory arrest. There was a delay in securing the patients airway which was felt to be below the standard expected. The patient was transferred to a regional unit but sadly passed away. There were multiple factors contributing to suboptimal airway management which included:

1) Difficult airway due to Retropharyngeal Haematoma
2) Staff being unaware of location of oropharyngeal airways
3) Lack of Laryngoscope blades; these had been used earlier in the day, and the trolley had not yet been restocked
4) Staff unfamiliar with equipment; Gum-Elastic Bougie (GEB) was handed to the doctor upside down and the Endotracheal (ET) tube was applied to the Bougie upside down

Although airway management was deemed substandard, the reviewing team felt it was unlikely to have contributed to this patient's outcome.

KEY LEARNING

- Local protocols which address difficult intubations should be adhered to
- Resus trolleys and difficult airway trolleys should have a documented check on a **daily basis,** and it should have subsequent **restocking** and a further documented check after each use
- All ED nursing staff should be trained in the use of intubation equipment so they can be of assistance when an anaesthetic assistant is not immediately available
- A dedicated anaesthetic assistant should be available, as per 2018 Association of Anaesthetists guidelines *'The Anaesthesia Team'*, available at the link below:

https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Guideline_The%20Anaesthesia%20Team_2018.pdf?ver=2019-01-08-163915-087&timestamp=1546967138246&ver=2019-01-08-163915-087&timestamp=1546967138246

Cauda Equina Syndrome

A patient attended the Emergency Department (ED) with acute on chronic back pain. They had a 1 year history of chronic back pain and no other co-morbidities of note. On the day of presentation they experienced a sudden onset atraumatic exacerbation of their back pain, experiencing 10/10 pain, which radiated down the left leg to the knee, with associated paraesthesia over the left leg.

The patient was assessed with the left knee being the focus of the pain, therefore a knee X-ray was undertaken to exclude a bony injury. Documentation from this assessment describes sudden-onset left knee pain with paraesthesia. Power and reflexes normal. There was no documentation of bowel or urinary symptoms, and no digital rectal examination was performed.

The patient was handed over to another clinician and following discussion with the Emergency Medicine Consultant, they were informed there was no injury to the knee, and explained it may be a 'bulging disc' in their lower back, so was referred for a Magnetic Resonance Imaging (MRI). The patient was discharged pending an outpatient MRI. No clear safety net or discharge advice was provided.

Four days later and still experiencing severe pain, the patient sought medical advice in the private sector. An MRI was subsequently performed which indicated cauda equina compression at the height of L5/S1. The patient was urgently transferred to the regional spinal unit for surgery, following a diagnosis of Cauda Equina Syndrome. Ten months post discharge the patient continues to experience ongoing pain, left leg weakness, bladder dysfunction and impaired sexual function.

KEY LEARNING:

- A patient presenting with acute, or exacerbation of back pain or leg pain, with a suggestion of a disturbance of bowel/bladder function OR saddle sensory disturbance should be suspected as having CES
- Suspected cases of CES should be urgently investigated; if imaging is not requested the reason should be clearly documented
- MRI scanning should be available on an emergency basis for cases of suspected CES and should not be delayed unless there is a clinical reason
- Normal bladder function does NOT rule out CES
- Normal anal tone does NOT rule out CES

Management of referrals from more than one source

A patient with diabetes attended the Eye Casualty complaining of visual disturbance over recent months, blurred vision in the right eye and photophobia. On clinical examination proliferative diabetic retinopathy was noted in the right eye and severe non-proliferative diabetic retinopathy in the left eye. Urgent pan retinal photocoagulation (PRP) laser therapy was carried out to treat the proliferative diabetic retinopathy and the patient's details were added to the waiting list for further PRP laser treatment.

The patient re-presented to Eye Casualty 12 weeks later complaining of further blurred vision and a stinging sensation to the right eye. The patient's eye condition had deteriorated further. A second referral for PRP was completed, at which time it was discovered they were already on the waiting list, following the initial presentation. 4 weeks after the second presentation they underwent a second PRP treatment; this was 16 weeks after the first presentation to Eye Casualty. Theoretically, if PRP laser therapy had been provided within 4 weeks of the patient first presenting to Eye Casualty, this treatment may have inhibited the disease progression in this patient's right eye.

At the time of presentation there were two separate pathways for referring patients for PRP laser therapy. These were 'day case with procedure' and 'outpatient with treatment'.

These pathways have since been combined and have resulted in decreased waiting times for urgent treatments. A single waiting list has allowed for more effective triaging and waiting time management by the waiting list office and clinical team.

KEY LEARNING

- Care should be taken by the receiving specialty when referrals are taken from more than one source to ensure that patients are triaged appropriately.

Transforming the culture

Key Learning:
Cauda Equina Syndrome (CES) is a relatively rare, but very disabling condition and can be a source of significant morbidity as well as litigation.

The British Association of Spine Surgeons and the Society of British Neurological Surgeons joint 'Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome' (Dec 2018) available at link below:
https://www.spinesurgeons.ac.uk/resources/Documents/News/Cauda_Equina_Syndrome_Standards_SBNS_BASS%20-%20Dec%202018.pdf

- A patient presenting with acute, or exacerbation of back pain or leg pain, with a suggestion of a disturbance of bowel/bladder function OR saddle sensory disturbance should be suspected as having CES.
- Suspected cases of CES should be urgently investigated, if imaging is not requested it should be clearly documented why.
- MRI scanning should be available on an emergency basis for cases of suspected CES, it should not be delayed unless there is a clinical reason for doing.
- Normal bladder function does NOT rule out CES.
- Normal anal tone does NOT rule out CES.

Learning from SAI's and complaints is key to ensuring safer systems throughout the HSC to improve clinical and care outcomes through learning when things within the system go wrong.

Transforming the culture

Learning from experience

10,000 More Voices. Care Homes & Covid-19- The Lived Experience of Care Home Residents, their Relatives and Staff during Covid-19 Pandemic.

Background

"We are a hidden treasure … and unfortunately no one is looking for us."

Words of a Care Home Resident

In May 2020 the 10,000 More Voices Team commenced a study to capture the experiences of residents, relatives and staff in Care Homes during Covid-19 pandemic. The findings of this project were central to *the Rapid Learning Initiative into the Transmission of Covid-19 in Care Homes (1)* as part of the second surge planning through the Department of Health. The 10,000 More Voices Initiative is part of Patient Client Experience (PCE) work, led within the Public Health Agency (PHA) and seeks to provide a person centred approach to improving and influencing the health and social care system, through the voices of Experience.

Approach

The study sought to collect experiences through three bespoke surveys exploring the following core concepts of the experience in Care Homes

- Communication
- Safety
- Care delivery
- Changes
- Good practice
- Challenges

Respondents were requested to share their story through an open question and to share deeper reflections by responding to self-indexing statements known as triads (three related elements of a concept) and dyads (extreme aspects of a concept). Surveys were available through an online link, printed copy or telephone/video conferencing consultation. Easy read versions were also developed to widely engage with the defined groups. Each core concept was analysed through Sensemaker® Analyst Software. This software captures the experiences from real people and supports the visualisation of patterns through triads and dyads, determining key messages from residents, relatives and staff.

Findings

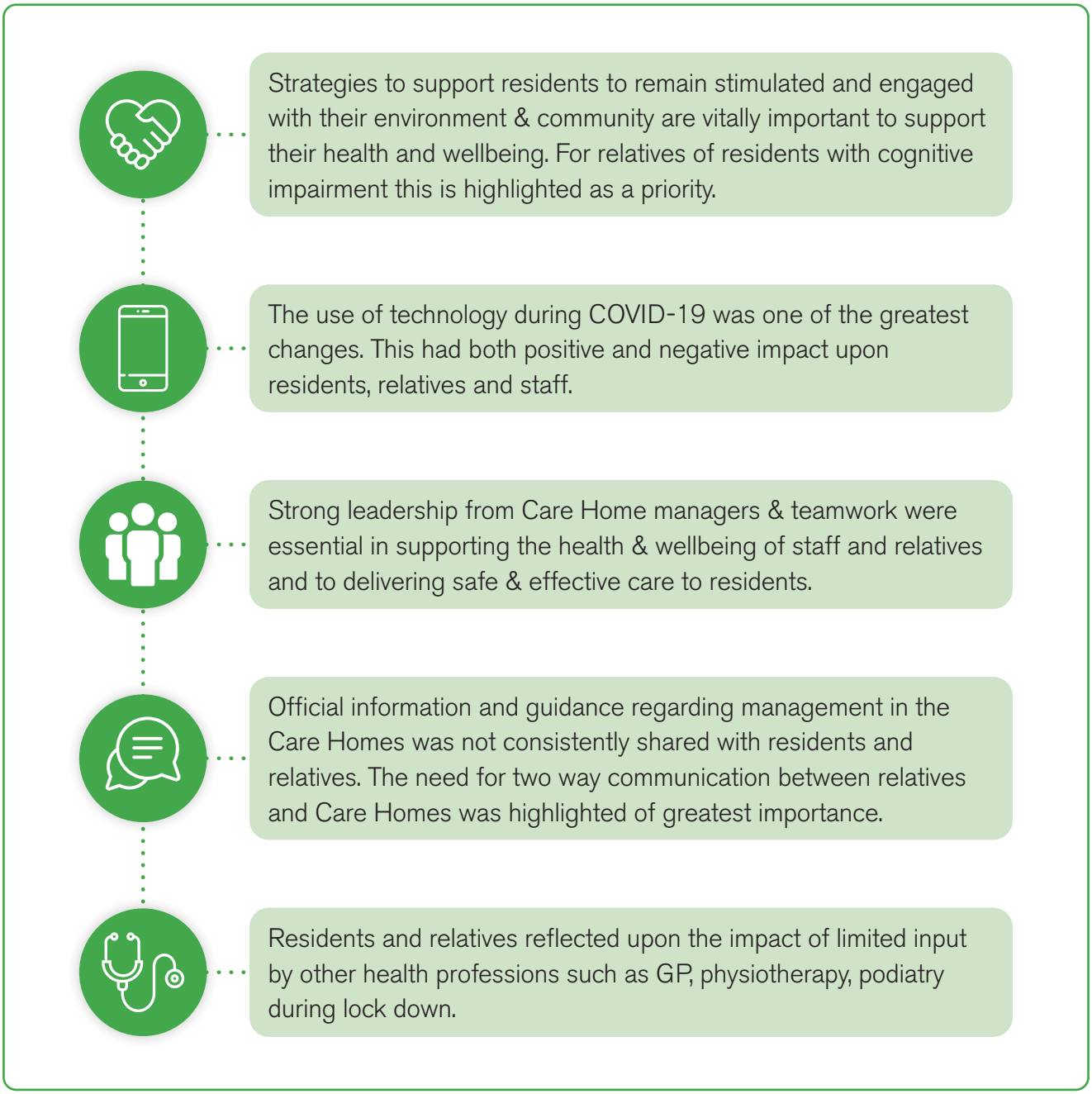
Table 1 outlines the number of returns according to each respondent group received between 24th June 2020 and 31st August 2020.

TABLE 1 NUMBER OF SURVEYS RETURNED PER RESPONDENT GROUP

Respondent Group	Number of returns
Residents	519
Relatives	109
Staff	116

Transforming the culture

THE FOLLOWING DIAGRAM OUTLINES THE KEY MESSAGES OF THE COLLECTIVE ANALYSIS OF ALL RETURNS.



Transforming the culture

Conclusion

> *"Hear the patient voice at every level- even when that voice is a whisper."*
>
> **Don Berwick-**[2]

The purpose of a 10,000 More Voices study is to ensure the voice of the respondents, in this case residents, relatives and staff, will make a difference at both a local and strategic level. The key findings outlined and the direct words of the respondents have informed actions to support residents, relatives and staff during a second surge of Covid-19. This study has also reinforced the need for a culture shift in engaging openly with the residents and relatives of Care Homes, affirming that at all levels of the health and social care system their voice are heard.

References

1. Department of Health, *The Rapid Learning Initiative into the Transmission of Covid-19 in Care Homes* Available from **https://www.health-ni.gov.uk/news/minister-welcomes-rapid-learning-initiative-report-care-home-pandemic-experiences**. [accessed on 3rd September 2020].

2. Berwick, D. *A promise to learn – a commitment to act. Improving the safety of patients in England.* Available from **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf** [accessed 5th October 2020]

Further information

Linda Craig (Regional Lead for Patient, Client Experience)
Email: **linda.craig3@hscni.net**
Contact: 028 9536 2869
Full report available through **www.10000morevoices.hscni.net.**

Transforming the culture

Online User Feedback – Care Opinion

In August 2020 a new online user feedback service was launched in Northern Ireland, called Care Opinion. This service offers the people of Northern Ireland and their families to give feedback on their experiences when engaging with the Health and Social Care system. Care Opinion supports the collation of the spectrum of experiences – from positive engagement which should be celebrated and shared to experiences where improvement can be made. Care Opinion is a moderated service offering a safe opportunity for people to share their experiences. The service promotes an open and transparent culture with the information posted on the Care Opinion website (**www.careopinion.org**).

Care Opinion also supports meaningful engagement between the person who has shared their experiences and the services involved, with responses provided by trained responders in each Trust. This service provides an opportunity to affect change at a local level and also collectively influence strategy and regional developments. In 2020 it has never been more important to engagement in a meaningful manner with the people who attend our services and to also provide a platform through which they can share their story.

From August 2020 to January 2021 there have been 523 stories shared on the website which have been viewed over 42,000 times. 74% of the stories have been positive and reach out to say thank you to the staff of Health and Social Care. As a result of the stories shared, there have been 31 local changes planned or made, demonstrating how the feedback informs and influences the services we deliver. Collectively the stories on Care Opinion are informing the regional work in relation to the COVID-19 pandemic. This is the start of our journey to embed an online user feedback system into Health and Social Care in Northern Ireland. If you would like to learn more about Care Opinion check out the website **www.careopinion.org** or contact Michelle Tennyson or Linda Craig in the Public Health Agency.

WORD CLOUD:

WHAT WAS POSITIVE ABOUT YOUR EXPERIENCE?

Transforming the culture

1.5 Signs of Safety

Whilst responding to COVID-19 has impacted on the implementation of Signs of Safety, the implementation process itself has continued within the Trusts.

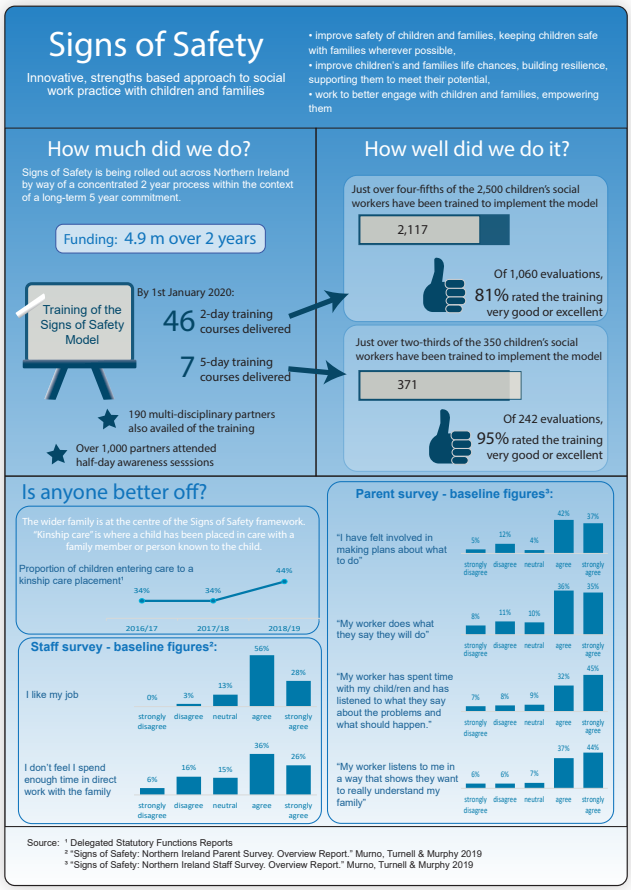
As part of the restart of services the Regional Steering Group for Signs of Safety has begun to meet again on a monthly basis. A fortnightly implementation group meeting has been set up with the 5 Trusts.

By 2020, 46, 2 day training courses had been delivered to 2117 of the 2,500 children's social workers to enable implementation of the model. 7 five day training courses had been delivered to 371 social workers. In addition 190 partners availed of the training.

A regional training plan for Signs of safety 2020/21 has been developed and is being implemented.

As part of monitoring the effectiveness of implementation, an annual staff and parent survey was undertaken initially in 2019 and then in 2020. In terms of the staff survey several areas of improvement can be noted from the first survey (2019). Most significantly there has been a substantial increase in workers who have used the practice from 49.3% to 77.1%. The dominant impression is of a workforce that is generally positive about using Signs of Safety. Areas for improvement have been noted for 2020/21.

The dominant message from parents continues to be positive. Most positive comments related



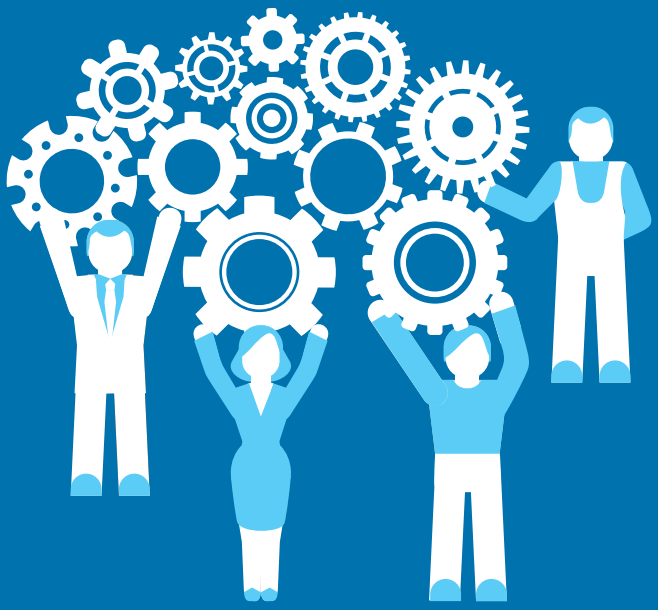
to-feeling listened to (79.8%), their worker doing what they say they will do (72.7%) and the worker being clear about their concerns about the family situation (85.4%).

A Northern Ireland Leaders day was held in June 2020 to review implementation progress and set goals for 2020/21.

Meaningful measures - work measuring the impact of implementation of Signs of safety continued. Dashboards were developed in Trusts, the parent and staff surveys were repeated and work was completed on an OBA Report card.

For 2020/21 Re-establishing dashboard Testing and developing further work on case outcome measures.

Theme two



Strengthening the workforce

Strengthening the workforce

2.1 Introduction

The HSCB and PHA, who collectively employ over 1000 staff, are determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution.

Health and wellbeing 2026: delivering together asks HSC to become exemplars of good practice in supporting staff health and wellbeing. The HSC Workforce Strategy 2026: delivering for our people also sets out ambitious goals for a workforce that will match the requirements of a transformed health and social care system. The World Health Organization (WHO) defines what is meant by workplace health:

"A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace..."

The HSCB and PHA are committed to supporting staff health and well-being and particularly over the last 18 months during the COVID-19 pandemic have introduced a number of initiatives to listen to and engage with staff; and promote best practice through investing in training and education.

2.2 Supporting staff within HSCB & PHA during COVID

Staff health and well-being

The response to COVID-19 brought unprecedented pressures for staff across HSC. In March 2020 a joint PHA, HSCB and BSO COVID-19 Staff Health and Wellbeing Group to support staff was established.

The group was led by PHA Assistant Director and has representation from across Health Improvement, Nursing and Allied Health Professionals, Human Resources, Operations and Personal and Public Involvement. This membership brings significant expertise and operates within three defined sub-groups:

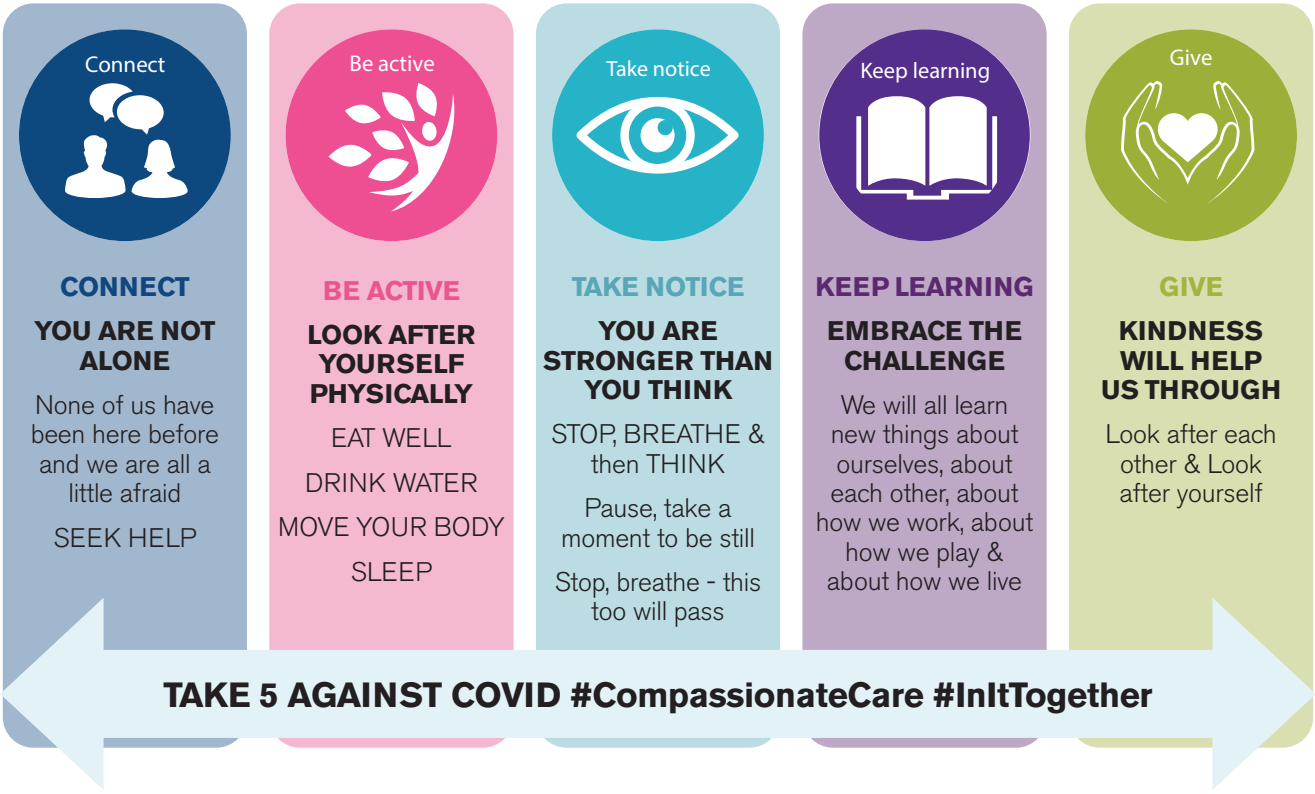
1. Feedback and monitoring.
2. Resources.
3. Comfort measures.

Feedback and monitoring

Effective workplace health action begins with employee engagement. Staff were invited to provide feedback through workplace health champions and a confidential email address. Concerns raised included home working, caring responsibilities, social distancing in a work environment and action was subsequently taken to address these and other issues raised.

A SharePoint resource was built by the resources subgroup and used the Take 5 messages as a template. This useful resource hosts a wide range of information and signposts staff to available help. **https://regional.sharepoint.hscni.net/sites/shw/SitePages/Home.aspx**

Strengthening the workforce



Comfort measures

Support for staff health and wellbeing is of course needed beyond COVID-19 and PHA, HSCB and BSO Staff Health and Wellbeing Group is developing proposals to build on this work. These proposals involve establishing a coordinated and consistent approach to workplace health and wellbeing, with employee engagement underpinning this work. A HSC publication 'Supporting the wellbeing needs of our Health and Social Care staff during COVID-19: a framework for leaders and managers offers an approach' will be integrated into future action plans.

Comfort rooms were established by the group – these rooms were a safe space for those staff who were working in the offices to avail of refreshments and to take time away from their desk to reflect and recharge. Staff were also invited to record their reflections and to contribute artwork in work buildings.

Support from Communications and IT Services proved to be essential to help ensure staff were made aware of available support and able to feed into suggestions. Personal stories were added to internal newsletters and using Take 5 themes, staff were invited to share how they were managing to maintain their wellbeing during COVID-19 lockdown.

The impact of these resources has been staff feeling supported through the pandemic by providing improved access to support mechanisms. The essential learning from this is to ensure we continue with these support mechanisms moving forward.

Strengthening the workforce

Knowledge Management

Knowledge Management Cell (KMC) article for Annual Quality Report

The Knowledge Management Cell (KMC) was established in March 2020 to support the Public Health Response to COVID-19. It provided support to the Emergency Operations Centre and the other Silver Cells to ensure the swift flow of accurate Public Health guidance and information and timely provision of responses to COVID-19 queries in a rapidly changing situation.

Chaired by Assistant Director of Nursing, the membership was drawn from across the PHA/HSCB to include staff from the Public Health Directorate, PHA Health Improvement Division, PHA & HSCB Communications, PHA Nursing, Midwifery & AHP Directorate, PHA Health Intelligence, HSC Research & Development Directorate, Social Care and HSC Quality Improvement and Innovation.

KMC continues to respond to queries received through a newly established bespoke KMC sharepoint system using a specific email address for this purpose. The KMC has direct access to a range of knowledge experts, including those already involved in other Cells, and expert colleagues who provide a critical friend role to ensure information is quality assured and up to date, in a rapidly changing environment.

A Service Handbook was developed to clearly outline the steps in the process for how the cell manages queries, this handbook was independently quality assured.

The Triage and Logging team function is operational between 9am-5pm Monday to Friday for non-urgent, non-clinical COVID-19 related queries.

KMC developed reporting systems against a number of Key Performance Indicators, which are then used to produce weekly monitoring reports for the Cell members and reported through to the Silver Huddle during the first wave and now via the Covid 19 huddle.

KPI Data

Since KMC was established in March 2020 the dedicated email address **CovKMT@hscni.net** has received 990 queries and 519 resources for inclusion in KMC Resources.

Strengthening the workforce

Knowledge Management

The reporting system was finalised on 22 April 2020, from which point 591 issues have been logged, details of which are summarised below.

Knowledge Management Cell – Report
For emails logged from 22/04/2020 – 18/02/2021
Item Range 316-990 inclusive
Data downloaded on 18/02/2021

Emails logged: 591
Status: 0 Open; 591 Closed
Priority: 586 Normal; 5 Urgent

Source of Email

PHA	310
KMC Member	187
Another Cell	30
HSCB	27
Silver	11
Duty Room	11
Non-HSC – Statutory	3
HSCT	3
Contact Us Page	3
Other HC provider eg care worker, nursing home etc	2
Individual member of public	2
DOH	1
Gold	1

Primary Source of Email

PHA	208
No additional Source	87
KMC Member	66
Other	62
HSCB	44
Non-HSC – Gov Dept.	40
DoH	31
Non-HSC – C&V sector	12
HSCT	10
Non-HSC – Statutory	7
Individual member of public	6
Contact Us Page	5
Another Cell	5
Other HC provider eg care worker, nursing home etc	4
Silver	3
Primary Care	1

Issue category

Information Provision	469
Information Request	50
Query	60
Other	12

Thematic Area
Note this field is multiple entry and so the totals are greater than the number of items.

Health Improvement	129
Health Protection	181
Health Services	97
Non-Health Services	70
Other	343

Strengthening the workforce

Traffic to other cells

Infection Control	10
Infection Control	10
Technical Scientific	5
Emergency Operations Centre	4
Social & Community	3
Health Protection	1
Communications & Media	1
Multiple/Other	10

Thematic area of 'Query' Issue Category

Health Improvement	19
Health Protection	22
Health Services	14
Non-Health Services	9
Other	26

Gaps in Advice / Guidance
8 Gaps identified
Issues 364, 370, 423, 498, 580, 623, 714, 801

Response time (*considers working hours only - 9-5 Mon-Fri)*

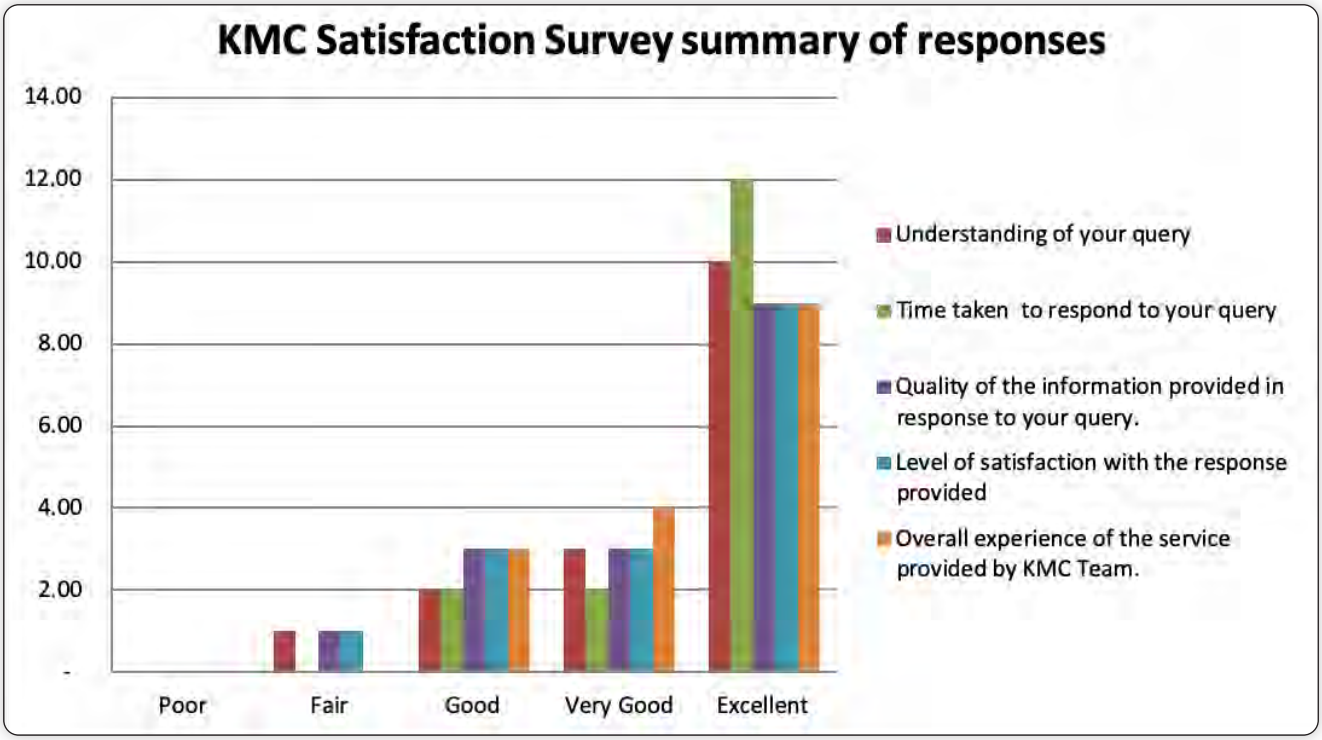
	Average TIme	Target Time
Time between mail received and logged	29 mins	1 hr
Time between mail logged and triaged	38 mins	1hr
Time between triage and issue resolved	2h 09 mins	2/6hr
Average time between mail received and issue resolved	3h 12 mins	4/8hr

KPI Areas

KPI Area	Average time between received and resolved (hh:mm)	No. of Issues
For information / guidance review / learning community	1:22	400
Forwarded to another cell for following up	14:48	21
Forwarded to knowledge experts for response	23:42	29
Response provided using existing guidance	2:32	25
Forwarded to another cell for info	6:44	7
Query unclear, requested further information	10:11	6
Unable to respond – query deemed inappropriate	2:49	9
N/A/Other/Misc/Multiple	3:19	76

***18 entries with date entry errors excluded**

Strengthening the workforce



Some direct quotes received from users:

> *It is a wonderful source for information especially during COVID when it is so difficult to keep up with so many email communications – a single source works better.*

> *This is the first time putting a direct query through and I was very pleased with the result – links to relevant information from which I could extract what was particularly relevant.*

> *I found the service really useful in terms of directing me to the right documents, however, I still had to read through docs and interpret the information provided but appreciate this is the nature of COVID with continual changes being introduced as lockdown eases.*

Strengthening the workforce

Emotional well-being support

There is significant research and evidence outlining the psychological impact of a pandemic, including the measures of social distancing and social isolation, on both the general population and healthcare staff.

Learning from the experiences of colleagues in other countries during the coronavirus pandemic – and our own experiences here in NI in terms of adjustment to societal trauma – that there is value in structured, planned and considered physical and psychological supports that support good mental health and wellbeing and that such frameworks should operate during the immediate crisis and extend into the longer term aftermath.

The pandemic called for a collective response that was caring and humane to help people affected by the pandemic. The Mental Health and Emotional Wellbeing Surge Cell (MHEWB) was formed in April 2020 as part of the wider Executive Cell response to COVID 19. The cell included representatives from DoH, PHA, HSCB, HSC Trusts and Community and Voluntary partners. The aim of the Cell was to ensure that the response to the psychological impact of the pandemic drew on and contributed to national and international clinical expertise and evidence-based practice and was consistent with guidance emerging from the UK four nations and Republic of Ireland.

A number of key resources and actions were delivered which also contributed to the DoH launching their COVID 19 Mental Health Response Plan. The plan focussed on seven strategic themes that had been identified to

respond to the impact of the pandemic on the population in Northern Ireland.

The overarching outcome of the plan is to increase the psychological wellbeing and good mental health for the population as a whole. The MHEWB Surge Cell ensured the delivery of an accountable, efficient, and effective network of services to implement the Response Plan. An important function of the cell was to carry out a rapid and rolling review of emerging evidence nationally and internationally and identify research priorities.

For further information see **https://www.health-ni.gov.uk/sites/default/files/publications/health/mh-impact-covid-pandemic**

All the resources and information developed by the MHEWB Cell are available on the **Minding your Head** website. **http://www.mindingyourhead.info**

Strengthening the workforce

Resources developed included:
Children and Young People's Strategic Partnership (CYPSP) (hscni.net)

AHP Education Webinar Series

The arrival of the Covid-19 global pandemic has resulted in an extraordinary challenge across the health and social care system. Allied Health Professionals (AHPs) have played a vital role across the acute/hospital, community and care home settings. The pandemic has resulted in clinicians' upskilling in particular specialisms. AHPs, alongside the wider Multidisciplinary Team (MDT) have adapted their service provision and embraced new ways of working to reduce the risk of transmission of the virus. This has included the use of virtual technologies and innovative practice to continue to provide high quality care.

To reflect on the events of pandemic and consolidate learning a series of AHP education webinars were developed to provide an accessible interactive learning opportunity for AHP and health care professionals. These webinars were commissioned by the Chief AHP Officer in the DoH and developed and hosted by the PHA and CEC in collaboration.

The aims of the AHP education webinar series were:

- To provide an accessible learning opportunity for AHPs and other health professionals across Northern Ireland to share and reflect on the learning from the first Covid-19 pandemic surge.
- To showcase the AHP role in the rehabilitation and recovery challenge during the pandemic.
- To help AHP and other health professionals to plan for a second surge.
- To provide a local and national perspective of the challenges faced in the pandemic.
- To explore the use of webinars as an appropriate tool for future sharing/learning.

Strengthening the workforce

A series of three AHP education webinars based on the Covid-19 pandemic and recovery were undertaken in August and September 2020. A range of AHP and MDT experts from across organisations within Northern Ireland and mainland UK were selected as panellists. Expert patients were also recruited through direct communication with HSC Trusts. This ensured that each webinar included up to date academic literature, as well as staff and patient experiences to accurately inform learning.

The three AHP education webinars covered the following areas:

- Critical Care
- Community Services
- Care Homes

Each AHP education webinar was delivered as a live stream via Zoom and recorded for watch back via an unlisted YouTube video with the link shared across the system to maximise the audience reach.

As the Covid-19 pandemic continues to create a complex challenge across the system, it is imperative that education continues on a safe and accessible platform to enhance the provision of services. Future events are being developed and will focus not only on the delivery of care, but the whole spectrum of service planning, commissioning, delivery and evaluation. In addition key stakeholders will be involved in future events where appropriate and this will include partners across organisations, staff, patients, carers and the public to ensure the correct content is being delivered.

2.3 Education, training and capacity building opportunities

Scottish Improvement Leader Programme

On Friday 18th Oct 2019 26 members of HSC staff graduated from the regional Scottish Improvement Leader (ScIL) programme, commissioned through the HSCQI transformation funding. This programme, which is run over 10 months, awards graduates a level 3 QI qualification linked to the NI attributes framework. The objective of the ScIL programme is for participants to develop an in-depth understanding of core Improvement Science concepts. Graduates will have the ability to apply Improvement Science tools, techniques and methods to improvement projects (including system thinking, building knowledge, understanding variation and measurement for improvement, the people side of improvement and how these factors interact). These ScIL graduates will be using their new skills to lead and manage change for improvement, generating and facilitating learning and coaching individuals and teams in Improvement Science.

Throughout the duration of the programme participants undertook their own improvement project to consolidate their learning and apply skills from learning workshops and events into practice.

Strengthening the workforce

The graduation ceremony was held in the long gallery in parliament buildings with invited guests from across the HSC system.

A second cohort of participants commenced the programme in October 2019.

This will lead to the improvement methodology being progressed through the HSC as the way to manage change by a testing and improvement message.

SciL data

Organisation (clinical)		Organisation (non clinical)	
Belfast Trust	6	PHA/ HSCB	6
Northern Trust	7	Arm's Length Bodies (ALB)	10
Western Trust	7	Department of Health	3
Southern Trust	6	Professional body	2
South Eastern Trust	7		
NIAS	3		
Primary Care	2		
Total	**38**		**21**

Primary Care Multi-disciplinary Teams (MDTs)

Multi-Disciplinary Teams (MDTs) involved the recruitment of practice-based physiotherapists, mental health workers and social workers to GP practices; these MDT members will work alongside GPs and practice staff with the aim of better meeting the needs social, physical and mental health wellbeing of the local population. This model also includes significant investment in additional nursing specialist roles such as health visiting and district nursing.

July 2018 saw the initial rollout of pilot areas, with GP Federations in Down and Derry/Londonderry to be the first to benefit from MDTs in their practices. 2019/20 and 2020/21 brought further expansion of the model into West Belfast, Causeway and Newry & District providing patient focused accessible care to population of c 640,000 with significant investment to date totalling £30m. The project has recruited significant numbers of additional staff to work within GP practices; over 260 staff are already in post across 95 practices to improve mental health and social wellbeing of patients.

The MDTs remain a key priority within the health and social care transformation programme, helping provide more care closer to people's homes and improving access for practice populations. Evidence suggests that this approach will see patient issues resolved more quickly, for instance by reducing the need for referrals and appointments elsewhere, easing demand and pressure on hospitals.

Plans are being developed to roll out MDTs across all 17 Federation areas.

£30m
of investments

260 staff across
95 GP practices

2.4 Supporting HSC Staff during COVID

Introduction of rainbow rooms resource boxes.

Rainbow Rooms were introduced across Care Homes in Northern Ireland to help and support staff that have done so much for our loved ones during the pandemic. The Rainbow Rooms idea was adopted from the rainbow symbol of solidarity used by the NHS/HSC during the current pandemic.

The rooms provided some much needed space and quiet time for staff during difficult periods resulting from the pandemic. Rainbow Room resource boxes were delivered to each of the 483 care homes across Northern Ireland and were filled with information and advice on health and wellbeing issues to support staff as well as activity packs, toiletries, water bottles, tea, coffee and snacks.

Each box was unique and acted as a gesture of support to help strengthen the relationships between the care homes and the local voluntary and community sector.

The initiative was delivered through a collaboration led by the HSCB, Integrated Care Partnerships (ICPs), PHA, HSC Trusts and the Healthy Living Centre Alliance. Healthy Living Centres across NI received donations for the Rainbow Rooms from the Red Cross and the Food Standards Agency as well as from a wide range of local organisations and businesses.

Strengthening the workforce

Project ECHO

Using videoconferencing technology, Project ECHO® NI provides a safe virtual space for education, training, sharing best practice and supporting staff working in highly pressured and challenging situations. Project ECHO NI uses Zoom technology to connect communities of practice.

This really came in to its own during the pandemic when social distancing measures were required. Participants come together in real time to receive updates, new guidance, build relationships and learn from each other. These sessions are interactive so all participants have the opportunity to seek answers to questions and concerns they have.

Participants also have the opportunity to learn through anonymised case discussions. As many networks were already established pre-COVID, having the foundation already there along with the infrastructure including the dedicated ECHO team and technology enabled ECHO NI to hit the ground with a change in focus where required.

Throughout the coronavirus pandemic, Project ECHO® NI has supported and continues to support various networks involving Secondary Care HCP's, GP's, Optometrists, Community Pharmacists, Nursing Homes, Residential Homes, Care at Home Staff and Community & Voluntary organisations to name a few.

An example of such support is the use of this established method by the PHA to get messages out quickly to the Care Home sector. Some of these sessions have had almost 300 people participate. Recent examples of this have been sessions on 'Swabbing of residents' and 'Environmental Cleanliness in Care Homes'.

ECHO has provided instant access to much needed support – demonstrated by the high numbers involved – over 10,000 people from mid-march until the end of November.

The ECHO model prides itself in moving knowledge, not people, in regular real-time collaborative education sessions where ***'everyone a teacher, everyone a learner'.***

For more info on Project ECHO:
www.echonorthernireland.co.uk

2.5 PPI Leadership programme

The PHA has continued to support cultural change within the HSC, to one whereby partnership working with people with lived and living experience, both service users and carers is the norm. Through the Leaders in Partnership programme and others, such as the bespoke training we have commissioned and delivered, including the webinars on Consultation, Involvement and Co-Production where more than 500 attended the sessions and a further 470 has since viewed them. The PHA are leading on the work of building a critical mass of people within and outside the HSC who have the requisite knowledge, skills, expertise and experience to effect real change, with associated consequent improvements in quality, safety and efficiency.

Leading in Partnership – Leadership Programme for Involvement and Co-Production

In 2019/20 the PHA commissioned two further cohorts of the successful 'Leading in Partnership' leadership programme. Over 130 participants have now undertaken the programme, including HSC staff, service users, carers and members of the community and voluntary sector. The programme continues to be in demand, with Cohort 5 (which finished on 12th January 2021) having three times as many applicants compared to the number of available places, with more than 60 applicants for 18 spaces. Cohort 6 which is due to start on 29th January 2021 and has had received 57 applications and a waiting list has been developed for any future programmes.

With the continued success of the programme, we developed a one off information session that will give applicants a 'taster' of the programme, as well as being able to reach a wider audience than the current programme can facilitate.

Through the growth of The Leaders in Partnership Programme and the continued development of other training, we are aiming to build a cohort of people in the region with knowledge, expertise and experience in involvement and co-production. This "critical mass" of people both within HSC and external to it, with these attributes, will be key in our collective endeavours to deliver systemic cultural change the HSC, in our drive to become a truly person centred service. One where partnership working is valued, respected and seen as standard practice and where we strive to co-design and co-produce services that are targeted to need, that are of the highest quality, that are efficient and owned and respected by the community.

Over 130 participants have now undertaken the programme

60 applicants for 18 spaces in COHORT 5

57 applications for COHORT 6

Strengthening the workforce

Ministerial support

The team were delighted that Minister for Health Robin Swann MLA took time out from his hectic schedule in October to join a cohort of the Leading in Partnership Programme, to discuss their learning experiences on Leadership in Involvement, Co-Production and Partnership Working. The Minister was welcomed to the virtual session by Director Rodney Morton. He was given an outline of the programme from our Assistant Director Michelle Tennyson, before hearing directly from the course participants themselves, who included HSC staff, service users and carers.

The Minister was unambiguous in his endorsement of this overall approach and saluted the PHA, and our partners in the HSC Leadership Centre, for our determination and creativity in rising to the challenge to deliver this programme in the circumstances. As Minister, he restated his commitment to the statutory duty of Involvement and re-iterated his and the Department's belief that we need to harness this collaborative approach to effectively tackle the challenges that we face in terms of health and social well-being.

60+ applicants for 18 spaces at Cohort 5

57 applications received for Cohort 6

Over 130 participants have now undertaken the leadership programme

Theme three

Measuring improvement

Measuring improvement

3.1 Introduction

The HSCB and PHA recognise the importance of measuring progress for safety, effectiveness and the patient/client experience in order to improve. We promote the use of accredited improvement techniques when gathering information or examining data, and recognise the importance of ensuring that lessons from the information and data are learned.

3.2 Quality Improvement Plan; measuring improvements

The HSCB and PHA recognise the importance of measuring progress for safety, effectiveness and the patient/client experience in order to improve. We promote the use of accredited improvement techniques when gathering information or examining data, and recognise the importance of ensuring that lessons from the information and data are learned.

Quality improvement plans

The quality improvement plans (QIPs) focus on key priority areas to improve outcomes for patients and service users. The HSCB and PHA support HSCTs on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout Northern Ireland.

Last year the QIP target areas were:

- Pressure ulcer prevention
- Falls prevention
- National Early Warning Scores (NEWS)
- Mixed gender accommodation

Pressure ulcer prevention

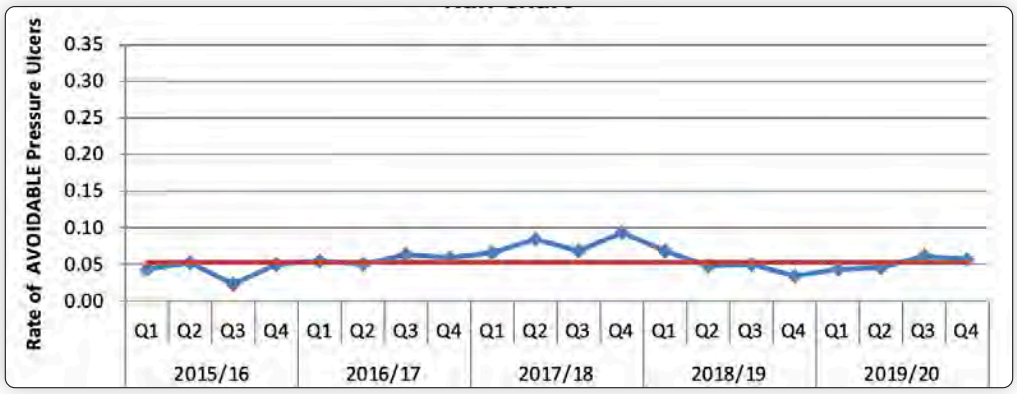
The PHA along with the HSCB supports HSC Trusts through the Regional Pressure Ulcer Prevention Group to implement the SSKIN bundle; an evidenced based collection of interventions proven to prevent pressure ulcers. This group provides advice and support and shares regional learning related to pressure ulcer prevention and management.

A basic principle of quality measurement is: if it can't be measured, it can't be improved. Therefore we recognise that pressure ulcer performance must be counted and tracked as a core component of our quality improvement programme. At the Regional Pressure Ulcer Prevention Group, HSCTs agreed to focus on reduction of avoidable grade 3 and 4 pressure ulcers, as these create deeper cavity wounds which can result in more pain and suffering to patients.

Measuring improvement

The graph below shows the total regional rates of pressure ulcers grade 3 and 4 from April 2015 – March 2020.

REGION: RATE OF AVOIDABLE GRADE 3&4 PRESSURE PER 1,000 BEDDAYSRUN CHART



The data indicates that there has been a decrease regionally since 2017/18 in the number of grade 3 and 4 avoidable pressure ulcers, with the 2019/20 data indicating rates remaining around the median. This demonstrates the impact of collective leadership and commitment shown by HSC Trusts in driving down the rate of hospital acquired pressure damage, thus improving the clinical care outcomes, as well as improved patient experience for those citizens who use health and social care services.

Falls prevention

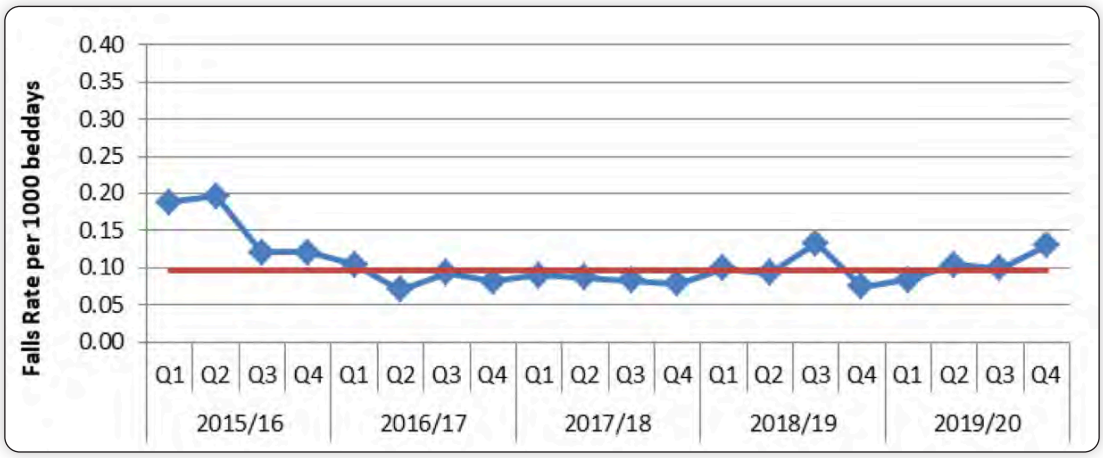
During 2019/20 the PHA and HSCB, through the Regional Falls Prevention Group, have continued to support HSCTs to implement and spread the Royal College of Physicians 'Fallsafe' bundle; an evidence-based collection of interventions proven to reduce falls in inpatient settings. HSCTs measure compliance against the 'fallsafe' bundle and report to the PHA and HSCB on a quarterly basis. The Regional Falls Prevention Group provides advice, support and shares regional learning across Northern Ireland and focuses on strategies for falls prevention and management across the HSCTs.

The 'Falls Bundle' as detailed here contains a number of regionally agreed elements, outlined below which are evidenced to reduce falls, against which Trusts measure compliance and report to the PHA and HSCB.

Part A Elements	Part B Elements
• Asked about history of falls in past 12 months • Asked about fear of falls • Urinalysis performed • Call bell in sight and reach • Safe footwear • Personal items within reach • No slips or trips hazards	• Cognitive Screening • Lying and Standing BP recorded • Full medication review requested • Bedrails risk assessment

Measuring improvement

REGION: RATE OF MODERATE TO MAJOR/CATASTROPHIC FALLS PER 1000 BED DAYS RUN CHART



During 2019/20 the focus was on prevention of the number and rates of falls incidents classified as causing moderate to major or catastrophic harm. The run chart here shows the regional picture on the rate of moderate to major/catastrophic falls per 1000 bed days since 2015 to quarter 4 2020.

Regionally there has been no significant trend in the rate of moderate to major/catastrophic falls over the past year across HSC Trusts, however it is important to note that rates of in-patient falls remain at their lowest since monitoring commenced in 2015. This low rate of falls clearly demonstrates the impact of the ongoing improvement initiatives and focus on prevention of falls across HSC Trusts, including use of a wide range of falls technologies and prevention strategies.

In quarter 4 of 19/20 it is evident there is a slight increase in the rate of moderate to major/catastrophic falls per 1000 bed days. From a patient safety perspective this will be kept under review to pinpoint areas which may be experiencing a rise in falls and ensure Trusts are supported to put the necessary improvements plans in place to address this.

National Early Warning Scores (NEWS)

Since its initial launch in 2012 by the Royal College of Physicians, the National Early Warning Scores (NEWS) chart has seen widespread uptake across the NHS. Currently all HSC Trusts in Northern Ireland are using NEWS. Through standardisation of NEWS we can reduce the number of patients whose conditions deteriorate whilst in hospital, and potentially save lives.

The HSC Safety Forum, now HSCQI, led the regional implementation of NEWS across HSCTs, including appropriate escalation arrangements to improve care of the deteriorating patient. The NEWS tool supports healthcare staff in the early identification of deterioration in a patient's condition as it advocates a system to standardise the assessment and response to acute illness. Abnormal scores prompt specific actions and/or referral to senior expertise. Part of the roll out of NEWS involved facilitating HSCTs to define their expectations regarding intervention when scores are abnormal.

Measuring improvement

NEWS2 is the latest version of the National Early Warning Score, updated in December 2017. Since April 2018 the Safety Forum/ HSCQI has worked with Trusts to:

- Develop a plan to implement and measure NEWS to identify early deterioration and prompt specific action.
- Develop arrangements to implement NEWS2.

The HSCQI hub led the Regional NEWS2 group to support Trust colleagues in the effective implementation and roll out of NEWS2 right across all HSC Trusts. The Chief Medical Officer requested that implementation of NEWS2 be completed by March 2020; however this may have been delayed in some areas due to the impact of the COVID-19 pandemic. It is of vital importance in terms of patient safety that such a tool is used across all appropriate healthcare facilities, as it has the impact of ensuring early recognition, response and appropriate escalation in patients who may deteriorate which undoubtedly saves lives.

Mixed Gender Accommodation

HSC is committed to the delivery of person-centred care. International and national evidence has highlighted that the provision of single gender accommodation has been identified by patients and relatives/carers as having significant impact on maintaining privacy and dignity while in hospital. There is therefore an expectation that men and women will not be required to sleep in the same area. In line with the DoH Guiding Principles for Mixed Gender Accommodation, each HSCT has developed a policy for the management of mixed gender accommodation in hospital. During 2019/20 the PHA and HSCB supported HSCTs to:

- Put in place effective arrangements to adhere to their policy for the provision of safe and effective care and treatment in mixed gender accommodation
- Put in place the findings of a thematic review of mixed gender accommodation in inpatient adult wards, which will help to inform the progression of further improvement in mixed gender accommodation for 2020/21
- Measure and report compliance with their policy for mixed gender accommodation in 100% of inpatient areas

Due to the nature of some estate in certain Trusts, it can be challenging to ensure mixed gender accommodation is always avoided; however it is evident that there is an ongoing commitment from Trust colleagues to ensure that the policy is adhered to. The HSC Trusts are committed to providing high quality, safe, person-centred care and by embedding these guiding principles they will ultimately have a positive impact and importantly enhance the patient experience for those who use our health and social care services.

NICE
National Institute for Health and Care Excellence

3.3 Implementation of National Institute for Health and Care Excellence (NICE) guidance

NICE is a non-departmental public body responsible for providing national guidance and advice to improve health and social care. NICE produces different types of guidance, including:

- Technology appraisals (new drugs, medical treatments and therapies).
- Clinical guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions).
- Public health guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

The HSCB and PHA have put in place processes to implement technology appraisals, clinical guidelines and public health guidance published by NICE and endorsed by the DoH.

Between 1st April 2019 and 30th September 2020, the HSCB/PHA issued 51 Technology Appraisals to the HSC and continues to monitor the implementation of 22 Clinical Guidelines which have been issued to the service.

More information about the technology appraisals and clinical guidelines that are being implemented can be found at **www.hscboard.hscni.net/nice**

3.4 Measuring Improvement during COVID-19 Pandemic

The importance of monitoring and measuring the performance of HSC services and improvements in the delivery of those services is a long-established function of the HSCB. This is done using information reporting and analyses against a suite of objectives, standards and associated quality and improvement indicators. This information is then used to inform a series of performance accountability and service improvement processes across the HSC.

Examples of specific services which were monitored and measured across these 3 key areas are as follows:

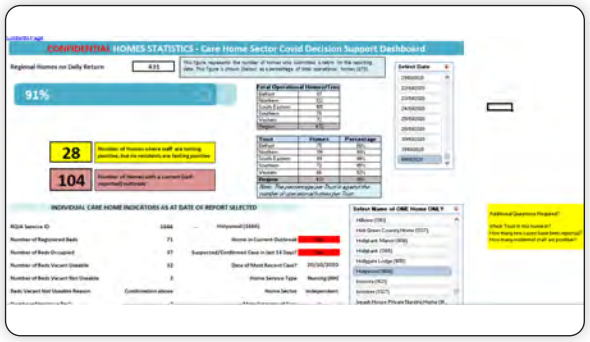
- Daily monitoring of acute hospital bed occupancy pressures – including the volume of Covid-19 patients
- Trends in ICU bed utilisation and patients needing respiratory support
- Bed modelling to project the potential future impact of the Pandemic
- The impact of Covid-19 on the delivery of elective services
- Decision Support monitoring for Care Homes
- The rebuilding of Cancer services
- Understanding the impact of Covid-19 on Delayed Hospital Discharges

Measuring improvement

Obviously the Covid-19 Pandemic has posed significant challenges across the HSC and this has also been the case when trying to monitor and measure performance and service delivery. Consequently, monitoring of HSC performance has had to focus on 3 key areas:

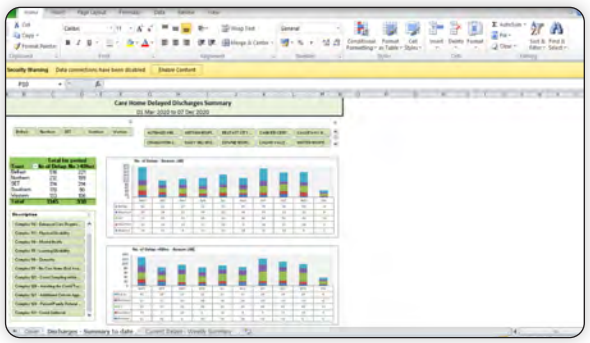
- The scale of the Covid-19 Pandemic challenge facing the HSC
- The impact of the Pandemic on the delivery of services
- The rebuilding of those services

In providing this level of monitoring, there is a continual challenge to ensure the information is provided in an easily consumable format for decision-makers. This leads to the use of a variety of tools being used such as Dashboards, Trend Charts, Sitreps etc. of which some examples are illustrated below.

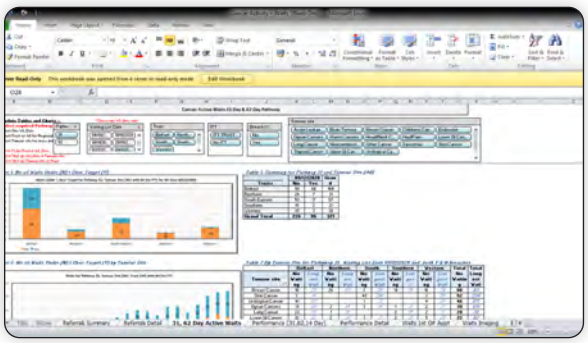


i) Care Homes Decision Support

ii) Acute Bed Occupancy and Covid-19 Inpatients



iii) Delayed Hospital Discharges due to Care Home and Covid-19 related Reasons



iv) Cancer Services Waits

The impact of measuring these areas allows the rebuild agenda to have the necessary data to know which areas require priority moving forward to ensure safer systems for the future.

3.5 Impact of COVID-19 on Screening Services

Population screening programmes have a key role to play in early detection of disease. The PHA has responsibility for commissioning, coordinating and quality assuring eight screening programmes.

Approximately 400,000 invitations for screening are issued per annum across these programmes.

Pause in screening during the first wave of COVID-19

The following five screening programmes were temporarily paused in the second week of March 2020, at the advice of the DoH:

- Routine breast screening
- Bowel cancer screening
- Cervical screening
- Abdominal aortic aneurysm (AAA) screening and surveillance monitoring
- Routine diabetic eye screening (DESP) and surveillance monitoring

This was in response to COVID-19; both to reduce the risk of exposure to the virus for the public and Health and Social Care (HSC) staff, and so that HSC staff and laboratory resources could be redirected towards the pandemic response.

While some the above programmes were paused due to COVID-19, screening continued to be offered to people who required:

- Higher risk breast screening - all eligible women continued to be screened at the higher risk screening unit in Antrim Area Hospital
- Diabetic eye screening for pregnant women (sight saving laser treatments and urgent intravitreal injections continued to be provided)
- Infectious diseases in pregnancy screening
- Newborn blood spot screening
- Newborn hearing screening

Restoration and recovery of paused screening programmes

The Strategic Framework for Rebuilding HSC Services, published by the DoH in June 2020, called for the phased restoration of these five programmes.

In early June 2020, the PHA established a Screening Restoration Group to coordinate the process of restoring these screening programmes. Individual programme-specific plans were developed and progress made across all areas.

Teamwork and collaborative working is a vital element of the recovery process – the Screening Restoration Group is working in close partnership with HSCB and all HSC Trusts and charity partnerships, in addition to liaising with colleagues in the UK Four Nations' groups and in the Republic of Ireland.

It is important to remember that screening services are provided to a 'healthy population' who have no symptoms. Between screening

Measuring improvement

appointments, or as people wait for a rescheduled screening appointment to take place, anyone who experiences any new signs or symptoms is encouraged to seek medical advice through their GP.

The PHA continues to promote regular public health messaging through a number of channels, advising people to be aware of the symptoms of cancer. The importance of partaking in screening programmes when invited also continues to be promoted and the PHA collaborates closely with all organisations involved in screening programmes to promote informed choice and uptake in screening.

Restoration of screening services and the on-going innovative work in screening is therefore vital over the coming years.

Screening programmes are adapting to the changes required due to new infection control measure and a variety of innovative solutions are being proposed to manage the restoration of screening programmes during the pandemic. Ultimately, the PHA continues to work towards improved screening services for the Northern Ireland population, and some examples of this innovation are highlighted below.

Breast Cancer Screening Programme

Before COVID-19, HSC Trusts utilised a system called SMART clinics – this maximises the number of participants that can be invited to attend a screening clinic based on probability of attendance. These were not in use when screening was initially re-started as it could result in more than one participant arriving at the same time, therefore compromising social distancing and infection control measures. The re-introduction of SMART clinics was piloted at the static unit in Linenhall Street. This was successful and was rolled out to other static units. A pilot has also been conducted in two mobile units where a Portakabin has been successfully used to manage multiple attendances.

SMART clinics have now been rolled out across all units from the beginning of October. As the reintroduction of SMART clinics allowed for better utilisation of appointment slots, self-referral for breast screening for women over the age of 70 could be reinstated at the same time.

Measuring improvement

Bowel Cancer Screening Programme

During the restoration period, extensive planning work has been continuing for the introduction of quantitative Faecal Immunochemical Testing (qFIT), which is on track for implementation from the end of December 2020.

This new type of test will replace the previous screening kit. As before, the test detects the presence of hidden blood in the stool which may be a sign of colorectal cancer and therefore warrants further investigation. The result from qFIT is more accurate than the current test and is expected to allow the programme to pick up more cancers. The other important difference is that qFIT is an easier-to-use kit for individuals to collect their sample of bowel motion.

Data from Scotland and England have shown that the uptake of bowel screening has increased following the change to qFIT.2

The PHA / HSCB are working collaboratively with all Trusts to assess and monitor the expected impact of qFIT on screening colonoscopy services.

We implemented the test in January 2021; however this was then followed by a challenging period for the screening programme. Due to service pressures related to the COVID-19 pandemic, some Trusts temporarily stood down their assessment services. This led to us taking an operational decision to reduce the frequency of invites issued.

It is anticipated that qFIT will result in increased uptake. It is also a more sensitive test and brings NI into line with the rest of the UK.

3.6 Measuring new ways of working

Reforming Rapid Angina Assessment Clinic (RAAC) Services

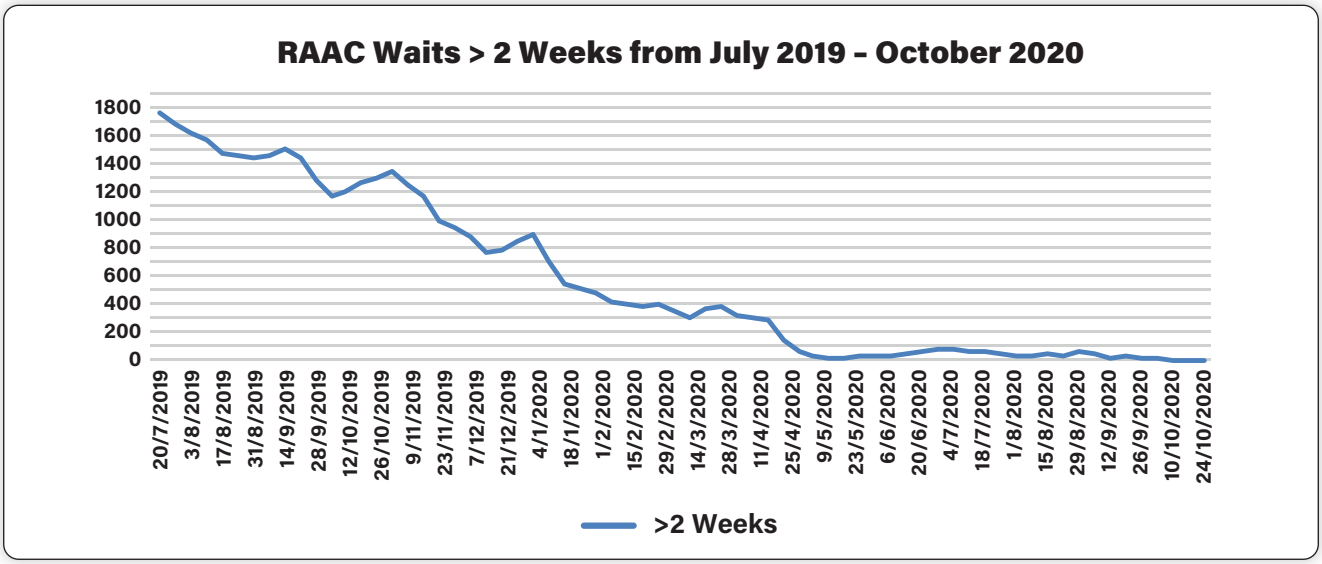
The recommended standard for the assessment of patients who develop new symptoms that might be due to angina is within two weeks of receipt of referral into the RAAC service. NICE guidelines updated in November 2016, reiterated the criteria to be used for assessment of suspected angina. However, a regional audit carried out in September 2018 demonstrated that 42% of RAAC referrals did not meet the updated guidance (*CG95: Chest pain of recent onset: assessment and diagnosis)*.

Following an SAI into the death of a patient whilst waiting on a RAAC appointment and the subsequent inquest into the death in early 2019, it was agreed that the HSCB / PHA would undertake a regional review of RAAC services and work with Trusts to address the long waiting times. At July 2019, approximately 1,800 patients were waiting over 2 weeks to be seen at RAACs.

A regional multi-professional Task and Finish Group was established who worked collectively to address the key issues facing the service. Actions included:

- developing regionally agreed referral protocols for ED staff, GPs and RAAC teams;
- developing standardised regional clinical template letters;
- establishing education and awareness sessions;
- applying NICE CG95 criteria to both new referrals and to the backlog;
- facilitating cross Trust patient transfers to support the equalisation of waiting lists;
- establishing robust performance monitoring arrangements so that individual patients could be tracked.

This collaborative approach resulted in no patients waiting over 2 weeks to be seen at the end of October 2020 as demonstrated in table.



Measuring improvement

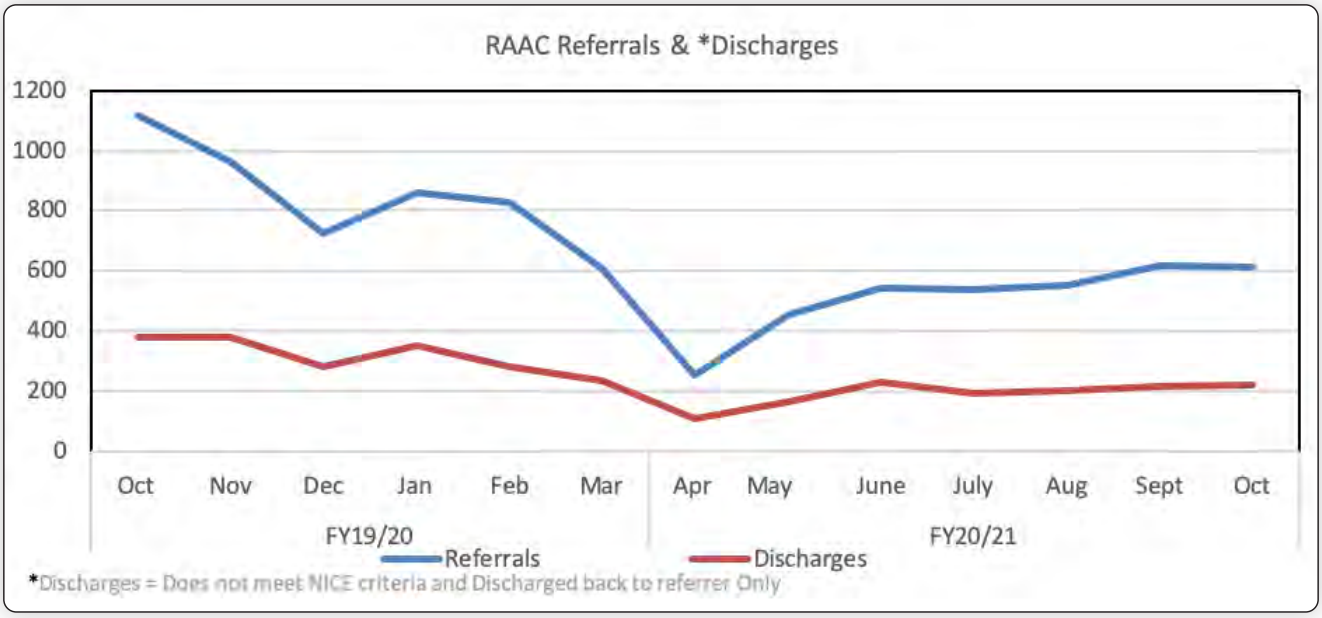
There has also been a 46% reduction in monthly referrals to RAACs due to improved adherence to NICE criteria for stable angina. RAAC referrals received not meeting NICE criteria has also reduced by 51% and are now either referred directly to cardiology (if another cardiac condition is suspected) or a letter sent to the referrer and patient outlining the reason why stable angina is not suspected and why the patient does not need to be seen. See table below.

A feedback loop to primary care, EDs, the Task and Finish Group and the Cardiac Network has helped reduce the variation in RAAC referrals and ensured patients are now seen within 2 weeks. The additional capacity created has also enabled RAAC nurses to co-work in cardiac ambulatory areas.

Although referral practice has changed, continued education and training for referrers and RAAC staff is required. The plan to address this is to use Project Echo to ensure service change is embedded and sustained moving forward.

The impact of this project is clear by the outputs in reducing waiting times for this service therefore improving both clinical outcomes and citizen experience for patients within this service.

RAAC REFERRALS & DISCHARGES (DISCHARGES INDICATES REFERRALS DISCHARGED FOLLOWING TRIAGE THAT DO NOT MEET NICE CRITERIA)



Theme four

Raising the standards

Raising the standards

4.1 Introduction

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA are continuously striving for excellence and raising the standards of care and the quality of services delivered.

4.2 Collaborative working

HSCQI maternity collaborative

The HSCQI maternity collaborative is a sub group of the Maternity Strategy Implementation Group (MSIG) that has cross-trust and multi-professional input. The HSCQI maternity collaborative aims to improve the safety and outcomes of maternal and neonatal care by reducing regional variation in practice to provide a high quality healthcare experience for all women, babies and families across maternity services. As part of the work of the Maternity Collaborative all HSC Trusts plan to introduce a physiological approach for interpretation of cardiotocographs (CTG) for intrapartum fetal monitoring to improve maternal and neonatal outcomes. By using a physiological approach to CTG interpretation and having greater understanding and incorporation of physiology, we expect to see a reduction in unnecessary intervention for women as well as a reduction in fetal hypoxic neurological injury, intrapartum stillbirth and early neonatal death. To achieve this transition a Regional Intrapartum Fetal Monitoring Guideline and intrapartum physiological based evaluation tool and checklist have been developed, along with the provision of regional masterclass training for maternity staff.

400 staff across NI trained in new assessment

200 first cohort

100 second cohort

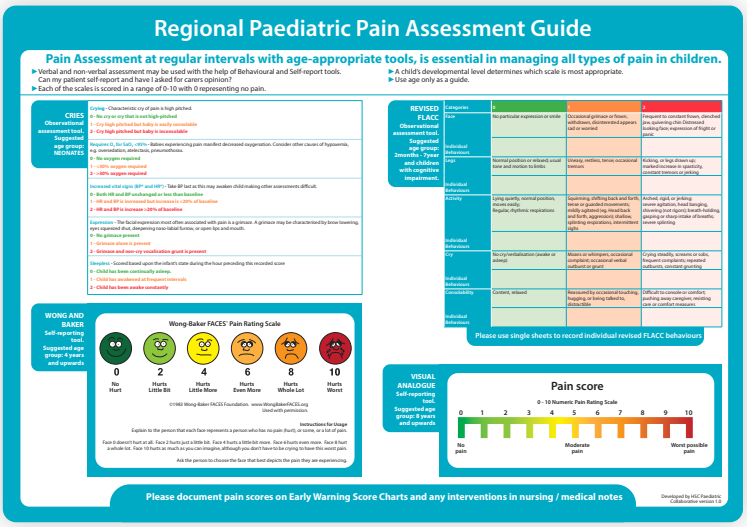
100 virtual session due to COVID

There are approximately 1500 maternity staff in NI so almost 1/3 complete.

Raising the standards

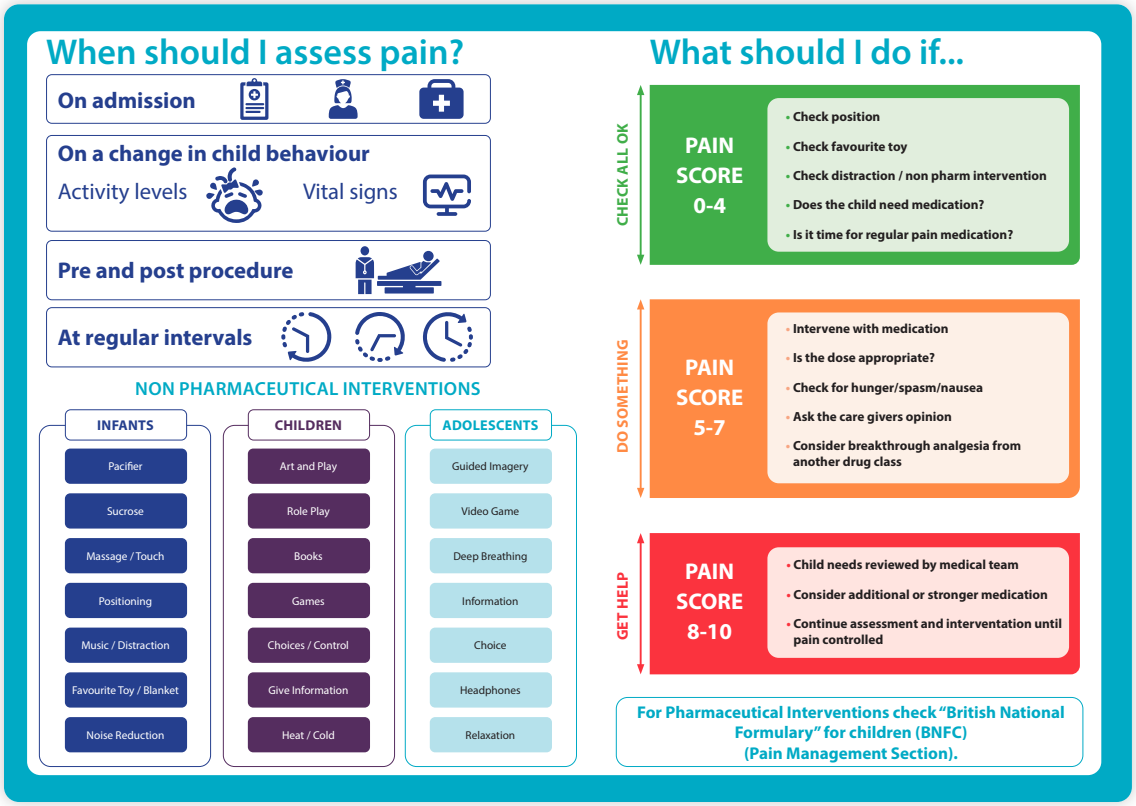
Regional Paediatric Pain Assessment Guide

In August 2019 a new Regional Paediatric Pain Assessment Guide was launched. This was developed by the HSCQI Paediatric Collaborative in consultation with RBHSC pain nurse specialist Louise Mac Donald.



Speaking at the launch Louise Mac Donald said *"Pain Assessment at regular intervals with age-appropriate tools, is essential in managing all types of pain in children. It is important to document pain assessment scores and reassess to ensure any intervention required is effective. Verbal and non-verbal assessment may be used by Healthcare professionals, with the help of behavioural and self-report tools. The NI HSCQI Paediatric Collaborative has developed this regional guide to aid the pain assessment process and facilitate timely and appropriate interventions."*

This chart will complement the updated paediatric early warning score charts.



Raising the standards

Mental and emotional wellbeing and suicide prevention

Improving mental health and emotional wellbeing and reducing suicide is a key priority for Public Health. Suicide is a preventable problem within our society and one that requires a collaborative approach across government departments and in partnership with a wide range of community & voluntary and statutory organisations.

Regardless of which sector persons within our community receive help, support or information from, it is essential that they receive a high quality service with a focus on improvement.

The PHA & HSCB have worked with partners within the community, voluntary and statutory sector to develop **Quality Standards for Services Promoting Mental and Emotional Wellbeing and Suicide Prevention (Quality Standards).** These set the minimum standards which organisations should work to, including:

- Management and governance
- Training
- Self-Harm
- Counselling
- Complementary Therapies
- Bereavement support, with a supplementary guidance for bereavement support groups

The Quality Standards are designed to encourage and support improved services and provide a legislative and best practice framework against which performance can be measured.

The standards are accessible to any organisation as a self-assessment tool allowing organisations to evaluate how they apply to their organisation. Additionally, each year a number of organisations are chosen at random for independent assessment. To date 21 organisations have participated in an independent assessment which provides a benchmark of organisational policies and practices against the standards and provides assistance to make changes where appropriate.

As best practice, organisations should revisit and review their standards assessment on an annual basis to account for legislative, best practice or individual changes within their organisation.

For further information:

- www.publichealth.hscni.net/publications/quality-standards-services-promoting-mental-and-emotional-wellbeing-and-suicide-prevent
- www.pharesourcehub.co.uk/

Raising the standards

Think Family Social Work Assessment

A family focused initiative, based on Falkov's Family Model (2012), was piloted across mental health teams in NI. The initiative was called the Think Family Social Work Assessment and consisted of three elements: a family conversation, assessment and review. This study aimed to investigate the benefits of this initiative for family recovery from the perspective of family members, social workers and other professionals.

A self-report questionnaire was constructed by the HSCB and was used to collate feedback at pre and post engagement stages in the initiative from social workers in adult mental health services in five HSC Trusts in NI. Questionnaires were also completed by parents, adult siblings, carers, children and other involved professionals at the post stage.

Findings suggest a positive shift in perceptions by social workers, family members and involved professionals. Key insights included: improved communication between family members and professionals; better understanding of the impact of mental health on the family; and the use of a strengths-based approach to identify professional and family perspectives on resources, needs and concerns. Professionals reported an improvement in collaboration between services.

This evaluation of the Think Family Social Work Assessment demonstrated preliminary positive outcomes. The assessment component contributed to needs identification and fuller understanding of each family's strengths and vulnerabilities.

Raising the standards

Children and Young People Strategic Partnership

CYPSP, led by HSCB and PHA continues in its commitment to improving the quality of early intervention services to children and young people through:

- The coordination of multi-agency, and multi-disciplinary collaborative children's services planning, and locality based service delivery
- Involvement and coproduction with children and families, and
- The use of data to continually drive our learning, shape our services and measure outcomes and achievements

Our Journey through Disability

A key priority identified for the CYPSP Newry Locality Planning Group (LPG) was to improve outcomes for children and young people with a disability. A Disability Sub-Group was established to plan for an event which would bring together services and organisations working in the locality area for children and young people with a disability and/or additional needs.

A consultation event took place on 27th March 2019, and a paper was co-produced with parents identifying 18 recommendations for action. The report was launched by the Children and Young People's Strategic Partnership (CYPSP) with the view that the recommendations would be taken forward as one of the CYPSP's main priorities in delivering better outcomes for Children and Young people with a Disability and their families.

Raising the standards

Building a research community

> *Our vision is that people in Northern Ireland who use our services will have confidence that social work and social care policy, practice and service outcomes are underpinned by a strong research evidence base committed to continual improvement.*

Since 2017 through an initiative taken by the HSCB, the application process of a Post qualifying *Research Methods* Programme, run as a partnership with Ulster University, was opened up to service users and carers. This has been facilitated through funding by the HSCB and responsibility for module design and accreditation being undertaken by the university.

The initiative was based on the belief that co-production would be better realized through having service users trained in rigorous research methods. Service users and carers undertake, on a part time basis three academic modules over the course of three years. Completion of all three modules leads to service users and carers gaining an MSc in Development and Co-Production in Social Care Research.

The uniqueness of the programme is that the academic entry requirements are the same as that required of social workers and likewise the classroom teaching is undertaken entirely with social workers and service users and carers together. Three service users and carers have gained accreditation at MSc Level and six others are on that learning journey.

Providing teaching on research methods for service users jointly with experienced social workers is an exciting development and shows potential for developing co-production of social care research and translating evidence into practice.

This initiative has been noted as good practice and has resulted in a publication in a peer reviewed journal and presentations at national and international conferences.

4.3 Supporting patients and clients through Networks

Diabetes clinical helpline

The Diabetes Network is led by HSCB / PHA. It brings together people living with **diabetes**, carers, and health and social care professionals working in partnership with **Diabetes UK** on the design and delivery of better diabetes services. Last year it set up a Clinical Helpline, in partnership with HSC Trusts to provide additional clinical support and advice to people living with diabetes and their carers. This service supported 430 people over the initial 12 week COVID first surge period 8 April – 28 June 2020 running 7 days a week, alongside existing Trust services Monday to Friday and as a stand-alone service, Saturday and Sunday, 9am until 3pm.

The service provided much needed resilience across secondary, primary and community care services and secured significant patient outcomes including much needed clinical advice and information for the diabetic population, clinical consultation in the absence of face to face appointments and consequent admission avoidance.

The Network hosted a Regional Helpline discussion 21 July 2020 to capture feedback and lessons across the service period. This information has been used to support thinking in this area with a view to considering how this service model could be best utilised/ mainstreamed in the future.

No More Silos Network

The No More Silos Network led by HSCB / PHA aims to ensure that urgent & emergency care services across primary and secondary care can be maintained and improved in an environment that is safe for patients and staff. This is both in terms of the pressures anticipated this winter, the pressures faced in the light of increase in COVID-19 cases; and the systemic issues faced by emergency care generally.

The initial work of the Interim Network was to establish a strategic network with 5 local implementation groups. The local implementation groups are made up of HSC local leaders and user representatives. Initially, these groups ensured that high level plans were presented to the Minister, have been agreed and developed on the basis of local knowledge and have secured buy-in from front line colleagues.

Raising the standards

Further to formal notification from the Department of Health on 22nd September 2020, the No More Silos Network has been given approval to oversee the implementation of the 10 Key Actions in the No More Silos Action Plan.

With the Ministers formal approval, the No More Silos Network has now moved to the implementation phase of the key actions. This approach will continue to build on the positive partnerships established during the COVID response, but also from our existing collaboration working across a number of specialities and pathways over the years which will translate into the implementation of our actions.

The NMS Network and Local Implementation Groups have engaged with all key HSC Stakeholders to progress a number of key actions that will have an impact in the short term on current ED pressures, winter pressures and the current pandemic response. All local implementation groups are progressing all key actions. Progress to date includes the implementation of Urgent Care Centres and the 24/7 Telephone Clinical Assessment Service - Phone First. The impact of this is to improve the citizen's journey and experience through urgent and emergency care and as a result improve clinical outcomes.

Raising the standards

Stroke Network

Stroke is a devastating disease for the patient and family and is estimated to cost the NHS around £3bn per year, with additional cost to the economy of a further £4bn in lost productivity, disability and informal care (National Audit Office, 2005). Over 50% of survivors are left with long-term disability. 85% of strokes are ischaemic, resulting from a blood vessel becoming blocked. Brain tissue is then damaged from a lack of oxygen and nutrients. Up to 20% of people with ischaemic strokes are suitable for, and respond to intravenous thrombolysis (IVT). The benefit of which is time dependent.

The **door-to-needle time** (DNT) is the time from presentation of patient with symptoms at the hospital to the start of IVT. Stroke guidelines say this should be less than 60 minutes. Therefore, lowering the median DNT is an essential goal for quality improvement.

The SEHSCT Quality Improvement Lead, taking forward the quality improvement agenda of the NI Stroke Network, led by HSCB and PHA, sought to improve the Ulster Hospital thrombolysis grade as recorded in the Sentinel Stroke National Audit Programme (SSNAP).

In the monitoring period April-September 2019 the Ulster Hospital was graded 'D' and it was recognised that doing nothing was not an option! Retrospective data analysis highlighted the 'D-grade' was not synonymous with global underperformance but rather reflected a disparity in median DTN times in the in-hours and out-of-hours (OOH) setting – 31mins and 78.5mins respectively.

The 'Stroke-QI-Room' was developed as a platform to engage multi-professional cross-departmental thrombolysis team members. Interactive meetings were facilitated fortnightly in a dedicated room with representation from the Emergency Department, Radiology, Stroke Nurses/Doctors, Medical Registrars, Pharmacy, AHPs and Patient Flow. Mutual understanding of barriers and waste in process provided a basis for solution development. Team outputs included a role and responsibilities document and a streamlined thrombolysis algorithm co-produced through a value stream mapping exercise. Change ideas iteratively tested via PDSA cycling with out-of-hours DTN times recorded on run chart.

Implementation of 'Stroke QI Room' resulted in a signalled change on the run chart with an improvement 'shift' in DTN times. From 18/9/19 – 31/05/20, OOH DNT time reduced from 78.5 to 41minutes, aligning to the in-hours service and within the recommended timeframe. Consequently, the Ulster site achieved an 'A' grade in SSNAP thrombolysis domain (October-December 19). This ultimately improves patient outcomes.

The feedback and successful outcomes from this pilot has been shared with the regional Stroke Network with view to scale and spread the learning and approaches across other HSC Trusts.

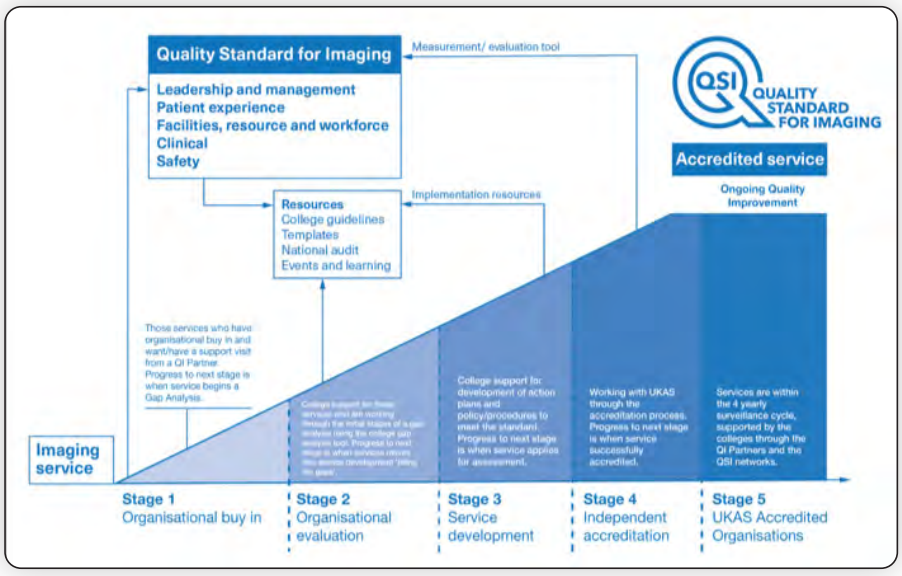
Raising the standards

Radiology Network

The Royal College of Radiologists (RCR) and College of Radiographers (CoR) developed the Quality Standard for Imaging (QSI) to support diagnostic imaging services to make continuous improvements to ensure that patients consistently receive high quality services delivered by competent staff working in safe environments. Services that meet the Standard can also opt to seek accreditation via an independent third party.

The Standard reflects wide consultation with professional colleagues, as well as relevant UK government agencies and regulatory bodies. It has been assessed for use in all four countries of the UK. In Northern Ireland, the regional programme commenced in 2017 to implement and embed the QSI Standard within imaging services and to support all five HSC Trusts to achieve accreditation. A Lead QSI Radiographer and Radiologist were appointed in each Trust and a Regional Lead from HSCB oversees the programme. After intensive preparation, and a formal assessment visit in February 2020, the Western HSC Trust received their award of accreditation in August 2020 (Stage 5). The Western Trust is the first Trust in NI and the first imaging service outside England to achieve this award. The Southern and South Eastern Trusts have successfully progressed through their pre-assessment stage with formal assessment visits planned for Spring 2021 (Stage 4). The Belfast and Northern Trusts are on track to submit applications to become accredited in early 2021 (Stage 3).

The regional QSI Programme has been commended as an exemplar model for collaborative working and a number of health economies in England have adopted the network approach based on the NI model. Fundamentally, this programme provides objective, external assurance that imaging services in NI are high quality, safe and effective and that continuous quality improvement is driving patient care.



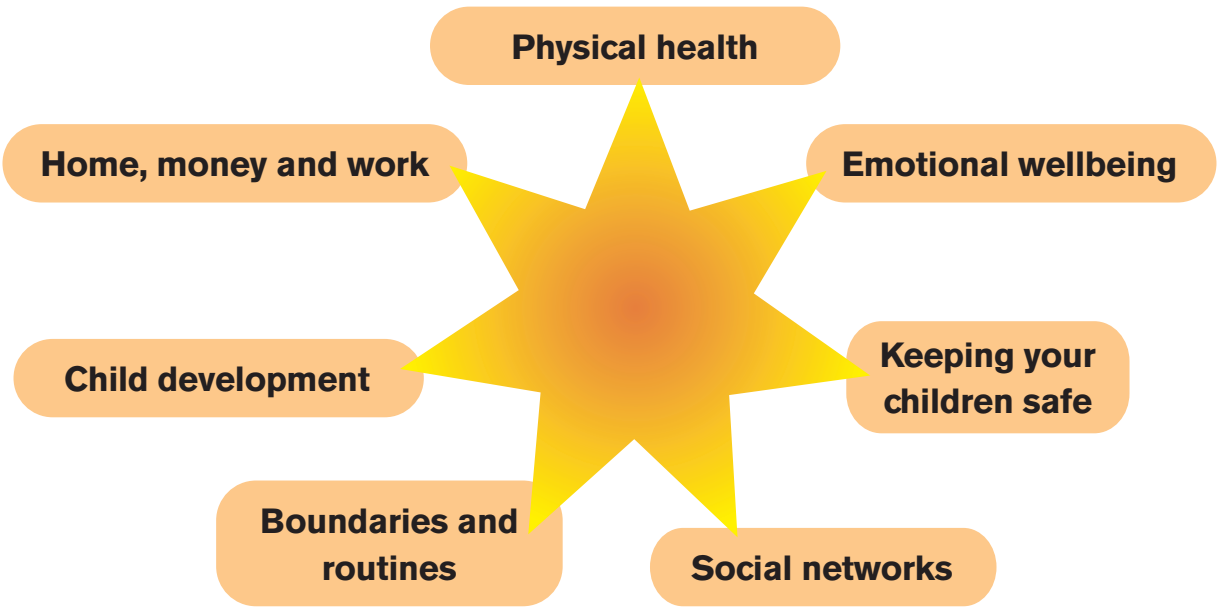
4.4 Children and Young People

Sure Start - Lighting the Future for Young Children

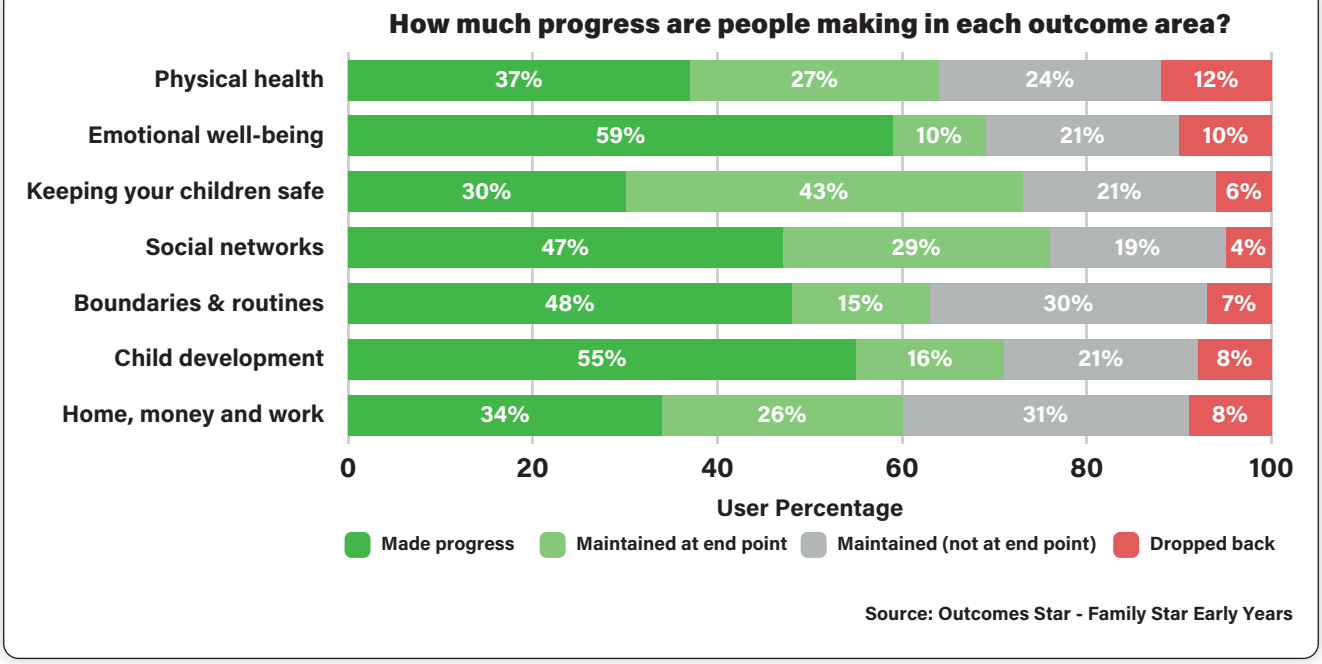
Sure Start is a programme targeted at parents and children under the age of four living in the most disadvantaged areas. It brings together health, family support and early education services which are designed to support children's learning skills, health, well-being, social and emotional development. There are around 39,000 children registered in 38 Sure Start Projects offering services both in the home and in group based settings. Sure Start offers outreach and home visiting services, family support and parenting information, good quality play and learning, primary and community healthcare and advice, and speech language and communication. The HSCB provides systems leadership and manages and administers the Sure Start Programme which is funded by DE. Partnership working is the very foundation of the Sure Start Programme and HSCB / PHA works with a range of voluntary and community providers as well as all five HSC Trusts.

The Outcomes Star is an evidence-based tool for measuring and supporting change. In 2019/20 it began to be introduced to Sure Start registered families. At present the tool is primarily used by family support staff working with individual families while delivering services in a home and group based format supporting a family's journey of change.

Outcomes Star - 7 outcome areas



Raising the standards



The family use the tool to chart their own journey of change and Sure Start offers each family a unique service pathway to meet their needs. An Outcome Star is completed at the start and end of the intervention to record the impact Sure Start had had on the family's progress in the key domains.

The figures provided below are based on 178 service users who completed both the first and second star readings after a Sure Start intervention before the beginning of the pandemic.

This sample of Outcome Star results clearly shows that Sure Start's holistic service offering of health, family support and early education services has a positive impact of improving outcomes across all 7 domain areas. 89% of families improve in at least one area, with 57% of families improving in 3 or more outcome areas. Many vulnerable families will require multiple areas of support and the results show that Sure Start as a multi-disciplinary team can provide a "one stop shop" for family support needs.

Are people making progress?

89%
of people are making progress in at least one outcome area

75%
of people are making progress in at least two outcome areas

57%
of people are making progress in at least three outcome areas

3.1
Average number of outcome areas someone is making progress

For further information visit Sure Start Webpage via CCP website to see how Sure Start supported families during COVID 19 #SureStartWorks http://childcarepartnerships.hscni.net/sure-start-during-covid-19/

Raising the standards

Supporting children with Special Educational Needs

It is recorded that in 2019 - there are 19,200 children with a Statement of Special Educational Needs (SEN) in NI which equates to 5.5% of the school population and is a 36% increase in the past 9 years (NIAO, 2020).

HSC plays an essential role in providing health advice for children undergoing Statutory Assessment to assist in both the early identification of a children's needs and ensuring the appropriate the intervention and support is available to enable to access the curriculum.

Standardisation and improvements across the HSC system in identifying and supporting children with possible Special Educational Needs undergoing Statutory Assessment. Improved identification and more integrated and timely provision has improved outcomes for children and young children enabling them to learn, achieve and develop and has enhanced greater co-operation across the Health and Education sectors."

Health and Social Care staff play a critical role working with the Education Authority to identify children who may have Special Educational Needs (SEN). This input is in line with the Special Educational Needs and Disability Act (2016) and helps to determine whether they need a Statement of SEN that outlines the supports from across the health and education they need to enable them to access the NI educational curriculum to the best of their ability. A NI Audit Office (NIAO) report carried out in 2017 identified that only 21% of Statements of SEN were completed within the 26 week statutory time limit, and the Education Authority (EA) stated that the majority of delays were primarily related to advice reports from Health and Social Care staff. This highlighted the importance of addressing these delays, not only to ensure Health and Social Care Trusts met the legislative timeframe but most importantly to enable children and young people to receive the supports they require to achieve, learn and develop, giving them the very best start in life.

The PHA worked with Department of Education, EA and Trusts to review the pathways and compliance rates across each of the 5 Health and Social Care Trusts. Measures were taken to improve not only compliance and performance in this area but also outcomes and achievements amongst children and young people with SENs. Non-recurrent transformation funding was secured from DoH to support the appointment of a SEN Co-ordinator and Data Analyst in each Trust who work closely with the PHA putting processes in place to reform the Health and Social Care input to the statutory process.
Significant achievements from this work include:

- Development of a single point of entry to co-ordinate requests and set a monitoring function to determine demand and performance.
- Successful implementation of an electronic exchange of information system across Health and Education to ensure timely and seamless sharing of information.
- Implementation of a standardised and streamlined process for the provision of timely and consistent health advice for children undergoing Statutory Assessment.

Raising the standards

- Increased knowledge in Health and Social Care on legislative frameworks associated with SEN and their requirements.
- Improved compliance with healthcare advice for children undergoing Statutory Assessment which was referenced in a 2020 NIAO report. From this initiative advice reports from Community Paediatricians, Occupational Therapy, Speech and Language Therapy and Physiotherapy across the 5 Trusts have improved in the 6 week complance 49% in December 2019 to 90% in October 2020.
- Early identification of children and young people's needs followed be timely supports and interventions to enable them to better meet their full potential.
- Enhanced working between Health and Social Care staff with EA and schools to ensure the requirements of the Children's Services Co-operation Act NI (2015) are met.
- More effective use of resources and greater standardisation and appropriate advice reports outlining the requirements to address the child's needs in the educational setting.

Work in this area to date has made significant positive impacts on the provision of health advice for children undergoing Statutory Assessment, which has been recognised by both DE and DoH and in a recently released NIAO report. An area for further development identified is to expand the services and professions in Trusts who could contribute to assessments. This provides a more integrated assessment of need and subsequent provision to ensure that the child's needs are met holistically.

There is evidence of greater partnership working from this initiative between EA, PHA and the Health and Social Care Trusts. This has led to more integrated, proactive models of care based on early intervention and developed regionally to ensure consistency of delivery at a local level.

Development of a regional Children and Young People (CYP) Emotional Health and Well-Being (EHWB) Services Framework to support the delivery of early intervention and integrated diagnostic approaches

The PHA and HSCB have worked closely with a range of stakeholders to support the development of a CYP EHWB Services Framework to deliver more integrated and early intervention models of support for CYP who are experiencing a range of difficulties in this area.

The development of this Framework was deemed necessary to ensure CYP and their parents/carers are able to access more streamlined and integrated support that focuses on early identification and proactively addresses presenting EHWB needs as soon as they arise and to provide necessary and consistent support for families.

Raising the standards

The Framework is supported by local, national and international studies with a key focus on early intervention at a population and specialist level to improve outcomes for CYP. The Framework is line with policy directions including 'New Decade New Approach' and aims to co-ordinate pathways to prevent CYP being managed by a range of professionals/ services through the development of a EHWB single point of entry. The Framework also aims to enhance integration across specialist diagnostic services particularly where ASD, ADHD or significant Mental Health diagnostic assessments are being considered.

This Framework has been developed to address negative experiences amongst CYP and families who have accessed EHWB services. Feedback received included the need for more joined-up and consistent EHWB models; greater access to timely and responsive support particularly at transition points; and the delivery of more holistic and personalised care that helps CYP realise and achieve their goals, hopes and ambitions.

A key driver of the Framework is partnership working to help meet the holistic needs of the CYP alongside the development of a needs-led model to meet any developing EHWB needs of the CYP and where necessary more specialist support to address diagnostic and/or co-morbid needs. This will ensure greater understanding and management of a continuum of needs in a co-ordinated and proactive way.

The EHWB Services Framework is designed to transform models of services and deliver the following key outcomes;

- The development of a co-produced model with active involvement of CYP and their families.
- Maintaining a prevention and early intervention focus.
- Re-aligning CYP EHWB services to meet identified needs through early intervention and integrated diagnostic pathways across CAMHs, ASD and ADHD.
- Enhanced co-working with other agencies and partnerships to ensure integrated, seamless and holistic models of support.
- Timely access for CYP and their families and the delivery of a wrap-around model of support.

In the development of this Framework there has been active engagement and joint working with the Department of Education in their development of the 'CYP EHWB in Education Framework', which is currently being finalised. This framework is focused on supporting the emotional and mental well-being needs of CYP in the school setting by strengthening their self-esteem and emotional resilience. The interagency working in the development of these Frameworks is critical to ensure the delivering of an integrated approach across the health and education sectors a more complex stage where more specialist supports are needed.

Theme five

Integrating the care

Integrating the care

5.1 Introduction

The HSCB and PHA are committed to supporting an integrated HSC system in Northern Ireland which will enable the seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the HSCB and PHA last year which contributed to raising the quality of care and outcomes experienced by patients, clients and their families.

5.2 New Models of Service Delivery

Primary Care Elective Services

In October 2016, the Health Minister launched *Health and Welling Being 2026: Delivering Together*, an ambitious 10 year approach to transforming the health and social care system in Northern Ireland. One of the key actions within the document was the development of a comprehensive approach for addressing elective care waiting lists on a sustainable basis, and as a result, in February 2017, the *Elective Care Plan: Transformation and Reform of Elective Care Services* was published.

The actions in the plan were designed to improve access to services for patients, their families and carers and to place elective care on a sustainable footing, resulting in improved waiting times.

To facilitate the primary care elective transformation agenda, the HSCB/PHA, in conjunction with GP Federations, have designed and implemented a range of pathways to enable the appropriate management of patients in primary care, and minimise the need to refer to secondary care. Beyond primary care capacity, this supports an improved approach to demand management via peer support, peer review, peer education, self-management and self-directed care at a population level within GP federations.

Current priorities across Federations are the implementation and delivery of Primary Care services in the following specialties, thus reducing the requirement to refer to secondary care:

- Dermatology: to safely manage a range of routine dermatological conditions in a primary care setting.
- Gynaecology: to safely manage a range of routine gynaecological conditions (Coil fitting, LARC) in a primary care setting.
- Vasectomy: to safely deliver non-scalpel procedures in a primary care setting.
- MSK/Pain: to safely manage a range of routine MSK conditions in a primary care setting.
- Minor Surgery: to safely manage a range of routine minor surgical procedures (lipoma excisions, sebaceous cysts, dermatofibroma, excisions for diagnostic purposes) in a primary care setting.

Planning is currently underway to introduce new pathways in specialties such as Cardiology and Dementia in 21/22.

The impact of this has been to improve the citizen experience by improving access within these pathways.

Integrating the care

Community pain support programme

An estimated 1 in 5 people in Northern Ireland live with chronic pain. Medication relieves chronic pain by around 30% only, in most cases. The Pain Support Programmes (PSPs) aim to help people with chronic pain to learn new ways to manage their pain, reduce their reliance on medication and improve their quality of life.

Examples of outcomes and feedback from the programmes (Sept - Dec 2019)

- 78% of participants completed the programme.
- At the beginning of the programme, only 15% used self management strategies in addition to medication. This increased to 83% at week 12, and 91% 3 months after the end of the PSP.
- 68% of all participants attended 8+ sessions and this resulted in an increase in Pain Self Efficacy1 score to each individual of between 6-8 points (out of a total of 16).

The HSCB and PHA have a role in commissioning pain management services and improving the use of medicines. 32 twelve week PSPs were run in 16 Healthy Living Centres across NI between September 2019 and March 2020. These were attended by approximately 500 people with chronic pain. Each week is devoted to specific activities known to help chronic pain. For example, as keeping moving is important, every week involves some light physical activity. Other weeks cover looking after your mind, the role of medication (by a local pharmacist) and the importance of having a 'pain self-management toolkit'. Sessions are also devoted to peer learning and sharing.

Further information on the NI Healthy Living Centres can be found at: **http://www.hlcalliance.org/**

The Pain Support Programmes were recently recognised with two prestigious PrescQIPP awards:

Winner: Category: Developing or Working across Integrated Care/Sustainability and Transformation Partnerships

Silver Award: Voted second place overall of all 2020 award winners

Integrating the care

Primary Care Infrastructure Development Programme

The HSCB continues to support the roll out of the Primary Care Infrastructure Development Programme, aimed at delivering a Hub and Spoke approach to the delivery of primary and community care services. Primary and community care is considered to be the appropriate setting to meet the majority of the health and social service needs of the population. The services and resources available within this setting have the potential to prevent the development of conditions which might later require hospitalisation as well as facilitating earlier discharge from hospital. The hub facilities will essentially encompass those services which do not require a hospital bed but which are too complex or specialised to be provided in a local GP surgery (a spoke).

A milestone was reached with planning permission being granted for a Community Treatment and Care Centre in Newry. It is expected that the contract for the centre will be awarded in 2021 followed by a 2 year build programme. It will facilitate the co-location of primary and community care and complementary secondary care services, grouped within a single facility for the purposes of delivering integrated care services and patient care. Significant investment in bespoke premises has allowed for increased capacity within primary and community care making services more accessible to patients as well as facilitating the roll out of multi-disciplinary working within GP premises and an increase in the number of practices who can provide GP training.

£3.9m invested in transforming GP premises to support new ways of working and providing more services closer to people's homes.

Integrating the care

Pharmacy and Medicines Management response to COVID-19 surge

A range of pharmacy and medicines management initiatives have contributed to improving the quality of services in response to the COVID-19 pandemic. These have been led by the HSCB working in partnership with Community Pharmacy contractors with support from PHA, BSO, HSC Trusts, DoH, and GP practices. Examples of those initiatives include:

- **Emergency Supply Service**

Given the demand on services during the initial COVID surge in March 2020, patients and/or their carers were encouraged to order their usual medicines in good time. Despite this patients reported running out of their medicines. Indeed, it was estimated that prior to COVID between 5-10% of GP OOH contacts were to access repeat medication that had not been supplied in-hours. The Emergency Supply service was commissioned from community pharmacies by HSCB, which has facilitated the provision of chronic medicines when patients have been unable to get a supply of their routine medicines obviating a contact with GP Out of Hours Services.

- **Serious shortage Protocol**

In order to maintain the continuity of medicines through the supply chain in preparation for EU exit, the DoH introduced a Serious Shortage protocol mechanism. This facilitated the lawful substitution of a specific dosage form of a medicine that was in short supply. HSCB commissioned a service from community pharmacy to implement this arrangement. This was not needed during EU exit in January 2020 but was implemented and used during the initial surge of COVID-19 pandemic. This service model will be reviewed to inform future use of this mechanism for the remainder of 20/21.

- **Access to medicines in out of hours and end of life care**

Access to medicines in out of hours and particularly for those requiring palliative care or end of life care was a particular issue which was addressed through enhanced community pharmacy rota opening over public holidays; increasing the coverage of dedicated palliative care community pharmacies; and, for a temporary period, putting in place an on-call arrangement for palliative care pharmacies linking to Trust pharmacies for access to palliative care medicines until end June 2020. Review of these services has led to extension of these service arrangements over the winter period.

Integrating the care

- **Pharmacy Services to Care Homes**

The need to support medicines management arrangements for care homes was recognised and to that end, enhancements have been made to the current contractual arrangements that are in place to align a dedicated community pharmacy to a care home. Further development of the pharmacy care home service had been planned for 2020/21 but funding has not been secured. During the period April to June, medicines stock boxes containing essential stock medicines for palliative and urgent treatment have been offered to all nursing homes and a mechanism to replenish stock has been established. During this period a process was established for the reuse of patients own drugs in care homes. This provision was recently stood down and will be evaluated before September to inform further plans. Oxygen supply to care homes was also recognised as an important issue and refinements have been made to the provision of oxygen to care homes. These will be maintained and kept under review for the remainder of the year.

- **Community Volunteer Service**

HSCB has worked with Community Development Health Network to establish a volunteer delivery service in response to the need to transport medicines to shielded patients during the first wave of the COVID pandemic. This service delivered in excess of 80,000 prescriptions.

- **Use of Video-consultation within pharmacies**

HSCB secured access to a Zoom enterprise licence for community pharmacies in order to undertake video-consultations. This has facilitated remote smoking cessation counselling and consultations for minor ailments

- **Community Pharmacy – Living Well Service**

As the most accessible and accessed health care venue before COVID and during COVID, pharmacies are a natural locus for the provision of health and well-being information and signposting to other services. The Living Well service was commissioned and delivered successfully in 19/20 and provided a unique and valuable mechanism to reassure, support self-care and signpost the public to services as appropriate. With the rebuild of HSC service, this service is providing a helpful source of information for the public and a series of campaigns are being delivered.

All of the above show how pharmacy services are integral to community response to COVID integrating all areas of health and social care.

Integrating the care

Community pan-disability support programme

Local government is responsible for a wide range of programmes and services that contribute to health and wellbeing of the communities in which they serve, including leisure and recreation, play parks, forest trails, green spaces, arts and cultural activities. These services empower people to utilise opportunities to improve their own health, and throughout this last year we have all looked towards council facilities in our local environments to provide a valuable alternative diversion from all things COVID.

Across Northern Ireland, 21% of the population are recorded as having a disability. This in itself creates health inequalities through economical, physical, communication and social barriers to accessing services and opportunities.

The PHA, HSCB, Departments for Communities (DfC), Department of Agriculture and Environment and Rural Affairs (DAERA) and the 11 local councils have developed an approach to support excellent and innovative practice in access inclusion for the pan-disability community through engaging this community, developing collaboration and creating the conditions for meaningful change. This has been achieved through:

- Piloting the local government access inclusion model within Fermanagh and Omagh District Council and Derry City and Strabane District Council. This model includes an Access Inclusion Officer working across council directorates to ensure all health events, activities and programmes are accessible and inclusive to the pan-disability community.

- Worked DfC, DAERA and the 11 councils, to implement a regional capital grants programme which has invested £800,000 in the 2020/2021 financial year (a total of £2.8 million over three years). This programme has assisted in making the physical changes for access inclusion practice within health improvement venues across Northern Ireland.
- Funded a training programme for council officers from all 11 councils to engage and train in excellent practice in access inclusion.
- Worked closely with Disability Sport Northern Ireland to create guidelines for local governments relating to excellent practice in the creation of inclusive outdoor spaces.
- Work is now underway to develop a funded Regional Access Inclusion Support Service to assist the 11 councils in Northern Ireland to continue their work on adapting fully inclusive, innovative, access and inclusion practice.

This valuable work is an excellent example of cross-departmental working which transforms culture and practice. This initiative will continue to break down the social, physical and communicational barriers to participation faced by the pan disability community, empowering people with disabilities to maximise local opportunities to improve their own health and encourage community-based rehabilitation.

5.3 Integrated Care Partnerships

Belfast Integrated Care Partnership – Together let's make it better

Palliative and End of life care is everyone's business. Current Palliative and End of Life Care services are not always reaching local people at a time and place they need them.

The Integrated Care Partnerships in Belfast (ICPs), including BHSCT, recently organised a workshop entitled Together Lets Make it Better. The main aim of the workshop was to promote collaborative working and use the combined wisdom and experience in the system to determine how we can be even better. The workshop included health care professionals from across all sectors with the common goal of addressing present challenges facing palliative care services in Belfast.

Themes discussed at the workshop included:

- How could care have been improved?
- Who should provide care?
- How could planning and provision of care have been improved?

Key messages which emerged from the workshop included:

- Early Identification of a patient with Palliative and/or End of Life needs
- Allocation of a key worker
- Advanced care planning
- Co-ordination/Co-ordinator

The workshop clearly identified current gaps in the service and work is underway to address these to help ensure that we continue to treat people with dignity and ensure that we can, where practical, carry out their wishes and that we are compassionate and responsive to their needs.

> *"At birth and death, we are privileged to accompany people through moments of enormous meaning and power, moments to be remembered."*

Integrating the care

Western Integrated Care Partnerships – End of life care during COVID-19

The Western ICPs met collectively and weekly in response to the COVID-19 restrictions, and the potential impact on the local population.

Supporting ICP partnership organisations, work included supporting Community Hubs through which WHSCT collaborated with Local Government and promoting flexible ways of delivering services, such as taking Healthy Living Centre programmes to streets and rural settlements.

As part of this, concern was raised on the impact wake and funeral restrictions may have on the ability to process bereavement and potential effect on people's mental health. Working with our Palliative Care in Partnership colleagues, a workshop was held examining what End of Life means and how this can begin to be normalised and supported within the local community.

The workshop was delivered virtually by the Project ECHO team and guest speakers included Dr Max Watson, Hospice UK, Palliative Care in Partnership and showcased existing good practice from Foyle Hospice Compassionate Communities programme, as well as ICPs Service User representatives.

There was a total of 73 participants in attendance at the event from a range of different backgrounds, such as community and voluntary sectors, Councils, Care Homes, health care staff such as nursing, social work and allied health professionals, GPs and Pharmacists. Feedback from the event was very positive, participants indicated that they found the event useful and would be able to take the learning into their respective areas of work, to improve their approach to conversations around death and dying.

An outcome of this work was the beginning of collaboration with the PHA Health Improvement Teams and linking some of the contracted work to promoting End of Life. This includes "Artscare NI" who are taking forward 'Life's Road Trip' within HSCT settings and Community organisations, and the development of a virtual 'Heart of Living and Dying' session for dissemination through Age Friendly Officers within Local Councils.

Northern Integrated Care Partnership - Diabetes Prevention Programme

Type 2 Diabetes Mellitus is one of the most common long term health conditions in Northern Ireland, associated with significant morbidity, mortality and healthcare costs. The prevalence continues to increase, and it is estimated that by 2027 there will be a further 45,000 cases of Type 2 patients across NI. The risk of developing Type 2 Diabetes Mellitus is strongly linked to modifiable health behaviours, in particular diet and weight.

In April 2019 the Northern Local Commissioning Group in partnership with NHSCT and the Northern Integrated Care Partnership commissioned a Diabetes Prevention Programme. The aim was to provide a 9 month intensive behaviour change intervention in individuals who are particularly high risk. Their risk was assessed using both a risk assessment score and blood tests. As of June 2020, 300 people had successfully completed the programme and reduced their risk of developing Type 2 Diabetes Mellitus.

300

people successfully completed the programme by June 2020

45,000

further cases of Type 2 patients across NI by 2027

5.4 Introduction of new ways of working as a result of COVID-19

SH: 24

SH:24 is a community interest company that has been providing an online sexually transmitted infections (STI) testing service in Northern Ireland on behalf of its HSC services since October 2019 as a pilot. This was due to end on 31 March 2020 and was highly successful with over 8,000 people ordering STI testing kits without the use of any paid advertising. Follow up of patients with diagnosed STIs was undertaken by NI HSCT's genitourinary medical (GUM) teams.

Uptake exceeded originally anticipated demand by more than 100%. Monthly monitoring reports have shown how over 40% of NI SH: 24 users had never been to a GUM clinic before and a further 15% had not been to one in over a year. This means that SH: 24 have been able to reach a different group of people than traditional GUM services.

Due to the success of the pilot and aware of the possibilities, GUM clinic service providers began to deliver much of their services to HIV patients and those at risk of HIV through SH:24 preferring telemedicine instead of face to face contacts. During lockdown the demand for on line STI testing increased significantly unlike in other parts of the UK, highlighting the level of ongoing unmet sexual health needs observed already during the pilot.

In light of the pandemic and due to the success of the pilot being able to deliver a virtual service which was cost effective, well received and efficient, the HSCB / PHA identified slippage to continue on line STI testing for the period April to December 2020.

Integrating the care

Urgent Dental Care during the COVID-19 Pandemic

COVID 19 had a catastrophic impact on the provision of dentistry in Northern Ireland. On the 18th March 2020 it was apparent that Aerosol Generating Procedures (AGPs) would be restricted under UK Government Guidance and this came into effect on the 23rd March 2020. The vast majority of urgent dental care entails an AGP. Consequently Hospital Dental Services, Community Dental Services (CDS) and General Dental Services (GDS) were equally impacted and unable to execute the critical function of providing urgent care.

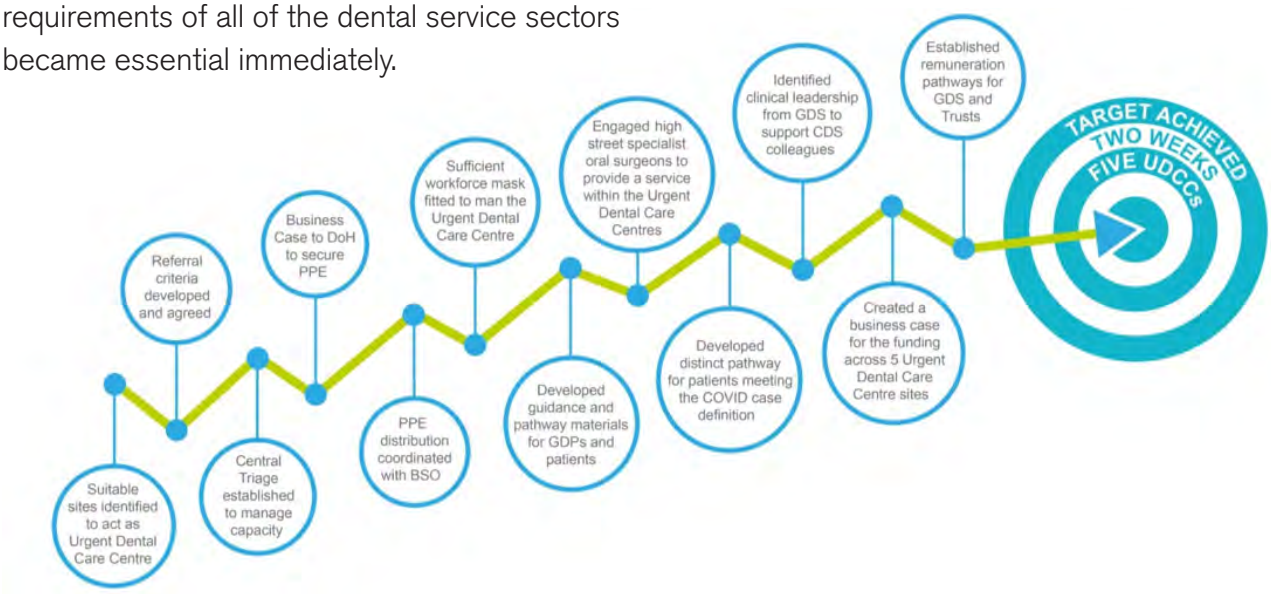
Life threatening dental emergencies are not common however they can develop quickly; early advice and intervention is important.

A gap in access to dental services, due to the restrictions, created a high risk that patients requiring urgent treatment would seek help in a General Medical Practice or at Emergency Departments. A model to deliver the urgent care requirements of all of the dental service sectors became essential immediately.

The HSCB Dental Team focused its efforts to deliver five Urgent Dental Care Centres (UDCCs) without delay. In just over a fortnight, a new single regional model for the delivery of urgent dental care for all patients was coproduced and operational.

CDS and their staff hosted the service in each Trust. General Dental Practitioners and high street oral surgery specialists provided the dental treatment whilst secondary care specialist advice could be called upon if required. The role of the HSCB Dental Team was to be the key enabler to deliver on this ambitious project. It was a great example of collaborative working across all the dental service sectors, the HSCB and the DoH.

The collaborative efforts of dentists and their teams at UDCCs have treated more than **5,000** patients to date in a COVID safe environment and continue to operate this service as we move through the pandemic.



Integrating the care

Ophthalmic Service Improvements

The impacts of covid-19 will be deep and profound and the challenges of maintaining services whilst protecting HSC through rebuilding and surge phases require an integrated approach like never before.

Ophthalmic services across primary, secondary and community and voluntary care pre-covid were already well integrated, with the Northern Ireland Eyecare Network taking a strategic approach to how services can be better coordinated and delivered.

The modernisation of the acute eye pathway is an example that was planned and in train pre-pandemic, but which Covid has pushed on at pace.

Pre-Covid, NI benefited from a regional Primary Eyecare Assessment and Referral Service (NIPEARS) which aims to be the first point of contact for non-sight-threatening acute eye problems which would otherwise present in eye casualty or general practice.

BHSCT eye casualty sees and treats in excess of 15,000 patients annually, but analysis indicates that over half of these could be appropriately managed in the community. Shifting this point of care would improve outcomes and experience for patients whilst also freeing capacity in hospital eye departments.

In line with the wider strategic review of reform of urgent and emergency care through “No More Silos” BHSCT eye casualty has moved from a “walk in” to an appointment-only service, reducing footfall into the acute hospital, secure in the knowledge that patients have an alternative pathway in place through NIPEARS.

Throughout Covid since March, primary care optometry practices continued to offer urgent eyecare aligned with NIPEARS, and since April 2020 BHSCT has operated an appointment-only system but one which supports primary care referrers with clinical advice and fast-tracked pathways for those requiring an eye

casualty appointment. Although a regional integrated IT platform is not yet in place, the pathways have also benefitted from a "virtual-where-possible" approach, using video and telephony, and remote consultations where appropriate.

Primary care optometry has been supported in provision of acute eyecare through the introduction of a remote training platform enabling webinars to be provided with local ophthalmologists and Eye Casualty staff delivering effective training.

These developments have involved integrated work between everybody involved in provision of the Acute Eyecare pathway including BHSCT and WHSCT, primary care optometry and the HSCB. It has also included sharing of information and guidance with main Emergency Departments, GPs and community pharmacies and with the general public through press and social media.

An impact of the service development has already been seen in a significant reduction in footfall in BHSCT Eye Casualty since the introduction pf the "appointment only" attendance and a simultaneous increase in primary care optometry NIPEARS attendances.

This quality improvement initiative has not only integrated services, and helped with the Covid response, it also offers a platform for improved communication and metrics to ensure that patients are seen and managed - "right person, right time, and right place."

Improving Access to Services for the Deaf Community

The COVID-19 pandemic has changed our lives. We are all working and communicating in different ways. We're learning, adapting, and figuring out how to stay safe but also how to maintain our connections with one another. For Deaf people, society's response to the pandemic has created new obstacles not just in everyday life but also in terms of their equal access to Health and Social Care. At the start of the outbreak, many services switched to telephone contact only. While this was done to protect everyone through social distancing, there was a risk that it would severely limit both the Deaf community's access to services, and the ability of our staff to communicate effectively with Deaf people.

To overcome this barrier, the DoH and the Department for Communities funded a remote sign language interpreting service. This novel service has been commissioned as a temporary COVID-19 measure. It is managed by the HSCB as one element of the wider *Regional Communication Support Services Programme.* This Programme refers to a range of projects led by the Health and Social Care Board, where we work with a range of internal and external partners and stakeholders to redesign and improve existing communication support services for people who are Deaf, deafblind and hard of hearing.

The pandemic created a unique opportunity to explore and test new ways of working, such as the remote sign language interpreting through the *Regional Communication Support Services* Programme.

Integrating the care

Provided by Interpreter Now, the service enables British Sign Language (BSL) and Irish Sign Language (ISL) users to access NHS111 and all non-emergency Health and Social Care services during the pandemic. It also allows health and social care staff to access a remote interpreter to support their clinical assessment and care of Deaf people. The service is free at point of use and available 24 hours a day, 7 days a week. All of the BSL and ISL interpreters are qualified, registered, and highly experienced.

The service includes two elements:
- Video Relay Service (VRS) and
- Video Remote Interpreting (VRI)

The **Video Relay Service (VRS)** was introduced first to ensure immediate access to telephone services. It allows Deaf people to connect with sign language interpreters online via video link. VRS can be used to:

- Organise a GP appointment,
- Make an outpatient booking,
- Translate medical advice received in the post, or
- Call a pharmacy.

With **Video Remote Interpreting (VRI)**, the Deaf person and health and social care practitioner are in the same location. They access an interpreter online via secure video link (e.g. a tablet, smart phone, or computer). It's like the interpreter is in the room.

The VRI service can be used for things like:

- Short HSC appointments such as a GP appointment,
- A pharmacy consultation, or
- Arrival at an Emergency Department until a face to face interpreter can be sourced.

Since the service went live in April 2020, almost 400 people have registered to use it. In the month of November alone, it enabled Deaf service users to make more than 1,000 independent, on-demand phone calls to a broad range of health and social care services, including:

The feedback so far is overwhelmingly positive: the service has the potential to transform Deaf service users' experiences and outcomes in relation to health and social care, supporting their independence and active participation in communication and decisions that affect them.

5.5 Northern Ireland Neighbourhood District Nursing (NDN) model of care

The Department of Health District Nursing Framework 2018-2026 (DoH 2018) provides the strategic direction for the District Nursing service in NI. One outcome in the Framework was to develop a regional community nurse-led model of care prototype and then scale and spread.

The Nursing and Midwifery Task Group (DoH 2020) highlights significant transformation of nursing and midwifery services is essential to the stability and sustainability of the NI HSC system and one theme is to deliver population health and wellbeing outcomes.

The aim of the NI NDN model is to improve safety, quality and experience by developing a 'one team' approach within a designated community and aligned to the GP Practice, with the ethos of home being the best and first place of care. Teams work in partnership with patients, carers, families, General Practitioners, and other health and social care professionals as part of a wider multidisciplinary team (MDT).

The objectives of the model are to:

- Test a new model of District Nursing linked to Primary Care MDT
- Promote a new public health model for District Nursing
- Improve patient care through proactive management of population health
- Develop self-organised teams under a collective leadership model
- Test a coaching model for District Nursing
- Reduce bureaucracy and maximise the use of technology in care
- Test Delivering Care staffing levels in District Nursing

Integrating the care

Five district nursing teams, one in each HSC Trust, started to test the model in stages in June-July 2019. A Quadruple Aim approach was used in the evaluation and interim results are outlined below.

The benefit of using a structured, proactive population health and public health based approach	Structured local population health needs assessment informed development of community health improvement plans and QI projects. E.g. Ballycastle undertook a Palliative Care IHI QI project. Outcomes 18% people died in hospital (NI average 48%)
Efficient use of DN resource (total 43 DN staff equating to 4% DN workforce aligned to 3% GP Population)	OBA scorecard monitoring return Q3 19/20- total working caseload 819 people, **average 17 patients per WTE** (regional figure is 13)
Effective education and supportive interventions enabling patient self-management	Q3 (19/20) **59 patients supported to self-manage** in areas of diabetes, continence, medicines and weight management
A highly rated service by patients, families and carers	10,000More Voices survey - **83%** of respondents rated experience as strongly positive
Coproduction and collaborative team approach supported by coaching	People Measurement survey - **overall engagement score 4.39** from 29 respondents (HSCNI 2019 engagement score was 3.78). One respondent said, "*Whilst the self-managing team aspect can be challenging at times, I feel well supported and the 'coach approach' encourages ownership and collaborative working.*"

An evaluation report has been completed and will be available on the PHA website. Further work will be undertaken to apply the principles of economic assessment and demonstrating value of the NDN model as part of scale and spread.

Conclusion

There is a requirement from the DoH that the PHA in conjunction with the HSCB produce an Annual Quality Report outlining our commitment to improving quality.

The report is split into 5 sections which are aligned to the Q2020 Strategy and each section uses a different theme & colour to represent its context.

1. **Transforming the culture**
   This section is green which symbolises organic and includes a tree / butterfly's to represent growth, transformation etc. This section includes information on:
   - Quality leadership & governance structure
   - How we learn from SAI's, complaints, patient experience
   - Our commitment to involvement and prioritising co-production and the difference this has made for patients and clients with reference to HSC Hospital passport, Always Events etc.

2. **Strengthening the workforce**
   This section is blue which traditionally represents industry and includes symbols of cogs working together. We have included a range of topics under this section to include how we support HSCB/PHA staff to grow. Opportunities we have afforded to wider HSC to upskill in terms of quality improvement and education/training opportunities we have commissioned to continue to improve. This has particularly focused this year on support through the Covid pandemic.

3. **Measuring Improvement**
   This section is red, representing blood – blood test being one measurement for health. The topics in this section include PHA/HSCBs lead in relation to quality improvement plans for pressure ulcer prevention, falls, NEWS and mixed gender accommodation. New examples are also included regarding the impact of the pandemic on certain services and new initiatives to reduce this.

4. **Raising the standards**
   We cannot print in gold – so this is the closest we got. This represents gold standard – which is what we are trying to achieve in order to become a 'leader for excellence in health and social care'.

   This section includes information relating to clinical networks established, improvements in maternity & children's services such as fetal monitoring in labour and improvements in primary care.

5. **Integrating the care**
   This section is represented using different healthcare symbols linking together to show how we integrate as one system between primary care, secondary care, embracing new technology & systems to improve the quality of services. Examples in this section include improvements to ophthalmology and dental services, access for deaf clients and neighbourhood nursing.

As stated in the introduction the HSCB and PHA both recognise that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, and transparent and, in particular, patient and client focused. Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff and, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

For further information
please contact

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HSC Public Health Agency

item 5

Title of Meeting	PHA Board Meeting
Date	17 September 2020
Title of paper	Muckamore Abbey Hospital Leadership and Governance Review Report
Reference	PHA/C/03/08/20
Prepared by	Briege Quinn
Lead Director	Marie Roulston
Recommendation	For **Approval** ☐ For **Noting** ☒

The Review Team was independent of the HSCB/PHA who commissioned the review at the request of the Department of Health.

The TOR for the Review accepted the findings from "*Way to Go*" report.

The team had access to extensive documentation from the Trust and others and carried out approximately 50 face to face or Zoom meetings with individuals.

Findings - Vulnerable people and their families were failed.

- The Trust viewed MAH as *a place apart*, out of their line of sight.
- Within Learning Disability the focus was on re-settlement.
- The management team at MAH was dysfunctional.
- Events/incidents that happened in MAH tended not to be escalated to Managers outside of MAH.
- There was a failure in 2012/2013 to identify Institutional abuse.
- The CCTV system had the potential to identify abuse 2 years earlier. The Trust was slow, post 2017, to grasp the extent of the historical CCTV and the capacity needed to deal with it.

The Review Team has made a total of 12 recommendations:

- Department of Health - 3
- Health Social Care Board/Public Health Agency – 3
- The Belfast HSC Trust – 6

A Review of Leadership & Governance at Muckamore Abbey Hospital

The Muckamore Abbey Hospital Review Team

31 July 2020

Context

- January 2018 - Level 3 SAI
- Independent Report *'Away to Go'* November 2018
- January 2020: DoH commissioned through HSCB / PHA an independent review to:

"critically examine the effectiveness of the Belfast Trust Leadership and Governance arrangements in relation to Muckamore".

- Timeline – 2012 - 2017

Methodology

- Review of written documents provided by Belfast Trust
- Number of interviews with key staff at Muckamore, Belfast Trust, DoH, HSCB and PHA
- Impact of COVID-19 on meetings with relatives, patients and carers

Key Events

- Ennis Investigation 2012 “missed opportunity”
- Installation of CCTV – 2015
- Complaint – August 2017

The Ennis Investigation
Nov 2012 - Oct 2013

- The Ennis investigation took too long and lacked an action plan.
- It was a missed opportunity for the Trust to look at care across the wider hospital.
- It should have been treated as an SAI but wasn't despite repeated challenges from HSCB.
- The Review Team consider that the allegations constituted institutional abuse. There should have been a wider investigation.
- The Ennis investigation was not escalated to the Executive Team and Trust Board.
- There was no evidence of learning from the investigation.

CCTV

- Evidence points to CCTV recording from July 2015.
- It took 22 months for MAH management to draw up a policy to operate CCTV.
- Had CCTV been used earlier it could have prevented harm to patients.
- Without a parent's query and persistence it is likely the scale of historical CCTV would not have been discovered.
- A local manager stopped the reporting of an assault on a patient in August 2017 as an SAI.
- There was an unacceptable delay between some MAH managers knowing about the historic CCTV and notification to the Trust HQ and DoH and HSCB.
- The Trust consistently failed to identify the scale of CCTV recording in 2017 and 2018

Handling of a Parent's Complaint

- The persistence of the parent has been significant in the exposure of the abuse that was ongoing at MAH
- The parent's requests for information was not responded to in a timely or inclusive manner
- The Complaint has never been formally closed

Recommendations

- 12 in total
  - 3 DoH
  - 3 HSCB / PHA
  - 6 Belfast Trust

Recommendations for HSCB /PHA

- HSCB / PHA ensure that any breach of requirements is brought to Trust Board in first instance;
- Greater degree of challenge to Delegated Statutory Function report identifying areas of non-compliance;
- Specific care sensitive indicators developed for in-patient learning disability services and community care environments.

Actions on-going within HSCB/PHA

- Review of DSF reporting to have an outcomes focused report
- Review of Adult Safeguarding arrangements
- Review of SAI – HSCB/PHA

Conclusion

“A Place Apart”

- Significant learning across HSC system
- Where is the voice for Learning Disability?

HSC Public Health Agency

minutes

Title of Meeting	58th Confidential Meeting of the Public Health Agency Board
Date	20 August 2020 at 3.15pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street

Present

Mr Andrew Dougal	-	Chair
Mrs Olive MacLeod	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Ms Michelle Tennyson	-	Assistant Director of Nursing and Allied Health Professionals (*on behalf of Mr Morton*)
Professor Hugo van Woerden	-	Director of Public Health
Alderman William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB *(via video link)*
Dr Aideen Keaney	-	Director of Quality Improvement *(via video link)*
Ms Marie Roulston	-	Director of Social Care and Children, HSCB *(via video link)*
Ms Jenny Redman	-	Boardroom Apprentice *(via video link)*
Mr Robert Graham	-	Secretariat

Apologies

Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals

C16/20	**Item 1 – Welcome and Apologies**
C16/20.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Rodney Morton.
	Report on Muckamore Abbey Hospital
C16/20.2	Prior to the commencement of the main confidential session, the Chair invited Ms Roulston to give members an update on the recent report

published regarding Muckamore Abbey Hospital.

C16/20.3 Ms Roulston advised that she wished to update members on two matters relating to the report, the first of which was the report itself. At the outset, she agreed to bring a fuller briefing to the next meeting of the Board, but by way of background, she outlined that this report was commissioned by HSCB/PHA and through the HSC Leadership Centre a team of four members was appointed. She said that the terms of reference for the review were drafted by the Department of Health.

C16/20.4 Ms Roulston explained that due to the pandemic there was a delay in the completion of the review and there were restrictions on the team being able to visit sites and meet with families. She advised that the final report contained 12 recommendations, 3 for the Department of Health, 3 for HSCB and 6 for the Belfast Trust. She noted three areas that the review team felt were missed opportunities – the lack of CCTV, the Ennis Report (2012), and the complaint that had been previously by the father of an inpatient. She added that issues relating to leadership and governance had been flagged up. In summary, she said that it was a sad report and the recommendations will need to be taken forward.

C16/20.5 Ms Roulston moved onto the second matter she wished to bring to the attention of members. She outlined that when the report was completed there was a briefing held with the Minister and the Permanent Secretary and it was the Minister's wish that the families affected would be the first to see the report. She advised that a meeting was arranged with families to share the report and later that evening the report was published on the Department of Health website. Within the report there was an appendix which contained an extract from the previous Ennis Report and Ms Roulston explained that this contained the initial of Service Users and Staff and its publication constituted a data breach. She advised that this has now been redacted and the breach reported to the Information Commissioner's Office (ICO). She added that HSCB/PHA are working with the Belfast Trust on the data breach.

C16/20.6 The Chair asked about the ownership of the report. Ms Roulston said that the report is owned by the Department of Health. Mr Stewart clarified that the Department is the publisher, and Ms Roulston confirmed this was the case.

C16/20.7 Alderman Porter said that he had been in contact with one of the carers and asked what mechanisms are being put in place to support them through the outworking of the report. Ms Roulston advised that at the debriefing she attended, the issue of support for families was raised and each family has a Liaison Officer and she had the impression that the Officers had been well received by families.

C16/20.8 Mr McClean noted that although HSCB/PHA commissioned this report,

they had no role is quality assuring the report nor did they comment on a draft version. He said that the independent panel produced the report and it was shared directly with the Minister as the Department felt that from a public confidence perspective, there should be no perception of any interference. Therefore, he said that it is a complex situation in terms of who owns the data if the report was commissioned by HSCB/PHA, but was published by the Department. The Chair asked who appointed the members of the panel. Ms Roulston explained that Mrs Briege Quinn (PHA) approached the Leadership Centre and it was the Centre who approached the reviewers.

C16/20.9 Professor Rooney noted that she had been previously informed that PHA had no role in this work, and she sought clarity on what PHA's role is. The Chair asked whether PHA's involvement was due to its role vis-à-vis Serious Adverse Incidents, and Ms Roulston advised that this was correct.

C16/20.10 Mr Clayton declared a potential interest in that some of the staff may be members of his organisation. He noted Mr McClean's explanation of where the responsibility for the data breach may lie, but he asked which organisation reported the breach as he noted the penalties for breaches can be severe and there could also be reputational damage. Ms Roulston said that there has been ongoing discussion over the last number of days with the Department regarding this and that HSCB/PHA submitted a notification to the ICO today. Mr Clayton expressed that HSCB/PHA submitted the notification when the report belonged to the Department. Ms Roulston advised that when the Department spoke to the ICO, the advice was that HSCB/PHA should report the breach caused by the manner of publication.

C16/20.11 The Chair asked if the ICO was aware of the roles of the various organisations. Ms Roulston said the ICO was aware. Mr McClean said that the situation that led to the data breach will be explained more fully to ICO but the initial breach had to be reported to the ICO within 72 hours. The Chair noted that PHA will have to review any lessons arising from this breach.

C16/20.12 Mr Stewart said that the report should be read by all NEDs as there are lessons in terms of leadership and visibility of NEDs. The Chair asked that the report is placed on the agenda of the next meeting.

C16/20.13 Alderman Ashe asked how PHA can be responsible for a breach when it did not publish the information. The Chair agreed and said that there are also lessons to be learnt on this issue. He thanked Ms Roulston and Mr McClean for their update on this matter.

C17/20 Item 2 – Declaration of Interests

C17/20.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

C18/20 **Item 3 – Minutes of Previous Meetings**

- **Minutes of Meeting held on 18 June 2020**
- **Minutes of Extraordinary Meeting held on 9 July 2020**

C18/20.1 The minutes of the meeting held on 18 June 2020 were approved as an accurate record of that meeting, subject to an addition to record that Alderman Porter was unable to participate in the meeting due to technological issues.

C18/20.2 The minutes of the extraordinary meeting held on 9 July 2020 were approved as a record of that meeting.

C19/20 **Item 4 – Matters Arising**

C19/20.1 There were no matters arising.

C20/20 **Item 5 – Update on Review of Epidemiology**

C20/20.1 The Interim Chief Executive advised that the Agency Management Team has reviewed the recommendations of the Report and unanimously accepts the recommendations with one exception. She said that a report on the progress against each recommendation will be brought to the next meeting. She reported that recruitment has commenced on some posts which will deal with some of the issues raised. She informed members that PHA is now producing a weekly epidemiological report instead of a monthly report.

C20/20.2 The Chair asked about the recommendation to appoint an Assistant Director (Epidemiology). The Interim Chief Executive advised that this post will be recruited on a temporary basis as part of the bid for COVID-19 funding. When asked by the Chair when this post would be recruited, the Interim Chief Executive said that an internal “expressions of interest” exercise will commence shortly.

C20/20.3 Mr Stewart asked if NEDs could receive a copy of the Report. The Interim Chief Executive undertook to provide this.

C20/20.4 Mr Clayton said that he had been concerned at the previous meeting to the reference made to “special measures” at the meeting of 9 July, and he noted that this has now abated. The Chair stated that it is important for PHA to maintain good relations with its Sponsor Branch.

C20/20/5 Professor Rooney asked about a meeting with the Chief Medical Officer. The Interim Chief Executive advised that a meeting is being set up.

C21/20 **Item 6 – Any Other Business**

C21/20.1 The Interim Chief Executive advised that PHA has dealing with an issue relating to a meat processing plant and has been trying to

support this plant over the last 3 weeks. However she said that the issue may now need to be resolved through a legal route.

C22/20 **Item 7 – Details of Next Meeting**

To be confirmed.

Signed by Chair:

Date: 17 September 2020

HSC Public Health Agency

minutes

Title of Meeting	59th Confidential Meeting of the Public Health Agency Board
Date	17 September 2020 at 3.15pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street

Present

Mr Joseph Stewart	-	Non-Executive Director (*Chair*)
Mrs Olive MacLeod	-	Interim Chief Executive
Mr Edmond McClean	-	Interim Deputy Chief Executive / Director of Operations
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals
Professor Hugo van Woerden	-	Director of Public Health *(via video link)*
Alderman William Ashe	-	Non-Executive Director
Mr John-Patrick Clayton	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director

In Attendance

Mr Paul Cummings	-	Director of Finance, HSCB
Dr Aideen Keaney	-	Director of Quality Improvement *(via video link)*
Ms Marie Roulston	-	Director of Social Care and Children, HSCB *(via video link)*
Mr Robert Graham	-	Secretariat

Apologies

Mr Andrew Dougal	-	Chair

C23/20	**Item 1 – Welcome and Apologies**
C23/20.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr Andrew Dougal.
C23/20.2	The Chair proposed that Item 7 be carried out in advance of Items 5 and 6 as the Interim Chief Executive had to leave the meeting at 3.30pm.
C24/20	**Item 2 – Declaration of Interests**
C24/20.1	The Chair asked if anyone had interests to declare relevant to any

items on the agenda. No interests were declared.

C25/20 **Item 3 – Minutes of Previous Meeting held on 20 August 2020**

C25/20.1 The minutes of the meeting held on 20 August 2020 were approved as an accurate record of that meeting, subject to an amendment in paragraph C20/20.4.

C26/20 **Item 4 – Matters Arising**

Data Breach

C26/20.1 Mr McClean advised that the data breach issue has been resolved to the satisfaction of the Information Commissioner's Office (ICO). The Chair still remained concerned that this was a PHA issue given that the report was published by the Department of Health. Mr McClean assured members that the fact that the Department of Health was the publisher had been made known to the ICO.

C27/20 **Item 7 – Workforce Issues**

C27/20.1 The Interim Chief Executive advised that there will be an "expression of interest" exercise conducted in the short term to fill Mr McClean's role following his retirement. With regard to Mr Cummings she said that she would need to speak to the new Chief Executive regarding this. She noted that there is a suggestion that this role may move to the Department of Health which would be an issue for PHA so the replacement for Mr McClean's post may need to be an individual with a finance background.

C27/20.2 The Interim Chief Executive reported that the Director of Public Health, Professor Hugo van Woerden, will be retiring at the end of December, and that his post has been offered to the candidate who was on the waiting list following the last recruitment exercise. She said that to date she has not yet received a response from this individual, but she had given a deadline of Friday 21 September. She considered that the scope of the post of Director of Public Health was so wide that the appointment of a Deputy Director was required.

C27/20.3 The Interim Chief Executive said that Mr Brendan Bonner had retried from his role as Assistant Director of Health and Social Wellbeing Improvement at the end of July, and that an "expression of interest" exercise will also be conducted for that role. She added that 3 of the 3 Head of Health Improvement roles in that directorate will also now be permanently recruited as PHA has obtained permission to commence this. She said that stability is required in that team as many staff are in temporary acting up roles.

C27/20.4 The Interim Chief Executive advised that PHA has submitted a bid for additional resources to strengthen areas such as information

management and epidemiology. She advised that four new staff have been recruited to support the epidemiological function.

C27/20.5 The Chair advised that the Board will be bringing forward wording for a new risk to be added to the PHA Corporate Risk Register with respect to the gaps in staff at senior level. He added that there will be a range of mitigations but the risk will be rated as "high". Professor Rooney agreed that there is a risk, both in terms of a gap at senior level, and in having staff in acting up roles.

At this point the Interim Chief Executive left the meeting.

C28/20 Item 5 - Muckamore Abbey Hospital Leadership and Governance Review Report

C28/20.1 Ms Roulston gave members an overview of the Report. She began by explaining that the review team was independent of both HSCB and PHA and that she and Mrs Briege Quinn had commissioned the review at the request of the Department. She advised that the terms of reference were based on the "Way to Go" report.

C28/20.2 Ms Roulston reported that the review team carried out a range of interviews but COVID-19 had placed restrictions in terms of being able to speak to family members. She outlined the key findings, saying that vulnerable people were failed and that opportunities were missed. She added that there had been delays in implementing CCTV and said how the review came about following a complaint made by the father of one of the patients.

C28/20.3 Ms Roulston advised that the report made 12 recommendations, three of which relate to HSCB/PHA. She said that HSCB/PHA should ensure that any breaches of requirements are reported to the Board of the Belfast Trust. She said that HSCB must ensure that where there are areas of non-compliance in relation to the Delegated Statutory Function report, these should be escalated to the Belfast Trust as soon as possible, and finally, the PHA should develop specific indictors for learning disability inpatient services. She informed members that Mrs Quinn is already leading on this work.

C28/20.4 Ms Roulston said that she and Mr Sean Holland had met with the families to share the findings of the Report. She noted that there will now be a public inquiry. In terms of the recommendations, she reported that HSCB and the Department are already looking at the Delegated Statutory Function reporting. She said that members may be aware that Adult Safeguarding legislation has now been passed. She also reported that a review of the Serious Adverse Incident (SAI) process, which had been paused due to COVID-19, has now recommenced.

C28/20.5 Mr Clayton declared an interest in that some of the staff involved may

be members of his trade union organisation. He commented that it will be important that the Board is updated regularly on the work that Mrs Quinn is doing. He added that the PHA should also ensure that its internal safeguarding policies are in place and lined up with those of any external provides that it works with. Ms Roulston advised that an "Adult Safeguarding Transformation Board" which will be multi-agency and multi-disciplinary, had been established, and that its first meeting is due to be held in October. Mr Morton noted that the Permanent Secretary has written to Chairs about the role of Boards in ensuring that they are provide the relevant scrutiny and making it clear that the learning from this Report should be applied across the whole HSC system. Ms Roulston agreed to provide a copy of this letter for members **[Action – Ms Roulston]**.

C28/20.6 Ms Mann-Kler noted that the Report had outlined how adequate arrangements were in place, but these had not been implemented. She noted how there was also commentary around leadership and she felt that there were similar issues for PHA in terms of continuity. She added that the Belfast Trust appeared to be more focused on acute care than care at Muckamore, and she asked whether COVID-19 has blindsided PHA in terms of altering focus and if there are any areas where there could be unknown issues. She said that she welcomed clarity on SAIs and what PHA's responsibility is in terms of oversight of SAIs and who enforces the trigger point of what is an SAI. She sought clarity on the timelines for following up and going forward, suggested that SAIs should be on the PHA Board agenda. She also felt that this issue should be discussed in open session to reinforce PHA's commitment to openness and transparency. The Chair noted Ms Mann-Kler's comment but pointed out that it may have been difficult to predict the content or sensitivity of the report at the time of creating the meeting agenda.

C28/20.7 Mr Cummings explained that the HSCB leads the SAI process and that each week, the senior management team of HSCB received a report on SAIs and the learning of SAIs is reported to the HSCB Board. The Chair said there should be clarity in terms of what organisation is responsible for. Mr Morton said that from a safety and quality perspective, there are discussions ongoing about a safety and quality framework and that when HSCB closes, the role of PHA may change in this regard. He added that there has already been an extensive review of the SAI process and that RQIA has carried out a review which may lead to further changes and greater clarification in terms of responsibilities. Ms Mann-Kler asked which organisation would be responsible for an SAI occurring today, and Mr Morton advised that it would be HSCB.

C28/20.8 Professor van Woerden commented that he found the SAI and Early Alert system complex, and that he and Mr Morton have a role where they are working for both PHA and HSCB. He said that there are challenges in terms of the capacity to be able to undertake SAI

investigations and suggested that additional resource may need to be brought in to support that. Professor Rooney commented that she has attended SAI meetings and it is not clear between HSCB and PHA in terms of where responsibilities lie. Mr Morton explained that between HSCB and PHA there are DROs (Designated Responsible Officers) for the SAI process and that they work together depending on whether there is a clinical context or a care context. He advised that there is a Committee that looks at SAIs and he suggested that it may be useful to bring a paper for the Board that outlines the current arrangements, albeit that they may change. The Chair felt that this is what the Non-Executive Directors are seeking.

C28/20.9 Mr Cummings said that he disagreed that Non-Executive Directors are not playing a role in terms of SAIs. He said that the Governance Committee in HSCB takes its role very seriously in terms of reviewing SAIs, and that HSCB could not fulfil its role without the support of PHA as it does not have specialist doctors or nurses. Ms Roulston agreed that it would be useful to bring a paper to the PHA Board on this.

C28/20.10 Ms Mann-Kler asked about the timelines for the development of the care indicators. Mr Morton agreed to report back on this **[Action – Mr Morton]**. He advised that there is a Muckamore group set up which is chaired by Professor Charlotte McArdle and Mr Sean Holland which will be monitoring the implementation of the recommendations as part of its action plan. Dr Keaney said that one of the reasons HSCQI was established was to look at learning from SAIs. She commented that when she was a DRO she found the process unclear. The Chair said that a paper on this should be brought to the public session of the next meeting **[Action – Executive Directors]**.

C28/20.11 The Board noted the update on the Muckamore Abbey Hospital Leadership and Governance Review Report

At this point Ms Roulston left the meeting.

C28/20.12 The Chair asked about the situation at Craigavon Area Hospital. Professor van Woerden advised that there situation is serious with four deaths having now occurred. He said that the microbiology and infection control teams in the hospital are leading a review and they would have data on patient flows and staff movement and are best placed to investigate. He said that PHA will have an advisory role as the Chief Medical Officer had asked PHA to be involved. He added that there is a public health consultant who is spending a significant amount of time on this. He clarified that the formal accountability in this matter lies with the Southern Trust Chief Executive up to the Permanent Secretary. Mr Morton added that the Trust will carry out an SAI and that a PHA officer has been nominated as DRO.

C28/20.13 Mr Morton advised members that he and Professor van Woerden are planning to hold a learning event on the back of the review to ensure

that any lessons learnt are picked up early. The Chair noted that SAIs were initially about learning, but are now more focused on being investigations. Mr Morton said that there is now a commitment to look at getting advocacy support for families to help clarify and manage their expectations regarding the SAI process, but does not seek in any way to replace any legal process.

C29/20 **Item 6 – Epidemiology / Bradley Report**

C29/20.1 The Chair expressed concern on behalf of all of the Non-Executives about the accuracy of some of the content of this Report, and that a Report has been received and the Board needs to agree how it should be responded to.

C29/20.2 Ms Mann-Kler referred to paragraph 9.4 of the Report and said that she felt strongly about the statement made regarding the PHA Board. She asked whether the Report has been circulated outside of PHA. She said that the statement in the Report at this section was based on the meeting which had taken place on 9 July and that the PHA Board should have been aware that this meeting was being used as a form of consultation. She added that the statement was misleading and a misrepresentation of the facts. The Chair added that the Report suggested that the PHA Board was aware of the reasons why the Department took the responsibility of publishing daily death data from the PHA when this was not the case.

C29/20.3 Mr Clayton said that his overarching concern is that from the Report it is not clear what the author was asked to review as the terms of reference are not included. He felt that a number of the recommendations are not based on evidence in the Report. He said that if the focus of the review was on epidemiology, it should have outlined what PHA has, what PHA needs and how PHA can reach that position. He felt that the references to the Department taking control of specific matters have been taken out of context and with no clear rationale as to why this happened. He said he found the report troubling. He added that in terms of the Agency Management Team (AMT) response, he noted that it was stated as being unanimous but added that it does not appear that all of the recommendations will be implemented, and some may be taken forward by other mechanisms.

C29/20.4 Mr Morton said that AMT has not signed off on all of the recommendations. He said that there was a discussion, and some issues have yet to be agreed upon.

C29/20.5 The Chair felt that the discussion could not be progressed further in the absence of the Interim Chief Executive. He asked what the outputs of the report were and how implementation could be assessed. Ms Mann-Kler asked how the Report links with the review of the PHA that the Chief Medical Officer has commissioned.

C29/20.6 Mr McClean said that while the remit of the review and the process for carrying it out were not fully shaped by AMT, efforts have been to take some of the findings that are related to PHA's COVID journey in relation to epidemiology and progress them. He said that some of the recommendations went beyond the remit of the review and are not well-founded. He said that recommendation 8 was inappropriate as these teams work in different ways. He felt that recommendation 6 was incorrect as the Business Continuity Plan is always kept under review and there is a separate process for reviewing the Joint Emergency Response Plan, and that the PHA element of that will be brought to the PHA Board for approval. In terms of the Chief Medical Officer's review, he said that some of the recommendations will be informed by it, when that review is complete.

C29/20.7 Mr Cummings said that his main concern about the Report was the neutrality of the author and he took great exception to some of the findings.

C29/20.8 Professor van Woerden said that there is no connection between this Report and the Chief Medical Officer's review. He said that this Report was to look at additional capacity in the area of data and he agreed it had exceeded its remit, whereas the review of PHA will look at PHA's needs going forward.

C29/20.9 Professor Rooney expressed concern at paragraph 5.3 which she said was clearly based on a judgement made at the meeting on 9 July and she wished to see this removed. She noted that this Report was written on the back of a suggestion of special measures being placed on PHA.

C29/20.10 Alderman Porter said that he was unhappy with the way the review was carried out, and he expressed concern that any future discussion will take place in the absence of two officers who have more experience and knowledge of PHA than anyone else. He asked how their feedback will be reported in. He also asked about the status of the Report and who it has been circulated to. The Chair advised that in the absence of any other vehicle for complaint he has considered making his own written response to it.

C29/20.11 Alderman Ashe asked if PHA has paid for this Report. Mr Cummings explained that the author was engaged through the HSC Leadership Centre so they will have been paid for their work.

C29/20.12 The Chair said that the Report should be brought back to the next meeting for further discussion. Professor Rooney asked it would be possible to request that the Report is not shared outside the PHA. Alderman Porter said would welcome feedback from Mr McClean and Mr Cummings on the Report.

C30/20 **Item 8 – Any Other Business**

C30/20.1 There was no other business.

C31/20 **Item 9 – Details of Next Meeting**

To be confirmed.

Signed by Chair:

Date: 15 October 2020

HSC Public Health Agency

minutes

Title of Meeting	62nd Confidential Meeting of the Public Health Agency Board
Date	15 April 2021 at 12.45pm
Venue	12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair (*via video link*)
Mrs Olive MacLeod	-	Interim Chief Executive (*via video link*)
Dr Stephen Bergin	-	Interim Director of Public Health (*via video link*)
Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals (*via video link*)
Mr Stephen Wilson	-	Interim Director of Operations
Alderman William Ashe	-	Non-Executive Director (*via video link*)
Mr John Patrick Clayton	-	Non-Executive Director (*via video link*)
Professor Nichola Rooney	-	Non-Executive Director (*via video link*)
Mr Joseph Stewart	-	Non-Executive Director (*via video link*)

In Attendance

Dr Aideen Keaney	-	Director of Quality Improvement *(via video link)*
Ms Tracey McCaig	-	Interim Director of Finance, HSCB *(via video link)*
Mr Brendan Whittle	-	Director of Social Care and Children, HSCB *(via video link)*
Mr Robert Graham	-	Secretariat

Apologies

Ms Deepa Mann-Kler	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

C1/21	**Item 1 – Welcome and Apologies**
C1/21.1	The Chair welcomed everyone to the meeting. Apologies were noted from Ms Deepa Mann-Kler and Alderman Paul Porter.
C1/21.2	The Chair welcomed Mr Aidan Dawson to the meeting following his recent appointment as PHA Chief Executive. He said that Mr Dawson will take on the role following the retirement of Mrs MacLeod in July.
C2/21	**Item 2 – Declaration of Interests**
C2/21.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

C3/21 **Item 3 – Minutes of Previous Meeting held on 19 November 2020**

C3/21.1 The minutes of the meeting held on 19 November 2020 were approved as an accurate record of that meeting.

C4/21 **Item 4 – Matters Arising**

C4/21.1 There were no matters arising.

C5/21 **Item 5 – Draft PHA Annual Report (PHA/C/01/04/21)**

C5/21.1 Mr Wilson advised that the Governance and Audit Committee had discussed the draft Annual Report at its meeting earlier today. He said that the Report is laid out following the parameters set by the Department and this year it aims to tell the story of how PHA responded to the COVID-19 pandemic. He noted that this is a live draft and is subject to further amendments following comments made by the Committee, but that the Committee approved that this be adopted as the PHA Annual Report.

C5/21.2 The Chair reminded members that he is keen that PHA produces a Report that is accessible to the public but he was aware that it is subject to Departmental requirements. He advised that he had had a conversation with the Comptroller and Auditor General who agreed that the Report should be more meaningful and suggested discussing this with the Director of Finance in the Department.

C5/21.3 Mr Stewart said he, Mr Clayton and Ms Mann-Kler had reviewed the Report earlier today and agreed that it was a much better Report and represents an excellent platform, from which an abstract could be used to produce a more meaningful report for the public and he would happy to work with Mr Wilson in developing this. He said that the Report shows the excellent work that PHA staff have done.

C5/21.4 Mr Clayton agreed that there had been good discussion earlier and said that he had suggested the inclusion of some narrative about the future of the Agency and how it has reviewed its response to COVID-19 and will move forward. He felt that there was potential to say that, linked to COVID-19, there are priority areas that need to be looked at, but not to increase the burden on staff. He added that a point was made about making reference to the fact that the Board met more often informally. Mr Wilson said that the comments made by Mr Stewart and Mr Clayton will be taken away and considered as part of a further draft

C5/21.5 The Interim Chief Executive advised that she had already prepared some narrative in terms of the challenges going forward and she would share this with Executive Directors at their next meeting on Tuesday. Mr Morton said that the inclusion of a section looking forward is an excellent recommendation, but he felt that in light of recent discussions about potential changes in the HSC system in terms of planning, it may

be worth getting Departmental imprimatur on any text to include. He said that the inclusion of narrative around the work that Ms Anne McMurray has been doing and the new structures would make the Report more meaningful. The Interim Chief Executive said that the piece she was working on was factual, and reiterated that she would share it with Executive Directors.

C5/21.6 The Chair asked when the Report will be finalised. Mr Wilson said that the Report is required to be signed off by early May. Ms McCaig advised that the timetable states that it should be submitted by 7 May but that the Department wishes to see the draft Governance Statement in advance. She added that the Report will remain a live document until it is signed off by the Board in June.

C5.21.7 The Board **APPROVED** the draft Annual Report.

C6/21 Item 6 – Draft PHA Governance Statement (PHA/C/02/04/21)

C6/21.1 Mr Wilson explained that the Governance Statement also forms part of the Annual Report and is the section where the Chief Executive gives an assurance about the overall governance of the organisation. He noted that members will be familiar with the format and he said that there was discussion about the Statement at the Governance and Audit Committee earlier today and in particular on section 9 relating to internal governance divergences.

C6/21.2 Mr Wilson advised that two divergences, relating to EU Exit and Payroll, have been moved to the section containing those divergences no longer considered to be control issues. In terms of those areas which remain control issues, he said that some additional narrative is awaited from the Department on one of those. He advised that there are two new divergences, but that the one pertaining to HSCQI will be amended as some funding is anticipated.

C6/21.3 Mr Stewart said that he had nothing to add, but noted that the narrative on the divergence relating to COVID-19 would be amended to make it more relevant to PHA.

C6/21.4 Mr Clayton advised that Ms Mann-Kler had raised a query as to whether there should be a reference to the Muckamore Report given it pertained to governance issues and whether it was aimed at PHA. Mr Morton said that Miss Rosemary Taylor had contacted him about this after the earlier meeting. He explained that the issue that arose was what the matter in the Report should have been raised as a Serious Adverse Incident (SAI) by the Belfast Trust and the Trust agreed that there had been a breach of protocol. He said that the recommendation in the Report said that HSCB/PHA should have sought an assurance from the Trust that this breach had been reported to the Trust Board. Following this, he said that the Permanent Secretary had written to all Trust Boards reminding them of the need to be seeking assurances

around safety and quality and ensuring that governance and reporting arrangements are in place. Therefore, in that context, he did not feel that this was a divergence for PHA and that as part of a review that has been carried out of the SAI process, HSCB/PHA are seeking assurance that there is a link between those who govern the SAI process and the Trust Board.

C6/21.5 The Chair asked what the process would be if there was an SAI within PHA. The Interim Chief Executive said that the Department and the PHA Board would be alerted. The Chair asked about the timeframe for dealing with SAIs but the Interim Chief Executive advised that this could vary, depending on the level of SAI.

C6/21.6 Professor Rooney said that she still struggled to fully understand the difference between the role of HSCB and PHA vis-à-vis the SAI process. Mr Morton advised that he had circulated a paper previously to members and he would be content to take members through the paper at a future time. In summary, he said that HSCB and PHA have joint responsibility in terms of governance, but HSCB is in the lead role. He undertook to re-issue the paper that had been circulated to members previously about SAIs **(Action – Mr Morton)**.

C6/21.7 The Board **APPROVED** the draft Governance Statement.

C7/21 Item 7 – Any Other Business

C7/21.1 The Interim Chief Executive informed members that following a meeting she attended yesterday, the modelling group looking at COVID-19 is suggesting that the number of daily positive cases could rise to approximately 2,000 per day by the summer. She said that it is therefore important for PHA to ensure that it has the staffing in contact tracing to deal with this. She advised that individuals who are close contacts are now being invited for testing. She added that PHA has extended the contracts of contact tracing staff.

C7/21.2 Professor Rooney asked what PHA is doing in terms of getting messages out about the need to isolate. The Interim Chief Executive explained that with each call a risk assessment is made and people can be signposted where to get help. She added that the Health Improvement team is working with local community and voluntary sector organisations, but she reiterated that PHA does not have the authority to make people stay at home.

C7/21.3 Mr Morton said that the data is worrying and it will be a difficult message to put out given that a majority of the population has been vaccinated. He said that there may not be the same level of hospital admissions, but the Interim Chief Executive pointed that PHA will have to deal with the demand of having to work through 2,000 cases a day in the contact tracing centre. She added that additional recruitment may be required as some staff have left the centre thinking that the

pandemic was over.

C7/21.4 Mr Morton advised that the Department has begun to have discussions with PHA about the vaccination programme and its transfer to PHA, which will place an additional stress on the work of the organisation. The Interim Chief Executive added that there is also increased testing being carried out and more work to be undertaken in terms of analytics.

C7/21.5 The Chair drew to the meeting to a close.

C8/21 Item 8 – Details of Next Meeting

To be confirmed.

Signed by Chair:

Date: 17 June 2021

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Chief Executives of HSC Trusts

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

Tel: 02890520559
Fax: 02890520573

Email: richard.pengelly@health-ni.gov.uk

Our ref: RP5485
SGM-0593-2020

Date: 21 August 2020

Dear Colleagues,

MUCKAMORE ABBEY HOSPITAL – REPORT OF THE INDEPENDENT LEADERSHIP AND GOVERNANCE REVIEW

You will be aware that the report of the independent panel commissioned to carry out a review of Leadership and Governance arrangements at Muckamore Abbey Hospital was published on Wednesday. The report is available on the Department's website at: https://www.health-ni.gov.uk/news/independent-review-muckamore-published

One of the central conclusions of the review is that while the Belfast Trust had appropriate governance structures in place – with the potential to alert the Executive Team and the Trust Board to risks pertaining to safe and effective care – these systems were not implemented effectively. While the review considered only the Belfast Trust's governance arrangements, governance systems are broadly similar across all five integrated Trusts, and in light of this I am writing to ask that you consider the findings of the report in the context of your individual organisational governance structures.

This requirement is in addition to the actions flowing from the report's 12 recommendations, which will have regional application. Implementation of the report's recommendations will be co-ordinated and monitored through the Muckamore Departmental Assurance Group.

Yours sincerely

RICHARD PENGELLY

Cc: Chief Executives HSCB/PHA and RQIA

Sean Holland

Charlotte McArdle

Michael McBride

Mark Lee

Business Services Organisation

Providing Support to Health and Social Care

INTERNAL AUDIT SERVICE – BALLYMENA OFFICE
GREENMOUNT HOUSE
WOODSIDE ROAD INDUSTRIAL ESTATE
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PUBLIC HEALTH AGENCY

PROGRESS REPORT TO GOVERNANCE & AUDIT COMMITTEE

11 APRIL 2022

MAHI - STM - 308 - 758

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Introduction

This report to the Audit Committee includes a report summarising progress being made against the 2021/22 Internal Audit Plan.

The Board Chairman and Chief Executive requested, following the issue of the draft report in January 2022, that further work be conducted on the board effectiveness audit in March 2022. This included the issue and analysis of a second board effectiveness survey and interviews held with 8 members of the Board. This second survey and subsequent work was resourced using 5 audit days originally planned for potential advisory work around HSCB migration that were not utilised.

Key Performance Indicators

Key Performance Indicator	Performance
% of SLA audit days delivered to date	**98% (March 2022)**
85% of First Draft Reports Issued within 4 weeks of fieldwork completion	**100%**
75% of reports finalised within 5 weeks of issue (and within 1 week of receiving management comments) *75% Management Comments should be received within 4 weeks*	***57% (100%)*** ***29%***
% of reports significantly amended between draft report and final report stage	**0**

Definition of Levels of Assurance

The Level of Assurance that Internal Audit can provide on audit areas is defined as follows:

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

The levels of assurance are limited to the scope of audit work carried out.

Prioritisation of Recommendations

Internal Audit prioritises recommendations using the following definitions:

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

INTERNAL AUDIT PROGRESS REPORT 2021/22

AUDIT ASSIGNMENT	DATE FIELDWORK WAS COMPLETED	DATE (WORKING) /DRAFT REPORT ISSUED	DATE MANAGEMENT RESPONSES RECEIVED	DATE FINAL REPORT ISSUED	DATE OF CONSIDERATION BY AUDIT COMMITTEE	OVERALL LEVEL OF ASSURANCE
Finance Audits						
Financial Review	16/02/22	23/02/22	05/04/22	05/04/22	11/04/22	SATISFACTORY - Non Pay Expenditure, Budgetary Control and Financial Reporting to the Board LIMITED - Payments to Staff
Corporate Risk Based Audits						
Vaccination Programme	Deferred – approved by the Governance and Audit Committee					
Recruitment of Vaccinators	20/06/21	30/06/21	16/09/21	17/09/21	07/10/21	SATISFACTORY
Governance Audits						
Performance Management	12/10/21	19/10/21	19/11/21	19/11/21	03/12/21	LIMITED
Board Effectiveness	10/01/22	11/01/22 28/02/22				
Migration of HSCB – advisory	Deferred to accommodate additional audit work required on Board Effectiveness audit					
Serious Adverse Incidents	17/02/22	25/02/22	21/03/22	21/03/22	11/04/22	LIMITED
Follow Up						
Mid-Year Follow Up	31/08/21	06/09/21	21/09/21	21/09/21	07/10/21	N/A
Year End Follow Up	27/02/22	21/03/22	30/03/22	31/03/22 05/04/22	11/04/22	N/A

Introduction

In accordance with the 2021/22 annual internal audit plan, BSO Internal Audit carried out a Financial Review audit between December 2021 and January 2022. The last Internal Audit of this topic was performed during 2020/21 when satisfactory assurance was provided.

The scope of this audit covers the controls and processes for which PHA and HSCB is directly responsible for and not those services that BSO Shared Services provides on its behalf. BSO Shared Services is audited and reported on separately. A Service Level Agreement is in place with BSO for the 2021/22 year with monthly performance reports issued to PHA against a range of Key Performance Indicators.

The audit specifically focused on controls within PHA in the areas of:

- Control over payroll processes; including in particular new starts, leavers, contract amendments, and additional payments.
- Non Pay Expenditure; including a review of payment control through, for example, FPM, link load payments and manual payments. Prompt payment was also considered as was access to systems.
- Financial Reporting to the Board, including a review of the financial information presented to Board.
- Budget control; including management of budgets, budget holders, training; and budgetary reporting etc.

PHA at November 2021 was reporting a year to date surplus of £0.8m. The organisation has an annual salaries budget of £25.5m with spend at November 2021 at £16.3m. Goods and Service budget is £2m with spend against that budget at November 2021 at £1.073m. Due to the Covid-19, PHA has had significant increase in the number of new starts and leavers during 2021 with 659 new starts in the period 1st January 2021 to 31st December and 180 leavers for the same period. At 17th November 2021, PHA had 990 staff.

Scope of Assignment

The objective of the assignment was to assess the appropriateness and effectiveness of the financial controls in place within PHA and financial services delivered by HSCB Finance Department for PHA. The focus of the audit was to review and test the systems in place for the areas detailed below:

- Payments to Staff;
- Non-pay expenditure and;
- Financial Governance
- Budgetary Control

Sample testing also included Safeguarding Board NI, which is hosted by PHA.

The audit was based on the following risks:

- Inaccurate payments made to staff. Failure to utilise HRPTS appropriately.
- Inadequate control over non pay expenditure may lead to inaccurate, duplicate or bogus payments being made. Failure to utilise FPL appropriately. Failure to meet statutory obligations and targets. Lack of control in purchase process could lead to poor value for money.
- Risk of financial instability of Board does not have good visibility of the financial position of the organisation.
- Risk that funding available will not be appropriately managed if there is not an effective budgetary control system.

The objectives of this audit were:

- To ensure appropriate controls are operating in respect of payroll and human resources.
- To ensure that appropriate and accurate payments are made to staff.
- To ensure system access is adequately controlled.
- To ensure that payments are processed appropriately and in a timely manner.
- To ensure that any purchase cards are managed in line with the requirements of HSC (F) 57-2016.
- To ensure there is good financial governance in the organisation.
- To ensure that budgets are appropriately managed in PHA.

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

Level of Assurance

Non Pay Expenditure, Budgetary Control and Financial Reporting to the Board

Satisfactory

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

Payments to Staff

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Executive Summary

Internal Audit can provide limited assurance in relation to Payments to Staff within PHA. Limited assurance is provided on the basis that significant issues were identified in relation to additional payments. New starts, leavers and contract changes were not processed on a timely basis, resulting in over and underpayments. Internal Audit noted that the Organisational Management structure was not being maintained up to date. The review of Staff in Post (SIP) reports by budget holders is not sufficiently robust.

Internal Audit can provide satisfactory assurance in relation to control over Non Pay Expenditure, Budgetary Control and financial reporting to the PHA Board. Controls were generally operating as intended. In terms of budgetary control, there is clarity as to who budget holders are, there are regular budgetary reports available and the budgets reviewed are being appropriately controlled and managed. In terms of non-pay expenditure, controls were operating effectively in terms of eprocurement, FPM and timely payment of invoices. There is a regular reports on financial position reported to PHA Board. These reports provide clarity on, for example current surplus position, year-end forecast position, capital position, Covid-19 programmes and salaries and goods and service budget position. Internal Audit tested a sample of payroll, payment processes for SBNI with no significant issues identified.

The following significant findings have been identified, impacting on the assurance provided:

1. 48 PHA staff received a total of 211 incorrect enhancements (relating to individual dates) between January and December 2021. These overpayments were due to the incorrect completion of electronic timesheet (ETM02s). Internal Audit estimate that the gross value of potential overpayments ranged from £1 to £4,640 (gross value, not the net value of potential overpayments to staff) - however Management cannot confirm these values until each item has been fully reviewed and any necessary corrections furnished to Payroll Shared Services for action.
2. Internal Audit noted significant delays in the processing of new starts, leavers and contract changes in PHA:
    - All 20 (100%) new starts reviewed were not processed on a timely basis – with delays ranging from 36 to 89 days from their physical start date to the date they were actioned on HRPTS. These delays relate, in some instances to bank staff that did not work significant hours. Internal Audit notes through sample testing that these delays had not been identified through the regular review of the SIP reports.
    - For 14 (70%) of 20 leavers reviewed, actions were not processed on a timely manner by PHA managers. Action has been taken in 13 of these to recover the overpayment, however in 1 instance (7%) at the time of the audit fieldwork, a loan had not yet been set up in HRPTS to recover the overpayment. This has subsequently been addressed. These leavers were not sufficiently identified through a review of SIP reports.
    - 6 (86%) of 7 contract changes reviewed were not processed in a timely manner, ranging from 28 to 88 days between the start date and it being actioned on HRPTS.

Internal Audit acknowledges that, during pre-pandemic / business as usual period, the prevalence of overtime and / or enhancement payments to PHA staff is minimal and that the levels of new starts / leavers and contractual changes will have been significantly higher during the time period reviewed by Internal Audit.

The other key findings in this report are:

3. In relation to the Organisational Management (OM) structure:
   - 108 staff of the 990 in PHA had not been assigned to a direct line manager on the OM structure in HRPTS. Of these 108 staff, 77 were bank clinical contact tracers (all at band 6 level) for which the HRPTS system was not used for Employee / Employer Self Service functions. Of the remaining 31, Internal Audit notes that Management has since audit fieldwork largely addressed this matter on HRPTS.
   - 8 (17%) out of 48 staff reviewed had been aligned to the incorrect line manager in the OM structure.
   - Between May and November 2021, 3 (3%) out of 91 SIP returns issued were not returned to BSO HR and Finance Departments by the budget holder as required. Whilst Internal Audit acknowledges that this is a high return rate, without the full cohort of returns being submitted/validated, there are risks of errors in the OM structure going unnoticed.
4. 1,543 claims processed via timesheets were not processed on a timely basis – with delays ranging from between 49 and 185 days. The significant majority of these related to Contact Tracers.
5. SBNI has a statutory duty to review instances where a child has died or been seriously harmed as a consequence of abuse or neglect. These reviews are known as Change Management Reviews (CMR) and must be conducted by an independent chair sufficiently independent of the 27 agencies involved in SBNI. SBNI currently has 11 such chairs. There are no formal agreements in place with Case Management Review (CMR) Chairs due to queries that have been raised in respect of who is responsible for indemnity.
6. In relation to link load payment spreadsheets:
   - For 1 payment (20%), a more junior staff member received permission from the link load approver to use their electronic signature to approve the link load for payment. There is a lack of evidence that the senior approver actually reviewed the link load spreadsheet for appropriateness however and was not copied into the email that was issued to BSO to process the payment. The value of the invoice was £8,292.

The other findings in this report are:

7. On 2 occasions, staff overtime claims were claimed in bulk, however these claims should be split into the individual days overtime was in fact worked. HRPTS is a date driven system and overtime should be entered for the specific dates worked.
8. Internal Audit noted 1 case where staff sickness was recorded on HRPTS 6 weeks after the absence commenced.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Enhancements	-	2	-
2.	Timely processing of new starts, leavers and changes	-	2	-
3.	OM Structure / SIP Reporting	-	1	-
4.	Timely processing of timesheets	-	1	-
5.	SBNI - CMRs	-	1	-
6.	Link Loads	-	1	-
7.	Overtime	-	-	1
8.	Absence Management	-	-	1
	TOTAL		**8**	**2**

Detailed Findings and Recommendations

1 Enhancements

Finding

Internal Audit reviewed a total of 12,582 enhancements made to 580 staff during the period 1 Jan 2021 to 18 October 2021. Internal Audit indicatively identified that 48 staff received a total of 211 potential incorrect payments (i.e. which relate to specific dates). It is the view of Internal Audit that these errors were due to the incorrect completion of electronic timesheet (ETM02s). These potential errors identified included staff due overtime claiming enhancements in error and part time staff claiming overtime without completing the required additional hours. These potential errors were authorised for payment by approving officers prior to submitting to BSO PSSC for payment. Internal Audit estimate that gross value of potential overpayments ranged from £1 to £4,640 (gross value, not net value of any overpayment to staff).

Internal Audit notes that there is already instructions and a training video in place to support managers in their role in this regard and that the precise value of potential overpayments cannot not be confirmed by Management until such time as the items highlighted by Internal Audit have been fully reviewed and any required corrections furnished to Payroll Shared Services for action.

Internal Audit acknowledges that, during pre-pandemic / business as usual period, the prevalence of overtime and / or enhancement payments to PHA staff was minimal.

NATURE OF INCORRECT ENHANCEMENT	NO OF INSTANCES OF INCORRECT PAYMENT	Number of Employees Impacted	Range Of Estimated (gross) Overpayments
Paid Overtime before working 37.5hrs	103	4	£25 - £4,640
Paid Saturday / Sunday / Bank Holiday Enhancements in error	108	44	£1 - £626

Implication

Regular overpayments are being made to staff through timesheet processing and payment of enhancements.

Recommendation 1.1	Management should review the 211 claims in detail and provide any necessary information to Payroll Shares Services in order to progress the recovery of any identified overpayments.
Priority	2
Management Action	**ACCEPTED** The Finance Directorate will work with PHA management to review the instances highlighted by Internal Audit and forward any necessary corrections to Payroll Shared Services for processing.
Responsible Manager	Assistant Director of Finance / PHA Operational Managers
Implementation Date	May 2022

Recommendation 1.2	Management should communicate to relevant Managers and staff to reinforce the appropriate use of ETM02 and what claims can be made and approved in line with Agenda for Change.
Priority	2
Management Action	**ACCEPTED** Completed: An urgent communication to all staff was issued week commencing 4/4/22 to remind staff managers and staff of requirements and to reinforce available guidance.
Responsible Manager	Director of Operations / BSO Assistant Director of HR
Implementation Date	April 2022

2 Timely processing of New Starts, Leavers and Contract Changes

Finding

Internal Audit noted significant delays in the processing of new starts, leavers and contract changes in PHA during the audit period.

New Starts

PHA employed 659 new starts in the period 1st January to 31st December 2021 – the majority (376) were bank staff and 245 were temporary posts. This is a significant increase in the number of new starts compared to previous years. All 20 (100%) new starts reviewed were not processed on a timely basis – with delays ranging from 36 to 89 days from their physical start date to the date they were actioned on HRPTS. These delays in some instances to bank staff who did not work significant or consistent hours. Internal Audit notes through sample testing that these delays had not been identified through the monthly review of the SIP reports.

Leavers

PHA had 180 leavers in the period 1st January 2021 to 31st December 2021. For 14 (70%) of 20 leavers reviewed, actions were not processed on a timely manner by PHA managers resulting in overpayments, which have been addressed through recoupment from final pay or via invoices raised. Action has been taken in 13 of these to recover the overpayment, however in 1 instance (7%), at the time of audit fieldwork, a loan had not yet been set up in HRPTS to recover the overpayment. This has subsequently been addressed by Payroll Shared Services. These leavers were not identified through a review of monthly SIP reports.

Contract Changes

Internal Audit identified 136 contractual changes that were actioned in HRPTS between 1st January 2021 and 31st December 2021. Internal Audit reviewed 7 contractual changes and identified the following:

- 6 (86%) were not processed in a timely manner, ranging from 28 to 88 days between the start date and it being actioned on HRPTS.
- For 1 (20%) staff a permanent reduction in hours from 37.5 hours to 30 hours has been made – however in HRPTS, this staff member has been set to go back to 37.5 hours in June 2025 (per the basic pay screen). This should be reviewed for appropriateness.

Internal Audit acknowledges that the levels of new starts / leavers and contractual changes will have been significantly higher during the time period reviewed by Internal Audit than during the pre-pandemic period.

Implications

Risk of over/underpayment if new starts and leavers and contract changes are not processed on a timely basis.

Recommendation 2.1	Management should remind all staff that all new starters, leavers and contract changes should be actioned on a timely basis. Formal monitoring and reporting on the timely processing of new starts and leavers, in the first instance, by Managers should be reported on a regular basis at an appropriate level within PHA with action taken where trends or Departments of concern are identified.
Priority	2
Management Action	**ACCEPTED** An urgent communication to all staff was issued week commencing 4/4/22 to remind staff managers and staff of requirements and to reinforce available guidance. BSO HR will provide information to PHA management to highlight where there have been delays in the processing of new starts and leavers, for PHA management to performance manage accordingly.
Responsible Manager	Director of Operations / BSO Assistant Director of HR
Implementation Date	May 2022

Recommendation 2.2	Management should review the exceptions above to ensure any overpayments made, where these have occurred, have been dealt with appropriately.
Priority	2
Management Action	**ACCEPTED** The Finance Directorate will work with PHA management, where necessary, to review the instances highlighted by Internal Audit to ensure appropriate action has been taken in respect of any overpayments made to staff, where these have occurred.
Responsible Manager	Assistant Director of Finance / PHA Operational Management
Implementation Date	May 2022

3 Organisational Management (OM) Structure

Finding

The following was noted in relation to the OM structure within HRPTS:

- Internal Audit identified that 108 staff of the 990 staff at 17 November 2021 in PHA had not been assigned to a direct line manager on the OM structure in HRPTS. This means that these staff do not have a direct line manager that can complete payroll/HR processes online in HRPTS on their behalf, for example, recording absence, setting up working patterns, completing leaver forms and processing contractual changes in a timely manner. Of these 108 staff, 77 were bank clinical contact tracers (all at band 6 level). 11 other bank contact tracers at the same grade that had been assigned a direct line manager on the system. Internal Audit note that of the remaining 31 non-Contact Tracing staff, that 28 have now a direct line manager on the OM structure, one of which is the Chair (who will not have a line manager associated with that post) and the remaining 2 have vacancies at line manager level. Where there are manager vacancies in the OM structure, the workflow will escalate any necessary items to the next line manager above. Internal Audit also note that in respect of Contact Tracing the HRPTS system was not being used for items such as annual leave approvals, therefore there was not requirement for a detailed OM structure within the system to be facilitated for the CT Bank staff. Internal Audit notes that Management have already taken action to address this matter.
- Internal Audit contacted 10 PHA managers to validate their OM structure. 8 (17%) out of 48 staff were aligned to the incorrect line manager in the OM structure at the time of audit fieldwork.
- Between May and November 2021, 3 (3%) out of 91 SIP returns issued were not returned to BSO HR and Finance Departments by the budget holder as required. Whilst Internal Audit acknowledges that this is a high return rate, without the full cohort of returns being submitted/validated, there are risks of errors in the OM structure going unnoticed.

Implication

Risk that payroll related processes will not take place on a timely basis if there direct line managers have not been accurately assigned and risk of inappropriate payments if there are not robust and appropriate controls in place for review of SIP reports

Recommendation 3.1	Managers should be reminded of the importance of robustly reviewing and challenging their monthly SIP reports to ensure the accuracy of the staff in post. This should specifically focus on new starts, leavers and contract changes.
Priority	2
Management Action	**ACCEPTED** Completed: An urgent communication to all staff was issued week commencing 4/4/22 to remind staff managers and staff of requirements and to reinforce available guidance.
Responsible Manager	Director of Operations
Implementation Date	April 2022

4 Timely processing of timesheets

Finding

Internal Audit notes significant delays in the processing of timesheet related payments for the period January 2021 to December 2021. 1,543 claims processed via timesheets were not processed on a timely basis – with delays ranging from between 49 and 185 days. The significant majority of these related to Contact Tracers.

Band 8 and above staff were excluded from this test as permission to claim overtime for the period July to December 2021 was only issued on 15th November 2021.

Implication

Risk that approvers cannot validate the claims being submitted if they are not submitted and approved on a timely basis. Risk that sick pay will not be accurately calculated if the system does have accurate up to date information included in respect of payments received.

Recommendation 4.1	Management should request all staff / managers ensure that all payroll claims processed via timesheets should be submitted and approved on a timely basis.
Priority	2
Management Action	**ACCEPTED** Completed: An urgent communication to all staff was issued week commencing 4/4/22 to remind staff managers and staff of requirements and to reinforce available guidance.
Responsible Manager	Director of Operations
Implementation Date	April 2022

5 SBNI – Case Management Reviews

Finding

Safeguarding Board NI is hosted by PHA in terms of payroll and payment processes with accountability for performance being to the DoH. SBNI has a statutory duty to review instances where a child has died or been seriously harmed as a consequence of abuse or neglect. These reviews are known as Change Management Reviews (CMR) and must be conducted by an independent chair sufficiently independent of the 27 agencies involved in SBNI. SBNI currently has 11 such chairs. Through sample testing, Internal Audit identified payments to 2 different chairs (£7,906 and £7,913 respectively) and then requested the contract or agreement under which these payments were made. Management confirmed that there are not currently formal agreements in place with these Chairs due to queries that have been raised in respect of who is responsible for indemnity – ie the Chairs or the DoH/PHA. Internal Audit understands that both BSO HR and Directorate of Legal Services (DLS) have been engaged to clarify these arrangements and that agreements will be put in place thereafter.

Implication

Risk that PHA is making payments to CMR Chairs without agreements in place and lack of clarity as to who is responsible for indemnity.

Recommendation 5.1	SBNI, working with BSO DLS and HR management should resolve the issues raised in respect of indemnity and ensure that agreements are put in place with Independent Chairs.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Director of Operations (Interim) SBNI
Implementation Date	March 2023

6 Link Load payments – Non Pay Expenditure

Finding

A sample of 5 payments paid via the Link and Load spreadsheet was selected and the relevant back up to support the payments was requested for review. Internal Audit noted the following:

- For 1 payment (20%), a more junior staff member received permission from the link load approver to use their electronic signature to approve the link load for payment. There is a lack of evidence that the senior approver actually reviewed the link load spreadsheet for appropriateness however and was not copied into the email that was issued to BSO to process the payment. The value of the invoice was £8,292.

Implication

Risk of inappropriate payment increases if invoices are not reviewed and approved at the appropriate level.

Recommendation 6.1	A procedure defining the appropriate use of electronic signatures for link and load approval should be developed. This should include the appropriate use of electronic signatures, which should ensure that the approver has visibility of the final payment request to Shared Services (Accounts Payable).
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	Assistant Director of Operations / Assistant Director of Finance
Implementation Date	April 2022

Introduction

In accordance with the 2021/22 Annual Internal Audit plan, BSO Internal Audit carried out an audit of Serious Adverse Incidents (SAIs) in both the HSCB and PHA. An audit of SAIs was last conducted in the HSCB in 2014/15 when satisfactory assurance was provided. An audit of learning from falls was conducted in 2016/17 in PHA, when satisfactory assurance was provided.

Definition

A SAI is:

- Serious injury to, or the unexpected/unexplained death of:
  - A service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit);
  - A staff member in the course of their work;
  - A member of the public whilst visiting a HSC facility;
- Unexpected serious risk to a service user and/or staff member and/or member of the public;
- Unexpected or significant threat to provide service and/or maintain business continuity;
- Serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;
- Serious self-harm or serious assault *(including homicide and sexual assaults*)
  - On other service users;
  - On staff or
  - On members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;
- Suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;
- Serious incidents of public interest or concern relating to:
  - Any of the criteria above
  - Theft, fraud, information breaches or data losses
  - A member of HSC staff or independent practitioner.

Any adverse incident which meets one or more of the above criteria should be reported as a SAI.

Purpose

The primary purpose of the SAI process is to improve patient safety by learning; to reduce risk of recurrence and to ensure full engagement throughout the process.

Numbers of SAIs

For the audit period reviewed, (1st June to 30th November 2021) 329 incidents were reported to the HSCB and 129 SAIs were closed. 822 SAIs were open on Datix as at 1st December 2021.

Roles and responsibilities

The role of the HSCB and PHA is covered in the Circular, HSC (SQSD) 08-10- Transfer of SAI reporting to HSCB issued May 2010 and also the HSCB's Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016). The circular created an interdependent relationship in respect of the HSCB and PHA SAI responsibilities and was developed in the context of the PHA Director of Public Health and Director of Nursing having duals roles across both HSCB and PHA Senior Management Teams. At a high level:

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

Process

All HSC organisations are required to report SAIs to the HSCB Governance Team within 72 hours of the incident occurring or being classified as a SAI. These will be recorded in Datix by the HSCB. A SAI Notification Form will then be forwarded to a lead officer in the HSCB or PHA who will assign the SAI to the relevant HSCB /PHA Professional Group (for level 1 SAIs) or a HSCB/PHA Designated Review Officer (DRO (for level 2 and 3 SAIs) who will be supported closely by a professional Group. The DRO could be a HSCB or PHA staff member, depending on the programme of care. There are 3 levels of SAIs, all of which require different levels of responses:

- Level 1 Review – in a level 1 SAI, Trusts are required to submit a Serious Event Audit Learning Summary Report to the DRO within 8 weeks for review, approval and identification of any learning.
- Level 2 Review – in a level 2 SAI, Trusts are required to submit Terms of Reference (TOR) and Membership of the Review Team to the DRO within 4 weeks and have completed a Root Cause Analysis Report within 12 weeks of notification.
- Level 3 Review – in a level 3 SAI, as a minimum the Chair of the Review Team will be independent of the Trust (and if required the entire team will be independent) and the TOR and team membership at the outset will be agreed by the DRO to include timescales for completion of the review.

Need for improvement

In December 2020, the HSCB Chief Executive raised concerns in respect of the SAI process and in particular the significant number of review reports that were outstanding from HSC Trusts. A Joint Improvement Plan was subsequently developed between HSCB, PHA and the HSC organisations to help address delays in the system and to improve timely learning. A number of improvements have been made including the establishment of HSCB/PHA weekly Incident Review Group and the weekly safety brief. These Groups ensure collective, multi-disciplinary decision making on the management of all notifications received into the SAI mailbox in a more timely manner. Any urgent action required is identified and areas of concern or importance are highlighted to HSCB SMT following each meeting. Directors across both HSCB and PHA now get Daily Reports highlighting all SAIs received the previous day. Any areas of concern are brought to the attention of relevant staff on a more timely basis. Touch point and external performance meetings are now regularly held with reporting organisations. At these meetings, actions required to expedite outstanding Review Reports, Terms of Reference for Review panels and Assurances from Trusts in relation to the implementation of identified learning are discussed.

Governance arrangements

There are a number of processes which support the Governance of the SAI process for which the HSCB and PHA are jointly responsible. These include:

Surveillance Measures / Group	Remit
Daily Report	A report highlighting all Early Alerts, SAIs and Interface notifications received the previous day is created by the HSCB Governance team and is then reviewed by the PHA Nursing Team. This is then circulated by HSCB staff to all relevant HSCB/PHA Directors with any areas of concern brought to the attention of relevant staff.
Incident Review Group - Weekly	This Group, which consists of PHA and HSCB staff, and jointly chaired by the PHA and HSCB, was established in March 2020, in order to escalate areas of concern as appropriate to HSCB SMT on a weekly basis. This Group ensures collective, multidisciplinary decision making on the management of all notifications received into the SAI mailbox in a timely manner. Any urgent action required is identified and areas of concern or importance are highlighted to HSCB/PHA Safety Brief following each meeting. This Group also has the ability to identify potential regional learning for onward dissemination.
Safety Brief - Weekly	Issues from the Weekly Incident Review Group and other pertinent issues including identified themes and trends are discussed and escalation to HSCB/PHA Safety Brief as required. Learning is reviewed /signed for dissemination, where appropriate. This Group is led by the Director of Nursing PHA and the Director of Strategic Planning HSCB and consists of staff from HSCB Governance and PHA Nursing. Any issues from this meeting are escalated to HSCB SMT or PHA AMT as required.

Surveillance Measures / Group	Remit
SAI Professional Groups - Monthly	These 7 Groups, which consists of staff from HSCB and PHA ensure collective, multidisciplinary decision making following review of SAI Review Reports identifying any regional learning and ensuring that learning is taken forward in the format agreed, for example, Professional Letter, Learning Letter and Newsletter Articles etc. SAI Professional Groups for each Programme of Care (PoC) are supported by the Governance and Safety and Quality Teams. Any themes/trends or areas of concern are escalated to the Safety, Quality & Patient Experience Oversight Group or Safety Brief as required. (see below).
Safety, Quality & Patient Experience Oversight Group – Monthly	This Group consider learning, patterns, themes or areas of concern from all sources of information and in particular Adverse Incidents / SAIs / Complaints and Patient and Client Experience to improve the safety and quality of services commissioned. This Group provides a platform for any issues or concerns to be discussed arising from SAI Professional Groups, issues in relation to Safety Alerts, Complaints, etc. Issues / areas of concern from this Group will be referred to the Directors Forum (per below) as required. This Group consists of staff from HSCB and PHA and is jointly chaired by the HSCB and PHA senior staff.
Directors Forum - Quarterly	This Group, which consists of Directors and senior staff from PHA and HSCB and jointly chaired by the HSCB and PHA, has been established to streamline and further enhance current arrangements in relation to Safety, Quality and Patient Experience. It ensures all sources of information in relation to the safety, quality and patient experience of services is being managed and appropriate action is taken. Any issues / areas of concern will be referred to the HSCB/PHA SMT/AMT as required.

Scope of Assignment

The objective of the assignment was to assess the robustness of the arrangements in place within both HSCB and PHA for the governance, oversight and performance management/ accountability arrangements in place in respect of Serious Adverse Incidents (SAIs). The audit also considered whether learning was identified and disseminated on a timely basis across Health and Social Care. Given the significant interdependencies and overlapping roles, responsibilities and working relationships on SAIs between HSCB and PHA, including the joint committees and working groups compromising HSCB and PHA staff, there is merit in having a joint audit report including both the HSCB and PHA.

The audit was based on the following risk that learning from SAIs may not be sufficiently identified and disseminated increasing the risk of reoccurrence.

The objectives of this audit were:

- To ensure that there is clarity over roles and responsibilities between PHA and HSCB in respect of SAIs and that they are discharging those responsibilities.
- To ensure there is appropriate governance framework in place within the HSCB and PHA for the review and oversight of SAIs and there is appropriate systems in place to consider, identify, agree and disseminate learning.
- To ensure learning is disseminated on a timely manner.
- To ensure that there is an appropriate mechanisms to hold HSC Trusts to account in terms of their compliance with SAI processes.

Internal Audit completed high level analysis from Datix of all SAIs for the period June to November 2021 and reviewed 10 recently closed and 10 open SAIs as part of testing. A review of the various HSCB /PHA groups supporting the SAI process was also reviewed.

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

Level of Assurance

Limited

There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Executive Summary

Internal Audit can provide limited assurance in relation to the SAI processes within the HSCB and PHA. Limited assurance is provided on the basis that HSCB and PHA does not have a joint accountability mechanism in place to ensure each partner delivers their respective responsibilities. Management indicate that HSCB (SPPG) and PHA, as part of their improvement plan, are developing a partnership agreement which will set out the escalation arrangement between SPPG and PHA.

There is a backlog and delay in the dissemination of regional learning in particular learning letters and learning matters articles to be published – Internal Audit recognises that this is largely due to PHA staff redeployment. A number of the HSCB/PHA professional group meetings have had to be cancelled over recent months, often at short notice due to the redeployment of PHA staff, these redeployments were part of the PHA business continuity response. This impacted on the ability to consider SAIs and subsequent learning and impacted on the overall performance and effectiveness of the SAI process that HSCB is ultimately responsible for. Overall performance management on SAIs, particularly within PHA needs to be further strengthened and there is a need to consolidate and develop more specific performance measures across both HSCB and PHA. Internal Audit are aware that this is incorporated into the HSCB/PHA Improvement plan and changes and improvements have been made and continue to be made as a result of this.

While providing limited assurance, Internal Audit recognises the action that has been taken by senior management through the joint HSCB /PHA improvement plan to drive improvement in this area. This has included a review and improvement of SAI assurance/governance structures, more effective operational reporting and the establishment of regular touch point meetings with HSC Trust Governance Department to discuss current status of their SAIs. This has resulted in more timely completion of SAI processes for new SAIs within the HSCB/ PHA compared to pre-implementation of the plan. Work has and is being progressed to clear the backlog of learning to be issued on the older/legacy SAIs. Management indicate this be completed in the coming weeks.

The following significant findings were identified, impacting on the assurance provided:

1. In relation to the relationship between HSCB and PHA regarding SAIs:
   - If one organisation does not fully or effectively discharge their responsibility, the other organisation, under the current joint arrangement, does not have a formal mechanism to hold that organisation to account to drive improvement going forward.
   - With the migration of the HSCB to the Strategic Planning and Performance Group (SPPG) within the Department of Health (DoH), there is a need to review and update the key circular (May 2010) and procedures (from 2016) to define the role of the SPPG in respect to SAIs and to review and formalise the relationships, role and responsibility between SPPG and PHA in respect of SAIs.
2. In relation to dissemination of learning:
   Learning
   - 6 instances were identified relating to 12 SAIs where regional learning/best practice letters had not yet been disseminated, despite the fact that the need had been identified and agreed. In 4 cases, the delays related to unavailability of maternity and child health professionals from within the PHA. Management indicate that this unavailability was due to the necessity for them to be redeployed to other areas as a response to the Covid-19 priorities. Delays ranged from 178 to 626 working days from the date that the learning was identified and agreed. PHA staff is responsible for writing these letters and HSCB is then responsible for sending them out. 2 further instances were noted where a Learning Letter and a Reminder of Best practice letter had been retracted, however had not yet been reissued. 1 of these has been outstanding for 121 working days and the other 55 days. Management indicate that as the issues were extremely complex and required senior clinical input and as this clinical expertise was redeployed during the

pandemic they had not been finalised for reissue. Management indicate that these have now, since audit fieldwork, been progressed for reissue before 31st March 2022.

- 33 Learning Matters (LM) Articles (which are effectively reminder of best practice to be followed with the original learning having already been communicated out prior to this) were also identified relating to 57 SAIs that had not yet been published. The average amount of time outstanding is 403 working days from the time that Learning was identified and agreed with the longest being 1,530 working days. PHA is responsible for developing and publishing these Learning Matter articles. HSCB has overall responsibility for the governance and performance management of SAIs.

  Management indicate the majority of that these learning matters are a reminder of best practice, rather than specific new learning and that guidance in these areas was already in the system. It is the nevertheless the view of Internal Audit that learning letters and letter matter articles should be issued on a more timely basis. Management indicate the recovery plan will reduce the number of outstanding LM articles to approximately 10 by 31st March 2022.

Professional Groups

- A number of professional group meetings (membership comprising of PHA and HSCB staff) had to be cancelled over recent months, due to the redeployment of PHA professional staff to attend (Management confirmed as a result of business continuity arrangements put in place at direction of the Chief Medical Officer due to the Covid-19 response). The cancellation of these meetings impacts on the ability to consider SAI reports and determine / disseminate learning as appropriate. Management indicated that while these meetings had to be cancelled, contingency arrangement were established, specifically that the PHA Assistant Director of Nursing for Q&S met with the appropriate governance lead to ensure there was no urgent requirement for learning and if this was identified this would have been appropriately and directly escalated to the necessary professional for advice.

3. Learning from SAIs is included in the Annual Quality Report which was last considered by October 2021, however this was very brief and did not give a sense of number of number of learning letters etc that are outstanding and the length of time that they are outstanding. Performance information to PHA AMT and Agency Board needs to be significantly developed. Internal Audit notes that PHA Management previously presented a detailed report on learning arising from SAIs, however this was last presented to Agency Board in November 2015.

The other key findings in the audit are:

4. A Joint Improvement Plan, with 23 actions, has been developed to help improve SAI processes across PHA and HSCB, with regular updating to HSCB SMT. 4 (17%) actions are still underway and 3 (13%) actions have not yet commenced. Red actions include the need to take forward the review of the Procedure for the Reporting and Follow Up of SAIs; the need to take forward the review of the Regional Safety and Quality Alerts Procedure; and the need to consider amending timescale for submission of Review Reports. Despite the positive action taken over recent months, Internal Audit notes that the number of open incidents has actually increased over the last 24 month period. Further work is needed to drive improvement in the timely submission of high quality SAI review from HSC Trusts.

The other finding is:

5. While Datix captures the date that the incident occurred and the date that it was reported to HSCB, it does not capture the date that it was discovered as being as potential incident within the HSC organisation to be reported to the HSCB. While the incident date and the discovery date may be the same, Internal Audit notes instances where these were different. It is important that this date is also recorded in Datix.
6. Terms of Reference need to be put in place for a number of the new groups and reviewed and updated for existing groups. Minutes need to be taken to maintain a record of discussion at the Safety and Quality Directors Forum including who attended, apologises etc.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
9.	Relationship between HSCB and PHA	-	2	-
10	Learning and Professional Groups	-	2	-
11	Reporting	-	1	-
12	Joint Improvement Plan	-	1	-
13	Reporting of Incidents	-	-	1
14	Groups	-	-	2
	TOTAL	**-**	**6**	**3**

Detailed Findings and Recommendations

1 Relationship between PHA and HSCB

Finding

HSCB and PHA work in close partnership and are highly dependent on each other to ensure that their respective roles and responsibilities in respect of SAIs are fully discharged both in terms of governance, performance and timely dissemination of learning. If one partner does not fully or effectively discharge their responsibility, the other partner, under the current joint arrangement, does not have a formal mechanism to hold that organisation to account to drive improvement going forward. Internal Audit notes instances per findings below, for example, where PHA professional staff have been unable to attend meetings relevant to SAIs, however HSCB does not have a formal mechanism to hold PHA to account in terms of their performance/ service delivery.

Roles and responsibilities of both HSCB and PHA are defined under a HSC Circular from May 2010 and also the HSCB's Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016). With the migration of the HSCB to the Strategic Planning and Performance Group (SPPG) within the Department of Health (DoH), there is a need to review and update the key circulars and procedures to define the role of the SPPG in respect to SAIs and to review and formalise the relationships, role and responsibility between SPPG and PHA in respect of SAIs.

Implication

Risk that SAIs may not be appropriately managed if HSCB and PHA do not have a formal mechanism to hold each other to accounts in terms of the service they deliver.

Recommendation 1.1	Management should request that the Circular (May 2010) be updated to reflect the migration of the HSCB to SPPG/DOH. The HSCB should notify ALBs of the arrangements for the Reporting and Follow up of Serious Adverse Incidents post HSCB migration to SPPG/DoH.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	HSCB: Director of Strategic Performance
Implementation Date	April 2022

Recommendation 1.2	Particularly in context of HSCB migration to DoH, a partnership agreement outlining escalation arrangements and a joint accountability mechanism between PHA and SPPG regarding SAIs should be formalised.
Priority	2
Management Action	**ACCEPTED** This should be formalised in a partnership agreement between SPPG and PHA
Responsible Manager	HSCB: Director of Strategic Performance PHA: Director Of Nursing, Midwifery and Allied Health Professionals
Implementation Date	October 2022

2 Dissemination of learning

Finding

Learning

It is important that learning arising from SAIs is disseminated on a timely manner – this can take the form of Learning Letters / Reminder of Best Practice Letters, Professional Letters, Learning Matters Articles and Thematic Reviews. The following was specifically noted:

Learning Letters

Internal Audit acknowledges that the number of outstanding Learning Letters has reduced from 19 (as at January 2021) to 6 as at February 2022. Internal Audit identified that for the 6 instances relating to 12 SAIs, regional letters (3 learning letters, 2 Reminder of Best practice Letters and 1 Professional Letter) had not yet been disseminated despite the fact that the need had been identified and agreed. In 2 of these cases, the issue of the learning was on hold due awaiting further approval from the DoH; however in the other 4 cases, the delays related to unavailability of maternity and child health professionals from within the PHA. Delays ranged from 178 to 626 working days from the date that the learning identified and agreed. PHA staff are responsible for writing these letters and HSCB are then responsible for sending them out.

Internal Audit noted 2 further instances where a Learning Letter and a Reminder of Best practice letter had been retracted, however had not yet been reissued. 1 of these has been outstanding for 121 working days and the other 55 days.

Management indicate that as the issues were extremely complex and required senior clinical input and as this clinical expertise was redeployed during the pandemic they had not been finalised for reissue. Management indicate that these have now, since audit fieldwork, been progressed for reissue before 31st March 2022.

Learning Matters Articles

There has been a significant increase in the number of editions of Learning Matters that have been issued since March 2020 (10 editions between 2020-22 compared with 10 editions between 2014-2020). However, at February 2022, Internal Audit identified 33 Learning Matters Articles relating to 57 SAIs that had not yet been published. The average amount of time outstanding is 403 working days from the time that Learning was identified and agreed with the longest being 1,530 working days. PHA is responsible for developing and publishing these Learning Matter articles.

Management indicate the majority of that these learning matters are a reminder of best practice, rather than specific new learning and that guidance in these areas was already in the system. It is the nevertheless the view of Internal Audit that learning letters and learning matters articles should be issued on a more timely basis. Management indicate the recovery plan will reduce the number of outstanding LM articles to approximately 10 by 31st March 2022.

Professional Groups

There are 7 Professional Groups (with each group consisting of staff from both PHA and HSCB) across 7 Programmes of Care covering Acute Services, Children, Corporate Services, Maternity, Older People and Physical Disability / Sensory Impairment, Paediatric and Mental Health and Learning Disability. These Groups are responsible for ensuring collective, multidisciplinary decision making following review of SAI Review Reports identifying any regional learning and ensuring that learning is taken forward in the format agreed, for example, through Professional Letter, Learning Letter or Newsletter Articles etc.

Through testing, Internal Audit identified the unavailability of PHA professional staff at professional group meetings over the last year, due to the impact of Covid-19, with a number of meeting having to be cancelled. The following was specifically noted from a review of sample of these meetings:

- 4 acute services meetings were cancelled between 1st August and 30th September 2021 due to redeployment of PHA staff. On other occasions, meetings went ahead however some SAIs could not be considered ie 20 SAIs had to be deferred from the September 2021 meeting due to medical representation not being in attendance. Management note that although there were 4 cancelled meetings there was no existing backlog in review of SAI reports.
- 3 maternity professional group meetings were also cancelled between August 2021 and January 2022 due to redeployment of PHA staff.

- All 6 paediatric professional group meetings were also cancelled between July and December 2021 – again due to redeployment of PHA staff. Management indicate that a paediatric nurse is now in post within the PHA and this will enable more timely review of reports moving forward.

Management confirmed that the main groups cancelled which created a backlog were Maternity and Child Health and that this was due to redeployment of professional staff due to business continuity measures in order to respond to the Covid-19 pandemic. Management also confirmed that considerable work has been carried out during this period in the Mental Health professional groups, in particular, to reduce the backlog within this area in review of reports from over 100 to less than 5.

The cancellation of these meetings significantly impacts on the ability to consider SAI reports and determine / disseminate learning as appropriate. Concerns in respect of the redeployment of key PHA professional staff to attend Professional Group was discussed at the HSCB SMT in October 2021 with the HSCB acquiring and paying for additional resources to address the PHA capacity issue through their SLAs with the HSC Leadership Centre.

Implication

Risk that SAI process is not effective if learning identified is not disseminated on a timely basis. Risk that learning is not identified and disseminated on a timely basis if professional groups are not meeting on a timely basis.

Recommendation 2.1	PHA should ensure protected clinical time to enable the timely formulation and dissemination of learning going forward for the specific professional group highlighted by Internal Audit. There should be regular reporting on status of outstanding learning to SPPG SMT and PHA AMT and at PHA Non Executive level.
Priority	2
Management Action	**ACCEPTED**
Responsible Manager	PHA: Director of Nursing, Midwifery and AHP
Implementation Date	End September 2022

Recommendation 2.2	PHA should strengthen resources and take action to ensure that they expand capacity in its paediatric team to ensure sufficient expertise is available to allow all professional groups are meeting to meet as intended each month as required.
Priority	2
Management Action	**ACCEPTED** It should now be noted that the maternity and paediatric groups have now been strengthened as the PHA has employed a Nurse Consultant for paediatrics who is responsible for reviewing any paediatric cases. The maternity group (due to release of staff from redeployment) is now also meeting regularly. Further recruitment within Midwifery in the PHA will further consolidate this.
Responsible Manager	PHA: Director of Nursing Midwifery and AHP
Implementation Date	End September 2022

3 PHA Reporting

Finding

There is limited information reported to PHA AMT and at Non Executive level in respect of performance of the organisation in discharging their responsibilities in respect of SAIs. The following was specifically reported recently:

- A paper and presentation was presented to AMT 24th November 2020 outlining the HSCB/PHA improvement plan including a data overview and improvements to date. An update on this to include the roles and responsibilities of the PHA Board within the SAI procedure was brought to AMT and shared with PHA Board in April 2021.
- Management confirmed that learning from SAIs is included in the Annual Quality Report which was last considered by October 2021, however this was very brief and did not give a sense of number of number of learning letters etc that are outstanding and the length of time that they are outstanding. Performance information to PHA AMT and Agency Board needs to be significantly developed. Internal Audit notes that PHA Management previously presented a detailed report on learning arising from SAIs, however this was last presented to Agency Board in November 2015.

Implication

Risk that SAIs are not appropriately managed if there is not robust performance reporting.

Recommendation 3.1	PHA should strengthen the performance information in respect of discharge of their responsibilities to AMT and Agency Board. This review should include any requirement regarding the status of outstanding dissemination learning and the length of time outstanding.
Priority	2
Management Action	**ACCEPTED** We will improve the information presented to PHA board regarding accountability and include a dashboard which will include more information on SAI's to the PHA.
Responsible Manager	PHA: Director of Nursing Midwifery and Allied Health Professionals
Implementation Date	April 2022

4 Joint Improvement Plan

Finding

A Joint Improvement Plan, with 23 actions, has been developed in May 2021 to help improve SAI processes across PHA and HSCB, with regular updating to HSCB SMT. 16 (70%) actions were scored Green (Action Complete), 4 (17%) were amber (Action Underway) and 3 (13%) were Red (Action not commenced). Amber Actions include:

- The need to address the current backlog of Regional Learning to be issued.
- The need to establish an oversight plan to monitor Level 3 SAI Reviews and ensure individual timescales have been established.
- The need to work with HSC Trusts to develop a time bound improvement plan for the current backlog and any deferred SAIs.
- The need to develop accountability protocols to hold Reporting Organisations to account for delays through their accountability meetings.

Red Actions include:

- The need to take forward the review of the Procedure for the Reporting and Follow Up of SAIs following the publication of the RQIA Review Report and the Statement of Patient Rights.
- The need to take forward the review of the Regional Safety and Quality Alerts Procedure.
- The need to consider amending timescale for submission of Review Reports.

Despite the improvements that have been being made, for example the regular touch point meetings between HSCB/PHA and individual Trust Governance leads to discuss current position in respect of SAIs, Internal Audit notes that the number of SAIs reports that are overdue from Trusts has actually increased by 33%, from 451 at December 2020 to 601, as at February 2022. Internal Audit appreciate that Covid-19 has led to an increase in the number of SAIs, however there is a need for HSCB/PHA to further strengthen their performance accountability framework with HSC Trusts to ensure timely completion of reports by HSC Trusts going forward including formal escalation arrangements where performance does not improve.

Implication

Risk that SAI process will not operate effectively if the actions identified through the Joint Improvement Plan are not taken forward and implemented on a timely basis.

Recommendation 4.1	PHA and HSCB/SPPG should further strengthen their performance accountability arrangements with HSC Trusts to drive more timely completion of reports that are of higher quality. A formal escalation process should also be developed for escalation of Trusts that do not show improvement.
Priority	2
Management Action	**ACCEPTED** The responsible Directors are arranging a meeting with Trusts to highlight concerns re their backlogs and develop escalation protocols which will include discussion of this area within accountability meetings with Trusts.
Responsible Manager	HSCB: Director of Strategic Planning PHA: Director of Nursing, Midwifery and Allied Health Professionals
Implementation Date	September 2022

Outline of the Role of the PHA Board in Respect of the SAI process

1. **Purpose of the Paper: -** This paper outlines the roles and responsibilities of the PHA in the management of Serious Adverse Incidents.

2. **Summary of Responsibilities:-** It is important for PHA members to note the role of the PHA is covered in the May 2010 Department of Health issued circular HSC (SQSD) 08-10-Transfer of SAI reporting to HSCB.(Enclosed) and is governed by the SAI policy 2016(Enclosed)

   PHA Board Members should note this circular created an interdependent relationship in respect of the HSCB and PHA SAI responsibilities. This is a complex role as authority was vested in both organisations particularly given the duals role of the Director of Public Health and Director of Nursing across the HSCB and PHA senior management teams.

   The Chief Executive and Board of Directors of the HSCB have primary responsibility for governing and ensuring the effective performance of the **SAI process** across the health and social care system.

   The PHA Board through the Chief Executive, the Director of Public Health and Director of Nursing, have primary responsibility for **providing professional and clinical leadership across SAI process** and are accountable for overseeing the **dissemination and application of regional learning** across the health and social care system in partnership with HSCB Directors.

   The role of the PHA Board is to be assured that PHA officers are fulfilling their responsibilities as required by the 2010 circular and in line with the SAI Policy.

3. **Policy Context: -** In May 2010 the Department of Health issued circular HSC (SQSD) 08-10-Transfer of SAI reporting to HSCB, outlining the transfer of the responsibility for SAI reporting to the HSCB working in partnership with the PHA.
"Transfer of the existing Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency"

The Health and Social Care Board Chief Executive is accountable to the Department of Health for the regional management of the SAI policy. The HSCB Director of Performance and Service Improvement supported by the HSCB Governance Team oversees the administration co-ordination and management of the SAI Processes.

The Chief Executive of the PHA, as outlined in the aforementioned circular has a specific role for ensuring the PHA:

- Work with the HSC Board to maintain a system to manage SAI reporting
- Implement regional and local learning recommendations
- Support the HSC Board in holding Trusts to account for these responsibilities and provide assurance to the Department that these responsibilities are being met.

The circular further states, The PHA, through its integrated commissioning responsibilities with the HSC Board, will support the HSC Board in holding HSC Trusts and Family Practitioner Services to account for the discharge of their responsibilities and ensuring that regional learning is identified and disseminated, and will work with the Board to maintain a system for managing SAIs:

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

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, Midwifery and AHP's.

The Director of Public Health and the Director of Nursing have joint professional responsibility for:

- the management of serious adverse incident reviews as delegated to Professional Officers of the PHA (Medical, Nursing, Midwifery & AHP)
- the identification and dissemination of SAI learning pertaining to their areas of responsibility
- the management of quality and safety alerts
- issuing reminders of best practice in response to identified safety and quality issues.
- undertaking thematic reviews relating to quality and safety issues
- the leadership of Quality Safety Experience and Safety Quality Alerts Teams.

4. **Summary of the SAI Process: -** The purpose of the SAI Process is to identify learning from serious incidents which occur within our healthcare system, with the overall aim to reduce as far as possible the risk of the same incident happening again. In summary the aim is to:

- Improve patient safety by learning
- Reduce risk of recurrence
- Ensure full engagement throughout the process

Summary of SAI Data Currently there are approximately 800 SAI's within the system (527 reported in 2020)

- 75% level 1, 20% level 2, 5% level 3
- 1/3 from acute POC, 1/3 MH and 1/3 across the remaining 6 POC's (maternity and paediatrics, family and childcare, elderly, learning disability, primary care and corporate services)

It is important to note there are 3 Levels of SAI, all of which require different levels of response:-

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all reported SAIs, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review will be noted on the SAI notification form.

For a SAI review, Trusts are expected to complete the process within specific timescales depending on the level of review required.

SAI Review Timescales

- **Level 1 Review** – in a level 1 SAI Trusts are required to submit a Serious Event Audit Learning Summary Report to the DRO within 8 weeks for review, approval and identification of any learning
- **Level 2 Review** – in a level 2 SAI Trusts are required to submit TOR and Membership of Review Team to the DRO within 4 weeks and have completed a Route Cause Analysis Report within 12 weeks of notification
- **Level 3 Review** – in a level 3 SAI, as a minimum the review Chair will be independent of the Trust (and if required the entire team will be independent) and the TOR and team membership at the outset will be agreed by the DRO to include timescales for completion of the review.

5. **SAI Governance Process**:-. It is important to note there are a number of interlocking processes which support the Governance of the SAI process for which the HSCB and PHA are jointly responsible.

    A. **HSCB Governance Team: -** All SAI's are notified to the HSCB Governance Team. This team co-ordinates and manages the response to SAIs and alerts, which involves the allocation of SAI's to Designated

Responsible officers by programme of care/professional grouping whilst ensuring the SAI process is managed in line with the policy standards and deadlines. The Director of Performance and Service Improvement in the HSCB has overall responsibility for ensuring the effective performance of the SAI processes.

B. **Daily Triage: -** on receipt of the SAI notification it is appropriately allocated and screened by professional officers in PHA (Nursing Teams) and DRO's. A daily report of all notifications is produced by the S&Q Nursing team and matters are escalated to Directors as required.

C. **Designated Responsible Officer: -** A DRO is a senior professional/officer within the HSCB/PHA who has a degree of expertise in relation to the programme of care/service area where the SAI has occurred. Their role is to liaise with the reporting organisation via the HSCB governance team and or responsible Director on any issues identified through the SAI process.

D. **Weekly Incident review team**. This multi-professional team comprised of senior staff from HSCB and PHA meet weekly to screen all SAI notifications received and may involve initiating actions for the Trust and to provide assurance that actions are being progressed by DRO's. The weekly incident review team produce a weekly report for HSCB SMT on all incidents. This report details all new incidents, actions taken and any escalation required.

E. **Professional Groups** review all SAI's monthly within their POC.
Professional Groups were formed to streamline and expedite the learning process. The Groups fall under various programmes of care (POC), where the aim is to bring DRO's from each POC together on a

regular basis to support the responses/actions to SAIs and importantly agree on the necessary learning if appropriate.

F. **Safety Quality Alerts Team (SQAT): -** a multi-disciplinary group that meets fortnightly. The team is responsible for overseeing the implementation and assurance of Regional Learning/Reminder Letters and Guidance issued by HSC Board/PHA and other organisations.

G. Quality Safety Experience Team (QSE): - Is a PHA/HSCB Director led group which oversee all matters relating to Quality Safety and Experience. This group has a wider remit than SAIs but is required as part of its role to provide assurance to the CE of PHA/HSCB on all system safety issues.

6. **Moving Forward** PHA Board Members should note a number of actions have been progressed by the HSCB to improve the management of SAI's across the HSC system.

- Appointment of a lead Director for SAIs, this is now the HSCB Director of Performance and Improvement. This Director will work in partnership with the Director of Public Health, Director of Social Care, Director of Nursing and Director of Integrated Care on a monthly basis to oversee the expected improvement in the management of SAI's across the Health and Social Care System.
- Establishment of a Joint PHA and HSCB Improvement Team to work with Trusts to clear existing backlogs.
- Securing additional capacity to progress the back log in mental health and family and child care services.

PHA Board members should also note while the SAI process is governed by the HSCB with support from the PHA, there are a number of processes

outside of the HSCB which will influence the SAI Policy and the future operational management for SAI's:

- Output of Inquiry into Hyponatraemia Related Deaths (IHRD) SAI sub-group is due to make a series of recommendations in relation to SAI management to include in particular a new statement of patient rights
- RQIA review of the SAI process which is due to report with recommendations in March 2021.This is likely to have an impact on the SAI procedure and its operation.
- Creation of the 'Group' as a result of the closure of the HSCB will inevitably result in changes in the management of the SAI procedure and require further discussion on the role and interface of the PHA in this moving forward.

Together, these will lead to a reform of the SAI procedure resulting in a strengthening of performance, streamlining of processes and overall improve services for those citizens impacted by a SAI.

NICE National Institute for Health and Care Excellence

NICE guideline

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

NICE guideline
Published: 29 May 2015

www.nice.org.uk/guidance/ng11

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is the basis of QS101 and QS142.

This guideline should be read in conjunction with NG93.

Overview

This guideline covers interventions and support for children, young people and adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges, and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and intervention for family members or carers.

NICE has produced an easy read version for people with a learning disability.

Who is it for?

- Healthcare professionals, commissioners and providers in health and social care
- Parents, family members or carers of children, young people and adults with a learning disability and behaviour that challenges

Context

A learning disability is defined by 3 core criteria: lower intellectual ability (usually an IQ of less than 70), significant impairment of social or adaptive functioning, and onset in childhood. Learning disabilities are different from specific learning difficulties such as dyslexia, which do not affect intellectual ability. Although the term 'intellectual disability' is becoming accepted internationally, 'learning disability' is the most widely used and accepted term in the UK and is therefore used in this guideline. The amount of everyday support a person with a learning disability needs will depend mostly on the severity of the disability. It is important to treat each person as an individual, with specific strengths and abilities as well as needs, and a broad and detailed assessment may be needed.

Some people with a learning disability display behaviour that challenges. 'Behaviour that challenges' is not a diagnosis and is used in this guideline to indicate that although such behaviour is a challenge to services, family members or carers, it may serve a purpose for the person with a learning disability (for example, by producing sensory stimulation, attracting attention, avoiding demands and communicating with other people). This behaviour often results from the interaction between personal and environmental factors and includes aggression, self-injury, stereotypic behaviour, withdrawal, and disruptive or destructive behaviour. It can also include violence, arson or sexual abuse, and may bring the person into contact with the criminal justice system.

It is relatively common for people with a learning disability to develop behaviour that challenges, and more common for people with more severe disability. Prevalence rates are around 5–15% in educational, health or social care services for people with a learning disability. Rates are higher in teenagers and people in their early 20s, and in particular settings (for example, 30–40% in hospital settings). People with a learning disability who also have communication difficulties, autism, sensory impairments, sensory processing difficulties and physical or mental health problems (including dementia) may be more likely to develop behaviour that challenges.

The behaviour may appear in only certain environments, and the same behaviour may be considered challenging in some settings or cultures but not in others. It may be used by the person for reasons such as creating sensory stimulation, getting help or avoiding demands. Some care environments increase the likelihood of behaviour that challenges. This includes those with limited opportunities for social interaction and meaningful occupation, lack of choice and sensory input or excessive noise. It also includes care

environments that are crowded, unresponsive or unpredictable, those characterised by neglect and abuse, and those where physical health needs and pain go unrecognised or are not managed.

Multiple factors are likely to underlie behaviour that challenges. To identify these, thorough assessments of the person, their environment and any biological predisposition are needed, together with a functional assessment. Interventions depend on the specific triggers for each person and may need to be delivered at multiple levels (including the environmental level). The aim should always be to improve the person's overall quality of life.

This guideline will cover the care and shared care provided or commissioned by health and social care, in whatever care setting the person lives.

Safeguarding children

Remember that child maltreatment:

- is common
- can present anywhere, such as emergency departments and primary care or on home visits.

Be aware of or suspect abuse as a contributory factor to or cause of behaviour that challenges shown by children with a learning disability. Abuse may also coexist with behaviour that challenges. See the NICE guideline on child maltreatment for clinical features that may be associated with maltreatment.

This section has been agreed with the Royal College of Paediatrics and Child Health.

Safeguarding adults

Adults with a learning disability are vulnerable to maltreatment and exploitation. This can occur in both community and residential settings. A referral (in line with local safeguarding procedures) may be needed if there are concerns regarding maltreatment or exploitation, or if the person is in contact with the criminal justice system.

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 General principles of care

Working with people with a learning disability and behaviour that challenges, and their families and carers

1.1.1 Work in partnership with children, young people and adults who have a learning disability and behaviour that challenges, and their family members or carers, and:

- involve them in decisions about care
- support self-management and encourage the person to be independent
- build and maintain a continuing, trusting and non-judgemental relationship
- provide information:
  - about the nature of the person's needs, and the range of interventions (for example, environmental, psychological and pharmacological interventions) and services available to them
  - in a format and language appropriate to the person's cognitive and developmental level (including spoken and picture formats, and written versions in Easy Read style and different colours and fonts)
- develop a shared understanding about the function of the behaviour

- help family members and carers to provide the level of support they feel able to.

1.1.2 When providing support and interventions for people with a learning disability and behaviour that challenges, and their family members or carers:

- take into account the severity of the person's learning disability, their developmental stage, and any communication difficulties or physical or mental health problems
- aim to provide support and interventions:
  - in the least restrictive setting, such as the person's home, or as close to their home as possible, and
  - in other places where the person regularly spends time (for example, school or residential care)
- aim to prevent, reduce or stop the development of future episodes of behaviour that challenges
- aim to improve quality of life
- offer support and interventions respectfully
- ensure that the focus is on improving the person's support and increasing their skills rather than changing the person
- ensure that they know who to contact if they are concerned about care or interventions, including the right to a second opinion
- offer independent advocacy to the person and to their family members or carers.

Understanding learning disabilities and behaviour that challenges

1.1.3 Everyone involved in commissioning or delivering support and interventions for people with a learning disability and behaviour that challenges (including family members and carers) should understand:

- the nature and development of learning disabilities
- personal and environmental factors related to the development and maintenance of behaviour that challenges
- that behaviour that challenges often indicates an unmet need
- the effect of learning disabilities and behaviour that challenges on the person's personal, social, educational and occupational functioning
- the effect of the social and physical environment on learning disabilities and behaviour that challenges (and vice versa), including how staff and carer responses to the behaviour may maintain it.

Delivering effective care

1.1.4 Health and social care provider organisations should ensure that teams carrying out assessments and delivering interventions recommended in this guideline have the training and supervision needed to ensure that they have the necessary skills and competencies.

1.1.5 If initial assessment (see section 1.5) and management have not been effective, or the person has more complex needs, health and social care provider organisations should ensure that teams providing care have prompt and coordinated access to specialist assessment, support and intervention services. These services should provide advice, supervision and training from a range of staff to support the implementation of any care or intervention, including psychologists, psychiatrists, behavioural analysts, nurses, social care staff, speech and language therapists, educational staff, occupational therapists, physiotherapists, physicians, paediatricians and pharmacists.

Staff training, supervision and support

1.1.6 Health and social care provider organisations should ensure that all staff working with people with a learning disability and behaviour that challenges are trained to deliver proactive strategies to reduce the risk of behaviour that challenges, including:

- developing personalised daily activities
- adapting a person's environment and routine
- strategies to help the person develop an alternative behaviour to achieve the same purpose by developing a new skill (for example, improved communication, emotional regulation or social interaction)
- the importance of including people, and their family members or carers, in planning support and interventions
- strategies designed to calm and divert the person if they show early signs of distress
- delivering reactive strategies.

1.1.7 Health and social care provider organisations should ensure that all staff get personal and emotional support to:

- enable them to deliver interventions effectively for people with a learning disability and behaviour that challenges
- feel able to seek help for difficulties arising from working with people with a learning disability and behaviour that challenges
- recognise and manage their own stress.

1.1.8 Health and social care provider organisations should ensure that all interventions for behaviour that challenges are delivered by competent staff. Staff should:

- receive regular high-quality supervision that takes into account the impact of individual, social and environmental factors
- deliver interventions based on the relevant treatment manuals
- consider using routine outcome measures at each contact (for example, the Adaptive Behavior Scale and the Aberrant Behavior Checklist)
- take part in monitoring (for example, by using Periodic Service Review methods)

- evaluate adherence to interventions and practitioner competence (for example, by using video and audio recording, and external audit and scrutiny).

Organising effective care

The recommendations in this section are adapted from the NICE guideline on common mental health disorders.

1.1.9 A designated leadership team of healthcare professionals, educational staff, social care practitioners, managers and health and local authority commissioners should develop care pathways for people with a learning disability and behaviour that challenges for the effective delivery of care and the transition between and within services that are:

- negotiable, workable and understandable for people with a learning disability and behaviour that challenges, their family members or carers, and staff
- accessible and acceptable to people using the services, and responsive to their needs
- integrated (to avoid barriers to movement between different parts of the care pathways)
- focused on outcomes (including measures of quality, service-user experience and harm).

1.1.10 The designated leadership team should be responsible for developing, managing and evaluating care pathways, including:

- developing clear policies and protocols for care pathway operation
- providing training and support on care pathway operation
- auditing and reviewing care pathway performance.

1.1.11 The designated leadership team should work together to design care pathways that promote a range of evidence-based interventions and support people in their choice of interventions.

1.1.12 The designated leadership team should work together to design care

pathways that respond promptly and effectively to the changing needs of the people they serve and have:

- clear and agreed goals for the services offered
- robust and effective ways to measure and evaluate the outcomes associated with the agreed goals.

1.1.13 The designated leadership team should work together to design care pathways that provide an integrated programme of care across all care services and:

- minimise the need for transition between different services or providers
- provide the least restrictive alternatives for people with behaviour that challenges
- allow services to be built around the care pathway (and not the other way around)
- establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- have designated staff who are responsible for coordinating people's engagement with a care pathway and transition between services within and between care pathways.

1.1.14 The designated leadership team should work together to ensure effective communication about the functioning of care pathways. There should be protocols for sharing information:

- with people with a learning disability and behaviour that challenges, and their family members or carers (if appropriate), about their care
- about a person's care with other staff (including GPs)
- with all the services provided in the care pathway
- with services outside the care pathway.

1.2 Physical healthcare

1.2.1 GPs should offer an annual physical health check to children, young people and adults with a learning disability in all settings, using a standardised template (such as the Cardiff health check template). This should be carried out together with a family member, carer or healthcare professional or social care practitioner who knows the person and include:

- a review of any known or emerging behaviour that challenges and how it may be linked to any physical health problems
- a physical health review
- a review of all current health interventions, including medication and related side effects, adverse events, drug interactions and adherence
- an agreed and shared care plan for managing any physical health problems (including pain).

  See the Royal College of General Practitioners' guide for GP practices on annual health checks for people with a learning disability for further information.

1.3 Support and interventions for family members or carers

1.3.1 Involve family members or carers in developing and delivering the support and intervention plan for children, young people and adults with a learning disability and behaviour that challenges. Give them information about support and interventions in a format and language that is easy to understand, including NICE's 'Information for the public'.

1.3.2 Advise family members or carers about their right to carer assessment, and assessment for respite care and other support (see the NICE guideline on supporting adult carers for recommendations on identifying, assessing and meeting the caring, physical and mental health needs of families and carers).

1.3.3 When providing support to family members or carers (including siblings):

- recognise the impact of living with or caring for a person with a learning disability and behaviour that challenges
- explain how to access family advocacy
- consider family support and information groups if there is a risk of behaviour that challenges, or it is emerging
- consider formal support through disability-specific support groups for family members or carers and regular assessment of the extent and severity of the behaviour that challenges
- provide skills training and emotional support, or information about these, to help them take part in and support interventions for the person with a learning disability and behaviour that challenges.

1.3.4 If a family member or carer has an identified mental health problem, consider:

- interventions in line with existing NICE guidelines or
- referral to a mental health professional who can provide interventions in line with existing NICE guidelines.

1.4 Early identification of the emergence of behaviour that challenges

1.4.1 Everyone involved in caring for and supporting children, young people and adults with a learning disability (including family members and carers) should understand the risk of behaviour that challenges and that it often develops gradually. Pay attention to and record factors that may increase this risk, including:

- personal factors, such as:
  - a severe learning disability
  - autism
  - dementia
  - communication difficulties (expressive and receptive)
  - visual impairment (which may lead to increased self-injury and stereotypy)
  - physical health problems
  - variations with age (peaking in the teens and twenties)
- environmental factors, such as:
  - abusive or restrictive social environments
  - environments with little or too much sensory stimulation and those with low engagement levels (for example, little interaction with staff)
  - developmentally inappropriate environments (for example, a curriculum that makes too many demands on a child or young person)
  - environments where disrespectful social relationships and poor communication are typical or where staff do not have the capacity or resources to respond to people's needs
  - changes to the person's environment (for example, significant staff changes or moving to a new care setting).

1.4.2 Consider using direct observation and recording or formal rating scales (for example, the Adaptive Behavior Scale or Aberrant Behavior Checklist) to monitor the development of behaviour that challenges.

1.5 Assessment of behaviour that challenges

The assessment process

1.5.1 When assessing behaviour that challenges shown by children, young

people and adults with a learning disability follow a phased approach, aiming to gain a functional understanding of why the behaviour occurs. Start with initial assessment and move on to further assessment if, for example, intervention has not been effective or the function of the behaviour is not clear (see recommendations 1.5.4–1.5.11). Develop a behaviour support plan (see recommendation 1.6.1) as soon as possible.

1.5.2 When assessing behaviour that challenges ensure that:

- the person being assessed remains at the centre of concern and is supported throughout the process
- the person and their family members and carers are fully involved in the assessment process
- the complexity and duration of the assessment process is proportionate to the severity, impact, frequency and duration of the behaviour
- everyone involved in delivering assessments understands the criteria for moving to more complex and intensive assessment (see recommendation 1.5.8)
- all current and past personal and environmental factors (including care and educational settings) that may lead to behaviour that challenges are taken into account
- assessment is a flexible and continuing (rather than a fixed) process, because factors that trigger and maintain behaviour may change over time
- assessments are reviewed after any significant change in behaviour
- assessments are focused on the outcomes of reducing behaviour that challenges and improving quality of life
- the resilience, resources and skills of family members and carers are taken into account
- the capacity, sustainability and commitment of the staff delivering the behaviour support plan (see recommendation 1.6.1) are taken into account.

1.5.3 Explain to the person and their family members or carers how they will be told about the outcome of any assessment of behaviour that challenges. Ensure that feedback is personalised and involves a family member, carer

or advocate to support the person and help them to understand the feedback if needed.

Initial assessment of behaviour that challenges

1.5.4 If behaviour that challenges is emerging or apparent, or a family member, carer or member of staff (such as a teacher or care worker), has concerns about behaviour, carry out initial assessment that includes:

- a description of the behaviour (including its severity, frequency, duration and impact on the person and others) from the person (if possible) and a family member, carer or a member of staff (such as a teacher or care worker)
- an explanation of the personal and environmental factors involved in developing or maintaining the behaviour from the person (if possible) and a family member, carer or a member of staff (such as a teacher or care worker)
- the role of the service, staff, family members or carers in developing or maintaining the behaviour.

  Consider using a formal rating scale (for example, the Aberrant Behavior Checklist or Adaptive Behavior Scale) to provide baseline levels for the behaviour and a scale (such as the Functional Analysis Screening Tool) to help understand its function.

1.5.5 As part of initial assessment of behaviour that challenges, take into account:

- the person's abilities and needs (in particular, their expressive communication and receptive communication)
- any physical or mental health problems, and the effect of medication, including side effects
- developmental history, including neurodevelopmental problems (including the severity of the learning disability and the presence of autism or other behavioural phenotypes)
- response to any previous interventions for behaviour that challenges

- the impact of the behaviour that challenges on the person's:
  - quality of life and that of their family members or carers
  - independent living skills and educational or occupational abilities
- social and interpersonal history, including relationships with family members, carers, staff (such as teachers) or other people with a learning disability (such as those the person lives with)
- aspects of the person's culture that could be relevant to the behaviour that challenges
- life history, including any history of trauma or abuse
- recent life events and changes to routine
- the person's sensory profile, preferences and needs
- the physical environment, including heat, light, noise and smell
- the care environment, including the range of activities available, how it engages people and promotes choice, and how well structured it is.

1.5.6 After initial assessment, develop a written statement (formulation) that sets out an understanding of what has led to the behaviour that challenges and the function of the behaviour. Use this to develop a behaviour support plan (see recommendation 1.6.1).

Risk assessment

1.5.7 Assess and regularly review the following areas of risk during any assessment of behaviour that challenges:

- suicidal ideation, self-harm (in particular in people with depression) and self-injury
- harm to others
- self-neglect
- breakdown of family or residential support

- exploitation, abuse or neglect by others
- rapid escalation of the behaviour that challenges.

  Ensure that the behaviour support plan includes risk management (see recommendation 1.6.1).

Further assessment of behaviour that challenges

1.5.8 If the behaviour that challenges is severe or complex, or does not respond to the behaviour support plan, review the plan and carry out further assessment that is multidisciplinary and draws on skills from specialist services (see recommendation 1.1.5), covering any areas not fully explored by initial assessment (see recommendation 1.5.5). Carry out a functional assessment (see recommendations 1.5.9–1.5.11), identifying and evaluating any factors that may provoke or maintain the behaviour. Consider using formal (for example, the Adaptive Behavior Scale or the Aberrant Behavior Checklist) and idiographic (personalised) measures to assess the severity of the behaviour and the progress of any intervention.

Functional assessment of behaviour

1.5.9 Carry out a functional assessment of the behaviour that challenges to help inform decisions about interventions. This should include:

- a clear description of the behaviour, including classes or sequences of behaviours that typically occur together
- identifying the events, times and situations that predict when the behaviour will and will not occur across the full range of the person's daily routines and usual environments
- identifying the consequences (or reinforcers) that maintain the behaviour (that is, the function or purpose that the behaviour serves)
- developing summary statements or hypotheses that describe the relationships between personal and environmental triggers, the behaviour and its reinforcers

- collecting direct observational data to inform the summary statements or hypotheses.

1.5.10 Include the following in a functional assessment:

- a baseline measurement of current behaviour, and its frequency and intensity, and repeated measurements in order to evaluate change
- measurements including direct observations and scales such as the Aberrant Behavior Checklist and self-reporting
- a baseline measurement of quality of life (such as the Life Experiences Checklist and the Quality of Life Questionnaire)
- assessment of the impact of current or past interventions, including reactive strategies.

1.5.11 Vary the complexity and intensity of the functional assessment according to the complexity and intensity of behaviour that challenges, following a phased approach as set out below.

- Carry out pre-assessment data gathering to help shape the focus and level of the assessment.
- For recent-onset behaviour that challenges, consider brief structured assessments such as the Functional Analysis Screening Tool or Motivation Assessment Scale to identify relationships between the behaviour and what triggers and reinforces it.
- For recent-onset behaviour that challenges, or marked changes in patterns of existing behaviours, take into account whether any significant alterations to the person's environment and physical or psychological health are associated with the development or maintenance of the behaviour.
- Consider in-depth assessment involving interviews with family members, carers and others, direct observations, structured record keeping, questionnaires and reviews of case records.

- If a mental health problem may underlie behaviour that challenges, consider initial screening using assessment scales such as the Diagnostic Assessment Schedule for the Severely Handicapped-II, Psychiatric Assessment Schedule for Adults with a Developmental Disability or the Psychopathology Instrument for Mentally Retarded Adults and seek expert opinion.

After further assessment

1.5.12 After further assessment, re-evaluate the written statement (formulation) and adjust the behaviour support plan if necessary.

1.6 Behaviour support plan

1.6.1 Develop a written behaviour support plan for children, young people and adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour. This should:

- identify proactive strategies designed to improve the person's quality of life and remove the conditions likely to promote behaviour that challenges, including:
  - changing the environment (for example, reducing noise, increasing predictability)
  - promoting active engagement through structured and personalised daily activities, including adjusting the school curriculum for children and young people
- identify adaptations to a person's environment and routine, and strategies to help them develop an alternative behaviour to achieve the function of the behaviour that challenges by developing a new skill (for example, improved communication, emotional regulation or social interaction)
- identify preventive strategies to calm the person when they begin to show early signs of distress, including:
  - individual relaxation techniques
  - distraction and diversion onto activities they find enjoyable and rewarding

- identify reactive strategies to manage any behaviours that are not preventable (see section 1.9), including how family members, carers or staff should respond if a person's agitation escalates and there is a significant risk of harm to them or others
- incorporate risk management and take into account the effect of the behaviour support plan on the level of risk
- be compatible with the abilities and resources of the person's family members, carers or staff, including managing risk, and can be implemented within these resources
- be supported by data that measure the accurate implementation of the plan
- be monitored using the continuous collection of objective outcome data
- be reviewed frequently (fortnightly for the first 2 months and monthly thereafter), particularly if behaviour that challenges or use of restrictive interventions increases, or quality of life decreases
- identify any training for family members, carers or staff to improve their understanding of behaviour that challenges shown by people with a learning disability
- identify those responsible for delivering the plan and the designated person responsible for coordinating it.

1.7 Psychological and environmental interventions

Early intervention for children and their parents or carers

1.7.1 Consider parent-training programmes for parents or carers of children with a learning disability who are aged under 12 years with emerging, or at risk of developing, behaviour that challenges.

1.7.2 Parent-training programmes should:

- be delivered in groups of 10 to 15 parents or carers

- be accessible (for example, take place outside normal working hours or in community-based settings with childcare facilities)
- focus on developing communication and social functioning
- typically consist of 8 to 12 sessions lasting 90 minutes
- follow the relevant treatment manual
- employ materials to ensure consistent implementation of the programme.

1.7.3 Consider preschool classroom-based interventions for children aged 3–5 years with emerging, or at risk of developing, behaviour that challenges.

1.7.4 Preschool classroom-based interventions should have multiple components, including:

- curriculum design and development
- social and communication skills training for the children
- skills training in behavioural strategies for parents or carers
- training on how to mediate the intervention for preschool teachers.

Interventions for behaviour that challenges

1.7.5 Consider personalised interventions for children, young people and adults that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time, and consist of:

- clear targeted behaviours with agreed outcomes
- assessment and modification of environmental factors that could trigger or maintain the behaviour (for example, altering task demands for avoidant behaviours)
- addressing staff and family member or carer responses to behaviour that challenges

- a clear schedule of reinforcement of desired behaviour and the capacity to offer reinforcement promptly
- a specified timescale to meet intervention goals (modifying intervention strategies that do not lead to change within a specified time).

1.7.6 Consider individual psychological interventions for adults with an anger management problem. These interventions should be based on cognitive-behavioural principles and delivered individually or in groups over 15 to 20 hours.

1.7.7 Do not offer sensory interventions (for example, Snoezelen rooms) before carrying out a functional assessment to establish the person's sensory profile. Bear in mind that the sensory profile may change.

1.7.8 Consider developing and maintaining a structured plan of daytime activity (as part of the curriculum if the person is at school) that reflects the person's interests and capacity. Monitor the effects on behaviour that challenges and adjust the plan in discussion with the person and their family members or carers.

1.8 Medication

1.8.1 Consider medication, or optimise existing medication (in line with the NICE guideline on medicines optimisation), for coexisting mental or physical health problems identified as a factor in the development and maintenance of behaviour that challenges shown by children, young people and adults with a learning disability (see also recommendation 1.10.1).

1.8.2 Consider antipsychotic medication to manage behaviour that challenges only if:

- psychological or other interventions alone do not produce change within an agreed time or
- treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour or

- the risk to the person or others is very severe (for example, because of violence, aggression or self-injury).

  Only offer antipsychotic medication in combination with psychological or other interventions.

1.8.3 When choosing which antipsychotic medication to offer, take into account the person's preference (or that of their family member or carer, if appropriate), side effects, response to previous antipsychotic medication and interactions with other medication.

1.8.4 Antipsychotic medication should initially be prescribed and monitored by a specialist (an adult or child psychiatrist or a neurodevelopmental paediatrician) who should:

- identify the target behaviour
- decide on a measure to monitor effectiveness (for example, direct observations, the Aberrant Behavior Checklist or the Adaptive Behavior Scale), including frequency and severity of the behaviour and impact on functioning
- start with a low dose and use the minimum effective dose needed
- only prescribe a single drug
- monitor side effects as recommended in the NICE guidelines on psychosis and schizophrenia in adults and psychosis and schizophrenia in children and young people
- review the effectiveness and any side effects of the medication after 3–4 weeks
- stop the medication if there is no indication of a response at 6 weeks, reassess the behaviour that challenges and consider further psychological or environmental interventions
- only prescribe p.r.n. (as-needed) medication for as short a time as possible and ensure that its use is recorded and reviewed

- review the medication if there are changes to the person's environment (for example, significant staff changes or moving to a new care setting) or their physical or mental health.

1.8.5 Ensure that the following are documented:

- a rationale for medication (explained to the person with a learning disability and everyone involved in their care, including their family members and carers)
- how long the medication should be taken for
- a strategy for reviewing the prescription and stopping the medication.

1.8.6 If there is a positive response to antipsychotic medication:

- record the extent of the response, how the behaviour has changed and any side effects or adverse events
- conduct a full multidisciplinary review after 3 months and then at least every 6 months covering all prescribed medication (including effectiveness, side effects and plans for stopping)
- only continue to prescribe medication that has proven benefit.

1.8.7 When prescribing is transferred to primary or community care, or between services, the specialist should give clear guidance to the practitioner responsible for continued prescribing about:

- which behaviours to target
- monitoring of beneficial and side effects
- taking the lowest effective dose
- how long the medication should be taken for
- plans for stopping the medication.

1.8.8 For the use of rapid tranquillisation, follow the NICE guideline on violence and aggression.

1.9 Reactive strategies

1.9.1 Only use reactive strategies for children, young people and adults with a learning disability and behaviour that challenges as a last resort and together with the proactive interventions described in section 1.7. When risks to the person with a learning disability or others are significant, or breakdown in their living arrangements is very likely, consider using reactive strategies as an initial intervention and introduce proactive interventions once the situation stabilises.

1.9.2 Ensure that reactive strategies, whether planned or unplanned, are delivered on an ethically sound basis. Use a graded approach that considers the least restrictive alternatives first. Encourage the person and their family members or carers to be involved in planning and reviewing reactive strategies whenever possible.

1.9.3 If a restrictive intervention is used as part of a reactive strategy, follow the NICE guideline on violence and aggression for the safe use of restrictive interventions and carry out a thorough risk assessment. Take into account:

- any physical health problems and physiological contraindications to the use of restrictive interventions, in particular manual and mechanical restraint
- any psychological risks associated with the intervention, such as a history of abuse
- any known biomechanical risks, such as musculoskeletal risks
- any sensory sensitivities, such as a high or low threshold for touch.

Document and review the delivery and outcome of the restrictive intervention and discuss these with everyone involved in the care of the person, including their family members and carers, and with the person if possible.

1.9.4 Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long-term behaviour support plan, to reduce the use of and need for restrictive interventions.

1.9.5 Ensure that planned restrictive interventions:

- take place within the appropriate legal framework of the Human Rights Act 1998, the relevant rights in the European Convention on Human Rights, the Mental Health Act 1983 and the Mental Capacity Act 2005, including the supplementary code of practice on deprivation of liberty safeguards
- are in the best interest of the person to protect them or others from immediate and significant harm
- are a reasonable, necessary and proportionate response to the risk presented.

1.9.6 Regularly review and reassess the safety, efficacy, frequency of use, duration and continued need for reactive strategies, including restrictive interventions (follow the NICE guideline on violence and aggression for the safe use of restrictive interventions). Document their use as part of an incident record and use this in personal and organisational debrief procedures to inform future behaviour support planning and organisational learning.

1.10 Interventions for coexisting health problems

1.10.1 Offer children, young people and adults with a learning disability and behaviour that challenges interventions for any suspected or coexisting mental or physical health problems in line with the relevant NICE guideline for that condition (see also recommendation 1.8.1). Adjust the nature, content and delivery of the interventions to take into account the impact of the person's learning disability and behaviour that challenges.

1.11 Interventions for sleep problems

1.11.1 Consider behavioural interventions for sleep problems in children, young people and adults with a learning disability and behaviour that challenges that consist of:

- a functional analysis of the problem sleep behaviour to inform the intervention (for example, not reinforcing non-sleep behaviours)
- structured bedtime routines.

1.11.2 Do not offer medication to aid sleep unless the sleep problem persists after a behavioural intervention, and then only:

- after consultation with a psychiatrist (or a specialist paediatrician for a child or young person) with expertise in its use in people with a learning disability
- together with non-pharmacological interventions and regular reviews (to evaluate continuing need and ensure that the benefits continue to outweigh the risks).

  If medication is needed to aid sleep, consider melatonin. In May 2015, this was an off-label use of melatonin in people aged 55 years and under. See NICE's information on prescribing medicines.

Terms used in this guideline

Adults

Aged 18 years or older.

Behavioural phenotypes

The expression of distinctive physiological and behavioural characteristics that have a chromosomal or genetic cause.

Carer

A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or has a disability. This does not include paid carers (care workers), who are included in the definition of staff.

Children

Aged 12 years or younger.

Expressive communication

The ability to express thoughts, feelings and needs verbally (using words and sentences) and non-verbally (for example, using gestures, facial expressions, gaze, signing and other methods that supplement or replace speech or writing).

Functional assessment

An assessment of the function of behaviour that challenges, including functional analyses and other methods of assessing behavioural functions.

Reactive strategies

Any strategy used to make a situation or a person safe when they behave in a way that challenges. This includes procedures for increasing personal space, disengagement from grabs and holds, p.r.n. (as-needed) medication and more restrictive interventions.

Receptive communication

The ability to understand or comprehend language (either spoken or written) or other means of communication (for example, through signing and other methods that supplement or replace speech or writing).

Reinforcer

An event or situation that is dependent on a behaviour and increases the likelihood of that behaviour happening again.

Restrictive interventions

Interventions that may infringe a person's human rights and freedom of movement, including locking doors, preventing a person from entering certain areas of the living space, seclusion, manual and mechanical restraint, rapid tranquillisation and long-term sedation.

Self-harm

When a person intentionally harms themselves, which can include cutting and self-poisoning. It may be an attempt at suicide.

Self-injury

Frequently repeated, self-inflicted behaviour, such as people hitting their head or biting themselves, which can lead to tissue damage. This behaviour is usually shown by people with a severe learning disability. It may indicate pain or distress, or it may have another purpose, such as the person using it to communicate.

Staff

Healthcare professionals and social care practitioners, including those working in community teams for adults or children (such as psychologists, psychiatrists, social workers, speech and language therapists, nurses, behavioural analysts, occupational therapists, physiotherapists), paid carers (care workers) in a variety of settings (including residential homes, supported living settings and day services) and educational staff.

Stereotypy

Repeated behaviours, such as rocking or hand flapping, that may appear to have no obvious function but often serve a purpose for the person (for example, to provide sensory stimulation or indicate distress or discomfort).

Treatment manual

Detailed advice and guidance on how to deliver an intervention, including its content, duration and frequency. A treatment manual may also include materials to support the delivery of the intervention for staff and people receiving the intervention.

Young people

Aged 13 to 17 years.

Recommendations for research

Preventing behaviour that challenges from developing in children aged under 5 years with a learning disability

Can positive behaviour support provided for children aged under 5 years with a learning disability reduce the risk of developing behaviour that challenges?

Why this is important

Behaviour that challenges is common in children with a learning disability and can have a considerable impact on them and their family members or carers. It is a common reason for residential placement with associated high costs. Positive behaviour support aims to reduce behaviour that challenges and increase quality of life through teaching new skills and adjusting the environment to promote positive behaviour changes. Early intervention with children at risk of developing behaviour that challenges offers an opportunity to significantly enhance their life and that of their family members or carers.

The question should be addressed by a programme of research that includes:

- developing interventions to prevent behaviour that challenges from developing in children aged under 5 years
- assessing the feasibility of the formal evaluation of the interventions in a randomised controlled trial
- testing the clinical and cost effectiveness of the interventions in a large scale randomised controlled trial with long-term follow-up
- evaluating the implementation of the interventions in routine care.

Interventions to reduce the frequency and extent of moderate to severe behaviour that challenges in

community settings

Are interventions based on the science and practice of applied behaviour analysis or antipsychotic medication, or a combination of these, effective in reducing the frequency and severity of behaviour that challenges shown by adults with a learning disability?

Why this is important

Behaviour that challenges is common in adults with a learning disability and can have a considerable impact on them and their family members or carers. It is also a common reason for hospital or residential placement. There is limited evidence for the effectiveness of either applied behaviour analysis or antipsychotic medication, or a combination of these in community settings. Little is known about which people respond best to which interventions or about the duration of the interventions. There is considerable evidence of the over use of medication and of limited skills and competence in delivering behavioural interventions.

The question should be addressed by a programme of research evaluating these interventions that includes:

- developing a protocol for assessing moderate to severe behaviour that challenges that:
  - characterises the nature and function of the behaviour
  - assesses all coexisting problems that may contribute to the behaviour developing or being maintained
- developing protocols for delivering and monitoring the interventions to be tested (including how any currently provided interventions will be stopped)
- assessing the feasibility of the formal evaluation of the interventions in a randomised controlled trial (in particular, recruitment)
- testing the comparative clinical effectiveness (including moderators and mediators) and cost effectiveness of the interventions in a large-scale randomised controlled trial.

Locally accessible care

Does providing care where people live compared with out-of-area placement lead to improvements in both the clinical and cost effectiveness of care for people with a learning disability and behaviour that challenges?

Why this is important

Many out-of-area care placements for people with a learning disability and behaviour that challenges are a long way from their home. This can have a considerable impact, limiting a family member or carer's ability to care for the person and leading to poorer outcomes and increased costs. It is widely recognised that locally accessible care settings could be beneficial and could reduce costs but there is no strong empirical evidence to support this. In the absence of such evidence significant numbers of out-of-area care placements continue to be made.

The question should be addressed by a programme of research that includes:

- a needs assessment and the care costs of a consecutive cohort of 250 people who have been placed in out-of-area care in a 2-year period
- developing standards for a range of support programmes designed to meet people's needs, which would provide detailed information on:
  - the needs to be meet
  - the nature of the care environments
  - the support, including specialist staff, needed
- testing the clinical and cost effectiveness of 'close to home' or home-based care that meet the developed standards (compared with consecutive cohorts in out-of-area placements).

Factors associated with sustained, high-quality residential care

What factors (including service organisation and management, staff composition, training and supervision, and the content of care and support) are associated with sustained

high-quality residential care for people with a learning disability and behaviour that challenges?

Why this is important

The quality of residential care for people with a learning disability and behaviour that challenges remains an issue of national concern. Reviews (most recently of Winterbourne View Hospital) have identified failings in care. Although recommendations have been made this has not led to a significant and sustained improvement in care. It is important to understand how improvement can be maintained.

The question should be addressed by a programme of research that includes:

- a systematic review of the factors associated with sustained and beneficial change in health and social care organisations
- designing service-level interventions to support the implementation of standards of care developed from the systematic review
- testing the clinical and cost effectiveness of service-level interventions in residential units through the formal evaluation of a quality improvement programme established to introduce the new standards (the follow-up period should be for a minimum of 3 years after the implementation of the intervention).

Finding more information and committee details

NICE has produced an easy read version of this guideline for people with a learning disability.

You can see everything NICE says on this topic in the NICE Pathway on learning disabilities and behaviour that challenges.

To find NICE guidance on related topics, including guidance in development, see our topic page for mental health and wellbeing.

For full details of the evidence and the guideline committee's discussions, see the full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.

Update information

Minor changes since publication

August 2020: We have linked to the NICE guideline on supporting adult carers in recommendation 1.3.2. We have incorporated footnote text into the recommendations to meet accessibility requirements.

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Accreditation

Positive Behaviour Support ECHO Knowledge Network

Case Presentation Programme

2018 / 2019

Emailed to ECHO Office	Presentation Date	Time	Case Presenters	Curriculum/Education Topic	Educator
28/01/19	Monday 4th February 2019	12.00 – 13.30	Sarah Stewart and Michael Lamont Confirmed	PBS as an Evidence Based Approach	Tom Evans BILD
22/02/19	Friday 1st March 2019	12.00 – 13.30	Julie Crymble Confirmed	PBS Competency Framework	Tom Evans BILD
22/04/19	Monday 29th April 2019	12.00 – 13.30	Siobhan Rogan Confirmed	Language, Culture and Values	Tom Evans BILD
14/06/19	Friday 20th May 2019	12.00 – 13.30	Rachael McAlorum-Jones Confirmed Amanda Lindsay	Quality of Life Outcomes	Tom Evans BILD
20/05/19	Monday 21st June 2019	12.00 – 13.30	Joanne Quinn Confirmed	Understanding trauma and its impact on the person, individuals and families.	Dr Noelle Blackman Confirmed
16/09/19	Monday 23rd September 2019	12.00 – 13.30	Patrick Fee Confirmed	STOMP	Dr Claire McKenna Confirmed
18/10/19	Friday 25th October 2019	12.00 – 13.30	Amanda Lyndsay	Behavioural Phenotypes	Speaker Professor Chris Oliver
18/11/19	Monday 25th November 2019	12.00 – 13.30	Deirdre Tominey & Shane Fearon	Restrictive Practice	Rosaline Kelly RCN

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Emailed to ECHO Office	Presentation Date	Time	Case Presenters	Curriculum/Education Topic	Educator
09/12/19	Monday 16th December 2019	12.00 – 13.30	Catherine Mulhern & TBC	Resilience	Dr Peter Baker

Positive Behaviour Support ECHO Knowledge Network

Case Presentation Programme

2020/21 – Please Note: Subjects/Dates may be amended depending on Speaker availability

Emailed to ECHO Office	Presentation Date	Time	Case Presenters	Curriculum/Education Topic	Educator
24/02/2020	04/03/2020	Wednesday 11.00am to 12.30pm	Siobhan Rogan	Transitioning	Louise McConnell
N/A	02/09/2020	Wednesday 11.00am to 12.30pm	N/A	**Reset Session Welcome & Introductions**	Ruth Gray (Project ECHO Educator)
27/09/2020	07/10/2020	Wednesday 11.00am to 12.30pm	Shane Fearon/Barry Davey	Mental Capacity Act	Stephanie Kerr Confirmed
24/10/2020	04/11/2020	Wednesday 11.00am to 12.30pm	Andrina Cairns	Peter Bakers Debriefing Model	Peter Baker Confirmed
22/11/2020	02/12/2020	Wednesday 11.00am to 12.30pm	Catherine McCarron	Restraint Reduction	TBC
26/12/2020	06/01/2021 (?move to 13/01)	Wednesday 11.00am to 12.30pm	Barbara Tate/Julie Crymble/ Orlaith Craig	Sensory Integration	TBC
23/01//21	03/02/21	Wednesday 11.00am to 12.30pm	Julie Sharkey/Jennifer Coulter /Heather Hanna	Rewards to Skills & Development	Alan Skelly- TBC
23/02/21	03/03/21	Wednesday 11.00am to 12.30pm	Naomi Flanagan/Deirdre Tominey	Attachment & Trauma	TBC
27/03/21	07/04/21	Wednesday 11.00am to 12.30pm	Louise McConnell	Staff Wellbeing	Peter Baker Confirmed
25/04/21	05/05/21	Wednesday 11.00am to 12.30pm	TBC	TBC	TBC

Emailed to ECHO Office	Presentation Date	Time	Case Presenters	Curriculum/Education Topic	Educator
23/05/21	03/06/21	Wednesday 11.00am to 12.30pm	Jane McKeown	Family Psycho Education	TBC

Positive Behaviour Support ECHO Network

Programme 2021/22

Wednesday's – 10.00am to 11.30am

ECHO Session	Topic	Educator	Case Presenters
1st September 2021	Complex cases and shared working	N/A	Lisa Finlay
6th October 2021	Quality of Life in relation to PBS outcomes	Gavin Davidson Professor of Social Care Queens University	Andrea Conway
3rd November 2021 (Cancelled)	Sensory Integration	Kate Boot	Linda Hamill
1st December 2021	Restraint Reduction	Update on planned PBS Survey and PBS Framework Development Deirdre McNamee	Louise McConnell
12th January 2022	Supporting others to understand 'behaviour' – sharing knowledge to others	Ailish McMeel (TBC)	Julie Crymble
9th February 2022	Transitions and commissioning services for environments	TBC	Ailish McMeel
9th March 2022	Is restrictive practice a safeguarding issue	Alexi Quinn (TBC)	TBC
6th April 2022	Sensory Integration	Kate Boot (TBC)	Tara McDermott Linda Hammill (TBC)
4th May 2022	MDT involvement in PBS - challenges/barriers	TBC	TBC

Half-Term Break –14 to 18 February 2022
Easter Break – Monday 18 & Tuesday 19 April 2022

Reserve Topics:

- MDT working & Blocked Care
- Neurodiversity model

- Active support
- Supporting minority communities

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Positive Behaviour Support Project ECHO network

Background: Positive Behavioural Support (PBS) is an ethical and effective way of supporting individuals with learning disabilities who present with behaviours of concern. The PHA recently invested £15,000 in training for staff in this modality across HSC services in Northern Ireland. Twelve staff from across the five HSC Trusts have successfully completed this training and are now accredited British Institute of Learning Disability PBS Coaches.

Network aim: to support PBS coaches, embed their new skills in their local areas and form the basis of a community of practice across Northern Ireland.

9 ECHO sessions

19 participants on average

14 case presentations

Evaluation findings

Increased knowledge in how to care for people with behaviors of concern

Increased level of skill to care for people with behaviours of concern

Increased level of confidence to care for people with behaviours of concern

65% agreed participation helped in assessment of individuals with behaviours of concern

61% agreed they have implemented learning from ECHO sessions into practice

"Provided insight into behaviours and forms of interventions that I have not experienced or utilised"

"Used learning to inform service developments relating to Learning Disability"

"Prompted us to consider other factors which may influence behaviour such as trauma or attachment"

"making support plan more staff friendly to aid implementation, also looking at audit and outcomes more specifically""

What was most useful?

"presentations especially trauma and behavioural phenotypes"

"offering practical advice and examples in respect of challenging cases"

"useful to have this network so we can learn from each other and share our knowledge"

MAHI - STM - 308 - 834

Positive Behaviour Support - Final Survey

Background: Improved Knowledge, Skills, Confidence & Competence in PBS Staff.
Evidence of practice leaders emerging in PBS.
Networking and peer support for staff implementing PBS practice.
Improved outcomes for people with learning disabilities.

7 ECHO sessions

27 participants on average

8 Education Presentations
3 Case Studies

What benefits were reported?

100% agreed the Quality of the Education was High to Very High

50% of participants have attended 5+ ECHO sessions

100% of participants agreed the topics delivered were relevant to their role.

100% would recommend ECHO as a useful learning tool to others.

100% of participants Agreed or Strongly Agreed that participation in ECHO helped them feel more supported in their role.

100% of participants would like to participate in this Network again.

Objectives Progress

Is Project ECHO helping you to achieve your Objectives:

60% To increase knowledge, skills, in Positive Behaviour Support (PBS) for staff working with individuals with behaviours that challenge.

60% Improve quality of care provided for people with learning disability

70% Develop a community of practice for PBS.

90% Share best practice in PBS.

70% Increase competency and confidence in PBS practice.

Project ECHO Northern Ireland 2018-2020

hospice UK

Project ECHO Northern Ireland

HSC Health and Social Care Board

Cover image: Project ECHO Northern Ireland in Action. This collage is a visual representation of the connecting nature of ECHO, linking colleagues across the health and social care system, and across geography. From right (front cover) to left (back cover): C Ekambar E Reddy and Mary Donnelly leading a session on Front Facial Pain and Rhinitis for the ENT Network at Daisy Hill Hospital Newry. Richard Whitehouse joins a session from the Braid Valley Hospital in Ballymena on Restrictive to Positive Practice within the Positive Behaviour Support Network. David Rodgers, a GP in Tandragee, participates in a session on Diabetes from the Tesco car park in Craigavon. Sheila Seaton, a Healthcare Assistant in the Community with Marie Curie, joins a session on mouth care in actively dying patients. Ruth Gray, from the Prisons Healthcare Network, joins a session from Hydebank Wood College Young Offenders Centre and Prison in Belfast. And, Riona Santiago facilitates a session on COVID-19 vaccines with the Working Safely in COVID Network from Altnagelvin Hospital in Londonderry/Derry. **Collage produced by Savannah Dodd.**

Executive Summary

Project ECHO has strongly demonstrated a positive impact across the health system in Northern Ireland. This report presents the results from an in-depth evaluation of the impact of 34 Project ECHO Networks in Northern Ireland from both before and during the COVID-19 pandemic. With few exceptions, healthcare providers from these Networks describe Project ECHO as contributing to improved knowledge, skills, confidence, self-efficacy, and satisfaction across all disciplines and levels of the health system. They report the ECHO model as being an important tool for building connections within the health system and reducing the isolation of health and social care providers, particularly those working in rural, remote and/or community roles.

Project ECHO (Extension of Community Health Outcomes) has been described as an evidence-based guided-practice model capable of transforming healthcare systems and reducing healthcare disparities. Having been implemented in over 45 countries, systematic reviews of evidence indicate that Project ECHO is an effective way of addressing knowledge gaps that healthcare professionals face due to the exponential growth in medical knowledge. Using video conferencing technology, and through the modelling of effective online professional collaboration, ECHO has the potential to remove barriers to training and increase access for practitioners in remote locations, while building virtual communities of practice.

Across all evaluated Project ECHO Northern Ireland Networks, 93% of survey respondents stated that ECHO had supported improvements to their practice and management of patients, with 89% reporting that their clinical knowledge, confidence and self-efficacy had also improved through their participation. 82% reported better relationships between levels of the health system, improved collaboration between healthcare providers, and improved knowledge about different services offered within their area.

Most importantly, qualitative evidence gathered within this evaluation suggests strong interconnectivity and correlation between improved healthcare provider outcomes, knowledge and confidence, and a positive impact on patients. Participants within the programme described learning from ECHO sessions directly supporting patient outcomes such as accessing new treatments or more efficient referral. Evidence presented within this report equally suggests strong interconnectivity between improved provider outcomes, increased confidence in managing patients at primary level, and reduced referrals to secondary or tertiary levels of the health system. The Optometry and Neurology Networks, included as case studies within this report, demonstrate the potential of the ECHO model in supporting such service transformation.

The ECHO methodology demonstrably breaks down barriers, supports the development of communities of practice, and facilitates a safe space for learning, sharing and collaborative problem-solving between colleagues. Networks such as the Prison Healthcare ECHO demonstrate the novel ways that ECHO can support relationship building not just within the health sector, but also between health and social care providers, other statutory agencies, and the community and voluntary sector.

While this evaluation focused on the period 2018-2020, COVID-19 has dramatically

disrupted and challenged all aspects of healthcare provision over the past 18 months. This report's preliminary analysis of the impact of Project ECHO during the COVID-19 response equally shows the strong impact of ECHO across domains of training, adaptation and staff wellbeing. Significantly, in a world now saturated with online learning options, the ECHO methodology was judged more effective and supportive than other online training and webinars accessed by healthcare providers participating in this evaluation.

Beyond evaluating the direct impact of ECHO on health and social care providers, patients and the health system, this report also explores what factors and variables determine the success of an ECHO network. Factors such as leadership and the wider ECHO infrastructure were described as being essential in supporting the success of different networks. The learning from this section of the report has implications for the creation of future ECHO Networks, strengthening existing Networks, and will help ensure resources are efficiently and effectively targeted.

Project ECHO in Northern Ireland is leading the way across the NHS in supporting novel and integrated ways of working. Healthcare providers describe ECHO as adding value to their practice, and it is likely that long term participation in networks has a positive impact on wider goals of establishing integrated care systems and improving patient care, as well as building stronger and equitable relationships across different levels of the health system. ECHO is a proven approach to building communities of practice in a respectful, safe, and accessible learning environment. This report should contribute to informing future resourcing decisions, particularly within the context of COVID-19 in which virtual and online training, as well as building virtual communities of practice and peer-support, are necessitated by ongoing social distancing requirements. Significant time and energy has been invested into supporting Project ECHO. Data from this evaluation strongly suggests positive impact facilitated by the project and that Networks operating for extended periods of time are most capable of integrating long-term service transformation.

Recommendations

1. Given the demonstrable benefits for healthcare providers, ensure that appropriate support for ECHO Networks exists across Northern Ireland to ensure equity of access and opportunity for healthcare providers should they wish to participate. Networks need to be supported over time to achieve long-term impact.
2. Given evidence of ECHO in improving relationships, connections and collaboration within the health system, further utilise the methodology to support leaders to achieve strategic goals in establishing integrated health care systems.
3. Networks need to have clear aims and objectives, a pathway to achieving these targets, and strong leadership. Networks should identify measurable ways that they can contribute to long-term service transformation.
4. Explore opportunities and options for integrating and embedding ECHO approaches sustainably into the NHS and HSC Quality Improvement.
5. Further develop evaluation and reporting processes to capture long-term data on impact of ECHO Networks for healthcare providers, patients, and in transforming the health system. Consider conducting a robust economic analysis of the cost-benefit of Project ECHO in Northern Ireland.

Report Contents

Author

This report was written by Chris Jenkins, Evaluation Fellow at Hospice UK.

Funding

Hospice UK was commissioned by the HSCB Northern Ireland to deliver Project ECHO Northern Ireland and to evaluate its impact.

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Thank you to Project ECHO Northern Ireland staff, the Programme Board and HSC Board members for their time, assistance and openness throughout the process of producing this report, and to all Network leads and participants who provided their thoughts and reflections on Project ECHO.

Dr. Tom Esmonde

October 14, 1960 – July 24, 2021

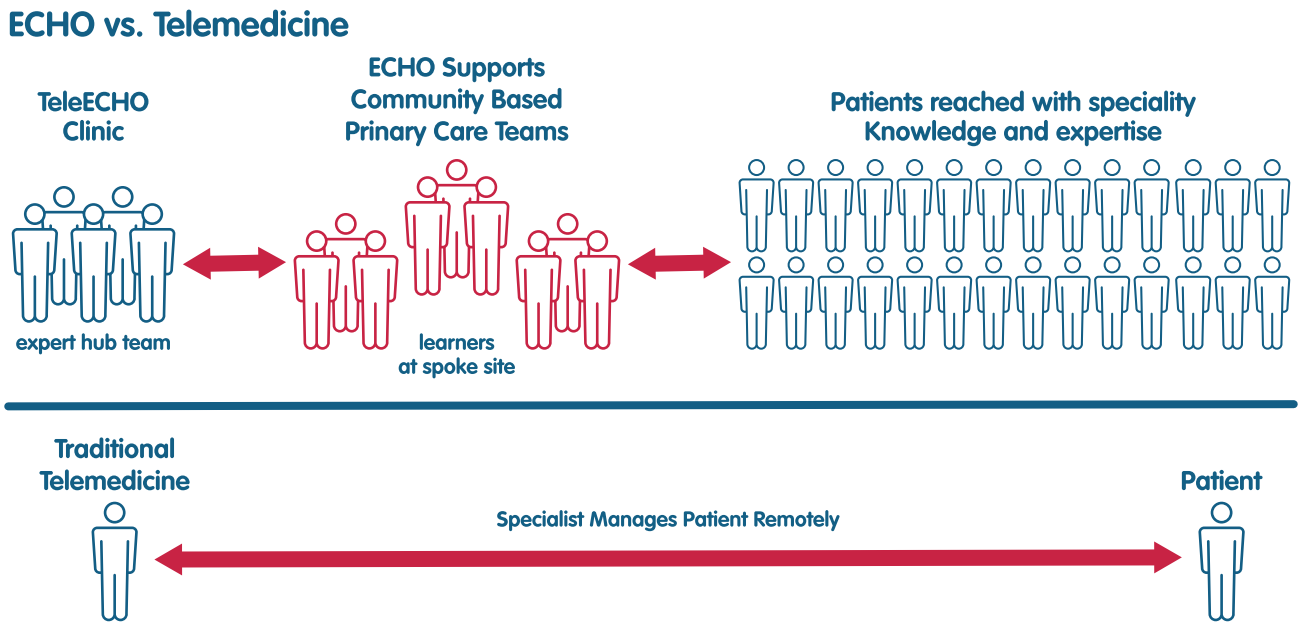
Dr. Esmonde was a dedicated member of the Neurology ECHO network. His considered advice and support for GPs based on years of experience as a senior neurologist was much valued and appreciated, for both his wisdom but also his quiet humility and encouragement.

Background and Introduction

What is Project ECHO?

Project ECHO (Extension for Community Healthcare Outcomes) is a pioneering tele-mentoring programme which was developed in the School of Medicine at the University Of New Mexico (UNM)[1]. Using easily accessed platforms such as ZOOM, Project ECHO aims to connect healthcare providers to share learning and experience in order to increase capacity for safe and effective treatment of chronic, common, and complex diseases especially in rural and remote areas. The ECHO model is designed to address the growing demand for secondary care services and is focused on increasing capacity within primary care, through de-monopolisation of specialist knowledge and improving relationships across primary and secondary care[2].

A typical ECHO session is 60- 90 minutes long. Normally, a 20 minute teaching session is delivered by a specialist healthcare provider followed by discussion. Participants then discuss and share any current issues or experiences they face and determine the best course of action together through one or two 'case presentations'. As of July 2021, Project ECHO has been implemented across 45 countries, with 317 hubs[3]. Peer-reviewed research across different countries and contexts suggest that Project ECHO is an effective way of addressing knowledge gaps that all healthcare professionals face due to the exponential growth in medical knowledge. With the use of video-conferencing technology,



1 Project ECHO. University of New Mexico, School of Medicine. https://hsc.unm.edu/echo/
2 Eaton L. Hierarchy disruptors: bringing specialist knowledge from hospital to community care BMJ 2019; 365 :l4376 doi:10.1136/bmj.l4376
3 Project ECHO Data Marketplace. https://hsc.unm.edu/echo/data-marketplace/interactive-dashboards/ (accessed 07 July 2021)

participants benefit by receiving evidence-based, best practice guidance from specialists, case-based learning from presentations, along with opportunities for questions and answers.

Project ECHO differs from many other online training programmes and webinars in that it is specifically intended to build relationships and communities of practice and encourage open discussion between participants. It is explicitly non-hierarchical and participatory in nature, with Network participants involved during all aspects of programme delivery including curriculum development, case presentation, discussion, and evaluation.

Two systematic reviews[4,5] have been conducted that assess the outcomes of studies evaluating the impact of the Project ECHO methodology across different health conditions and networks. Both reviews indicated positive results regarding the impact of ECHO on increased participant knowledge, competence, confidence, and satisfaction. Positive impacts have also been demonstrated for patient outcomes such as improved care and reduced waiting times, as has been seen in networks focusing on chronic liver disease[6], and declines in opioid prescribing to manage pain[7].

Project ECHO in Northern Ireland

In 2015-16 the Health and Social Care Board (HSCB) in Northern Ireland was awarded £403,000 from the Executive Change Fund to work in partnership with Northern Ireland Hospice to pilot the use of the Project ECHO model in the following 5 areas; (i) GP Trainees – Dermatology; (ii) Palliative Care – Nursing Homes; (iii) Optometry/Ophthalmology; (iv) Diabetes and Palliative Care; (v) Carers. With ever-increasing demands and focus on value-based healthcare delivery, the HSCB identified Project ECHO as an innovative methodology capable of developing the knowledge and skills of health and social care professionals, transforming service delivery, and ultimately improving patient care. Key evaluation findings from the pilot project included increased self-efficacy and knowledge, with participants reporting that they felt the care they provided to patients had improved.

Based on the success of the initial pilot the Project ECHO NI programme was awarded a further £474,000 from the Transformational Fund in 2016-2017 to establish 19 Project ECHO networks across a range of specialities. The main objectives of the 2016-2017 evaluation were to ascertain if Project ECHO had been effective in Northern Ireland and to measure an increase in knowledge and self-confidence of HCP's involved in the Project. Each network was required to complete an evaluation of their network on factors such as upskilling staff through increased knowledge and confidence, relationship building between primary and secondary care, and whether Project ECHO created opportunities to share best practice and changes in practice.

4 Zhou C, Crawford A, Serhal E, Kurdyak P, Sockalingam S. The Impact of Project ECHO on Participant and Patient Outcomes: A Systematic Review. Acad Med. 2016 Oct;91(10):1439-1461. doi: 10.1097/ACM.0000000000001328. PMID: 27489018.

5 McBain RK, Sousa JL, Rose AJ, Baxi SM, Faherty LJ, Taplin C, Chappel A, Fischer SH. Impact of Project ECHO Models of Medical Tele-Education: a Systematic Review. J Gen Intern Med. 2019 Dec;34(12):2842-2857. doi: 10.1007/s11606-019-05291-1. Epub 2019 Sep 4. PMID: 31485970; PMCID: PMC6854140.

6 Glass LM, Waljee AK, McCurdy H, Su GL, Sales A. Specialty Care Access Network-Extension of Community Healthcare Outcomes model program for liver disease improves specialty care access. Dig Dis Sci. 2017;62(12):3344–9. doi: 10.1007/s10620-017-4789-2

7 Anderson D, Zlateva I, Davis B, Bifulco L, Giannotti T, Coman E, et al. Improving pain care with Project ECHO in community health centers. Pain Med (Malden, Mass.) 2017;18(10):1882–9. doi: 10.1093/pm/pnx187.

The 2015-2017 evaluation identified that Project ECHO had the potential to be a key enabler to deliver system change and transformation of services within Northern Ireland. Following an EU-wide tender exercise in 2018, Hospice UK was commissioned by the Health and Social Care Board in Northern Ireland to deliver services for the provision and facilitation of 30 Project ECHO knowledge networks across Northern Ireland. This Report evaluates the period from 2018-2020, as well as providing a preliminary analysis of the role of ECHO in Northern Ireland during the COVID-19 pandemic.

Project ECHO is frequently examined as a research project and not in 'real world' settings. This evaluation addresses this gap by evaluating the impact of ECHO as an integrated service within the health system. Additionally, while most global research on ECHO focuses solely on healthcare providers, the 34 Networks in Northern Ireland represent a mix of clinical and social care, providing insights on the impact of ECHO across different disciplines.

Evaluation Objectives

The Evaluation aims to describe and assess the activity and impact of Project ECHO networks in Northern Ireland between 2018-2020. The evaluation seeks to identify:

- the outcomes that each ECHO network hoped to achieve and how successful they were in achieving these;
- trends and patterns regarding impact across all 34 Networks
- if participation in the ECHO programme added value to service delivery and patient and carer experience and outcomes;
- the effectiveness of the ECHO network hub delivery.

These evaluation objectives are based on the key measures and outcomes identified by the HSCB in their service specification and monitoring requirements for Project ECHO[8]. Beyond the delivery of 30 high quality Knowledge Networks, the HSCB sought to demonstrate key outcomes related to:

- the impact of ECHO in supporting participant's knowledge and support needs;
- impact on increasing confidence of participants to treat patients;
- impact on increasing skills and capacity to treat patients;
- evidence that Project ECHO is embedded in network plans for service transformation and is contributing to the transformation agenda.

8 Tender for the Provision and facilitation of Project ECHO® (Extension for Community Healthcare Outcomes) knowledge networks across Northern Ireland working in partnership with HSC ECHO Support Infrastructure. CFT 1098558

Approach to Evaluation

Project ECHO: a Case Study Approach

A case study approach[9] allows multiple data sources to be analysed in order to assess the impact and outcomes of the Project ECHO networks. Each network is evaluated as both a stand-alone case study, and as integrated case study of Project ECHO as a whole. The metrics of evaluation were related to each Network's individual and specific key objectives, short-term and long-term goals. Common and recurrent themes, patterns and trends were then identified from multiple data sources and highlighted in the Overview of Impact section of the report.

What is a Case Study and why is it an appropriate approach to evaluating ECHO?

A case study is often described as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2003). It allows for practical, real-time evaluation and the flexibility to evaluate multiple interconnected objectives. These different and complex data sources and types (quantitative and qualitative) can then be triangulated to identify themes, patterns and trends in the data, as well as improving rigour and confidence in results. A case study approach allows both the analysis of individual networks with Project ECHO, as well as themes, patterns and trends across all the networks as a whole.

Three in-depth case studies are presented to provide further insight into the impact and outcomes of the ECHO methodology in three different areas. The Optometry/Ophthalmology network highlights the role of the ECHO methodology in supporting service transformation over a long period of time; the Neurology Network highlights the possibilities that ECHO offers in a clinical environment, supporting improvement of clinical knowledge, confidence, and reducing referral; while the Prisons Healthcare Networks shows the role of ECHO in facilitating multi-agency working in a complex environment.

Data Sources Included within the Evaluation

Multiple and diverse data sources are included with the evaluation. Data were collected on each network's activities and outputs (e.g. quantity and quality of sessions), processes (how the Project ECHO methodology was used within different health and social care contexts), and outcomes (the impact on participants, patients and healthcare system).

Data Collection Methods

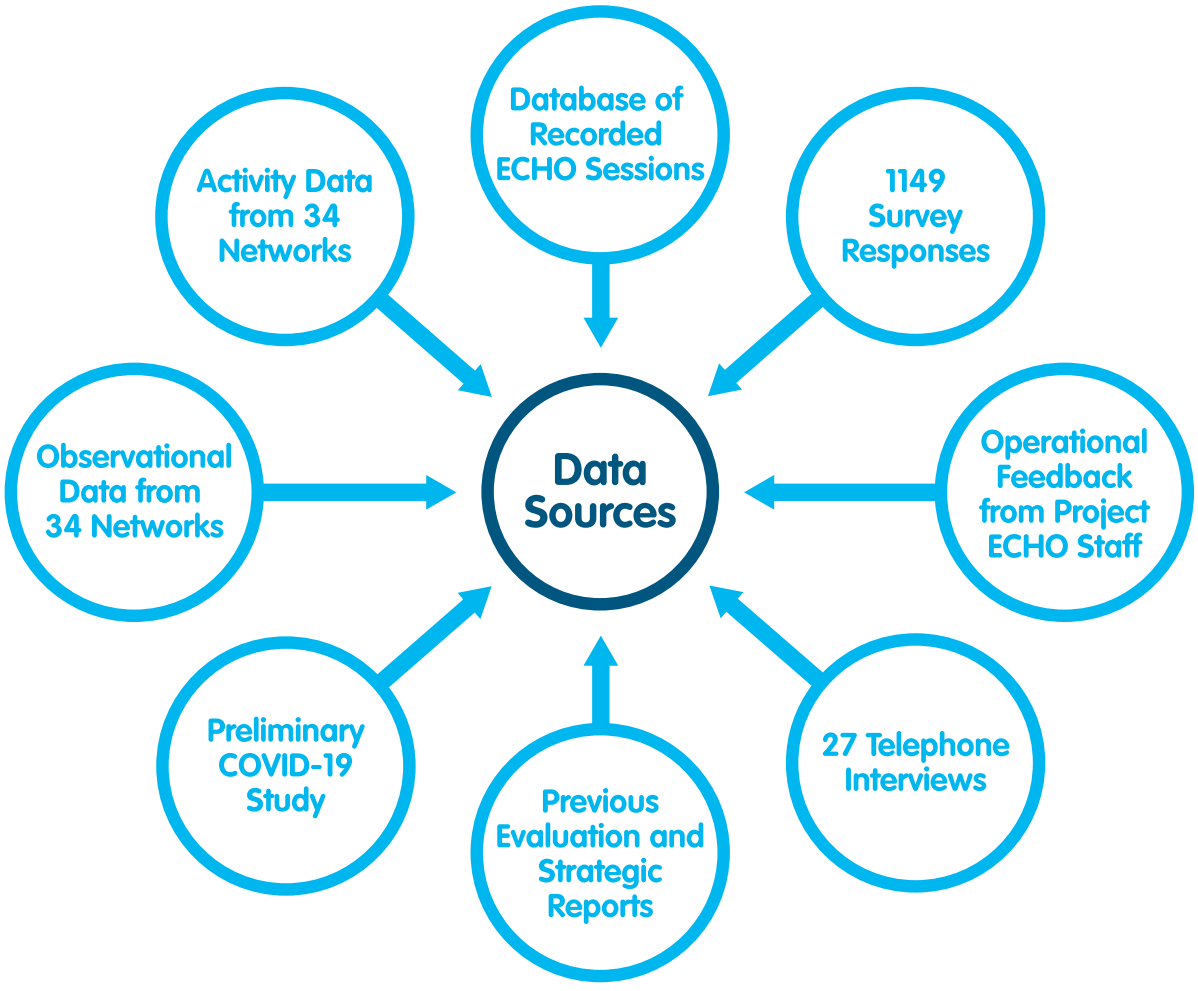
Co-designed and individually tailored surveys were issued to each network's registered participants. Participants were sent one reminder to complete the survey and the survey was open for between 2 weeks – 1 month. Additionally, a participant satisfaction survey was issued to all registered network participants on two occasions in 2018 and 2019. Observational data were collected at each ECHO session by the network administrator, who assessed the quality of the session and completed an observation form.

9 Yin, R. K. (2003). Case study research: Design and methods (3rd ed.). Thousand Oaks, CA: Sage.

Interviews were conducted with network leads and participants. Purposive sampling was used to identify a range of network leads, facilitators and educators across different health and social care contexts. Both high and low attending participants were selected in order to capture a wide range of perspectives across Project ECHO networks. Interviews lasted between 15 and 45 minutes, were digitally recorded and transcribed verbatim. Data was analysed thematically according to Braun and Clarke (2006)[10] (Familiarisation; coding; generation of initial themes; reviewing; refining and defining). A flexible approach incorporating both inductive and deductive approaches (Fereday, 2006)[11] was used, with deductive categories and codes identified from the ECHO 101 Evaluation Guide[12] (Processes and Outcomes) developed by the New York Academy of Medicine.

Note on Data Collection and Analysis

Given the participatory nature of the Project ECHO methodology, each network had co-ownership of the evaluation of their own networks. As such, surveys and survey questions issued to each network were specifically tailored to the needs of that network. This report, therefore, presents findings using multiple metrics, in order to best reflect the survey questions asked to different networks.



10 Virginia Braun & Victoria Clarke (2006) Using thematic analysis in psychology, Qualitative Research in Psychology, 3:2, 77-101, DOI: 10.1191/1478088706qp063oa

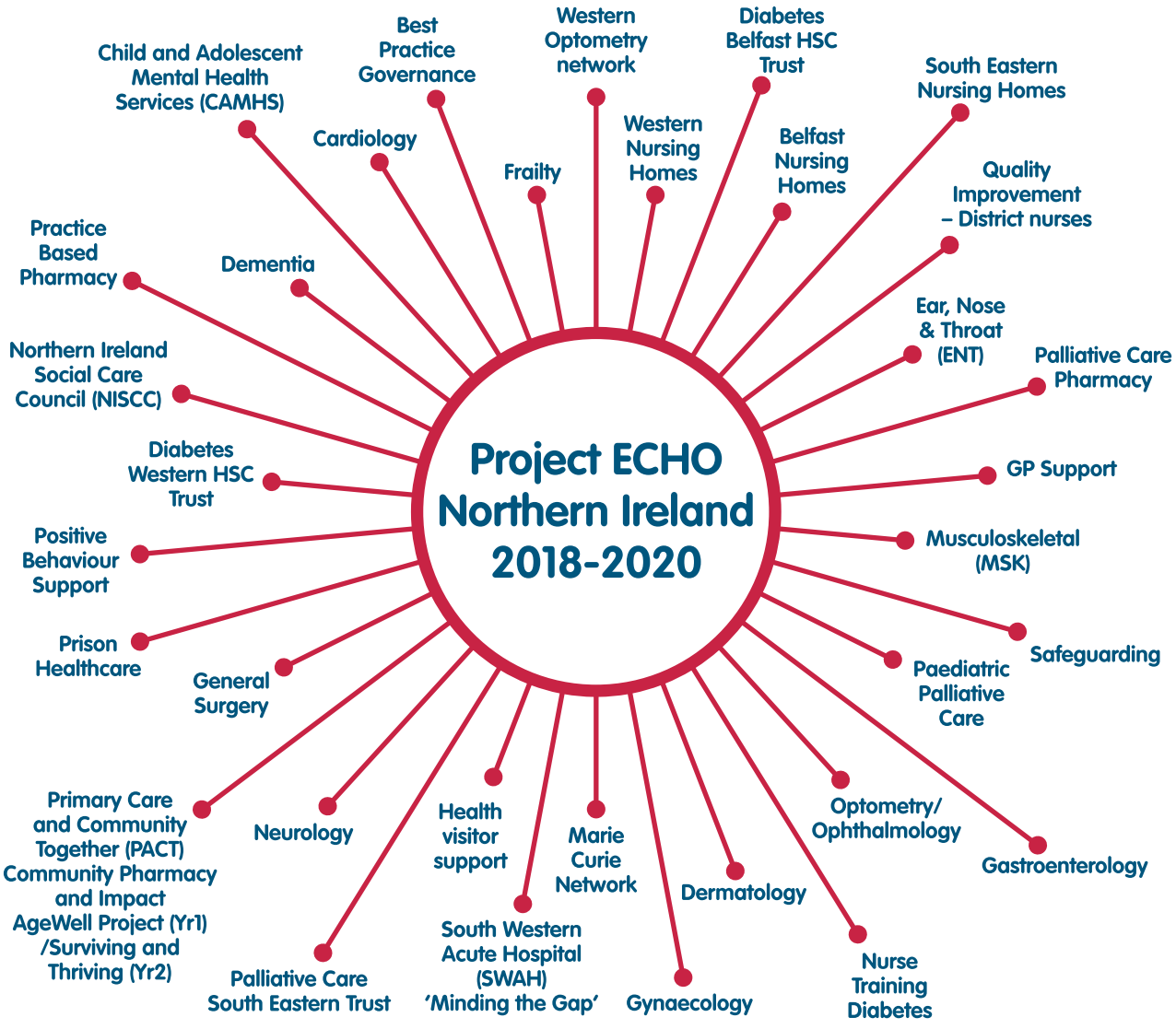
11 Fereday J, Muir-Cochrane E. Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. International Journal of Qualitative Methods. March 2006:80-92. doi:10.1177/160940690600500107

12 Project ECHO® Evaluation 101: A Practical Guide For Evaluating Your Program. NYS Health Foundation. https://nyshealthfoundation.org/resource/project-echo-evaluation-101/

Results of Project ECHO Northern Ireland, 2018-2020

Overview of Networks and Activity

A total of **34 ECHO networks** operated during the Evaluation period of 2018-2020. Over the course of the Evaluation period, these ran **357 ECHO sessions** attended by **2101 individuals** (number of individuals attending at least one session). The median number of participants per session was 13. A full breakdown of attendance per network is provided in Appendix Item 1. These figures represent a significant increase in ECHO activity from 19 knowledge networks supported by Project ECHO NI in 2016-17. A lack of individual data on participation between 2016-2017 means it is not possible to directly compare participant numbers, but these have also likely increased significantly. Two Networks (Best Practice Governance and Diabetes Western) did not complete their programmes due to challenges in recruitment, sustainability and the impact and disruption of COVID-19 (detailed in the Appendix section).



Network's Goals and Objectives

Each network set their own goals and objectives following individual curriculum setting days at the beginning of the year. A key objective, short-term, and long-term goals were identified within a logic model in order to focus activities and track progress. The majority of networks (80%), as they were at the initial stages of their ECHO journeys, focused their key objectives on improving outcomes for health and social care providers, such as improved knowledge, confidence or self-efficacy. 53% identified a key objective that included health system outcomes such as improving referral pathways and including the development of networks, collaboration and integrating care. Only 13% of Networks identified a key objective that specifically mentioned patient outcomes.

As networks progress, objectives are intended to evolve towards supporting embedding ECHO in service delivery models. Examples of the objectives identified by different networks are included below and a full list of objectives, short-term goals and long-term goals is provided in the Appendix (Item 2).

Examples of Networks' Key Objectives

To develop the capacity to effectively identify common ENT conditions, instigate treatment and manage these long term conditions within primary care, with appropriate specialist input when required.
Ear, Nose & Throat (ENT) Network

To improve the overall quality of patient care and the efficiency of training delivery to registered nurses.
Marie Cure Network

To create a regular virtual meeting place to share key learning, provide support to isolated practitioners and improve communication and understanding between primary and secondary care.
South Western Acute Hospital (SWAH) Network

Short-term outcomes focused on improving provider knowledge, awareness, confidence and self-efficacy, as well as improving professional satisfaction, support and improved relationships and communication between different levels of the health system. Short-term targeted outcomes included:

- Improved knowledge: of a condition, symptom management, medication management, red flags.
- Improved confidence: to diagnose or manage a condition, prescribe, manage patients without making a referral or making a more informed referral.
- Improved awareness: of guidelines or pathways, referral procedures (when to refer).
- Improved relationships and communication: between primary and secondary care and other professional boundaries, and/or across sectors
- For participants to feel more supported and less isolated: through access to peer support and the opportunity to network and build relationships with colleagues.

Longer-term outcomes and impact that networks hoped to achieve focused predominately on health system factors including reducing referrals and improved management on waiting lists. Longer-term targeted outcomes included:

- Increased capacity to manage patients within primary care.
- Improved management of patients whilst on waiting lists.
- Reduced demands for secondary care where appropriate / prevention of unnecessary admissions to hospital.
- Improvement in the quality of referrals to secondary care.
- Improvement in the quality of care delivered to patients, service users, and/or carers.
- Improvement in communication with patients and carers.
- Scoping of opportunities to innovate and transform care.

Overview of Levels of ECHO Networks

Year 1
- New to ECHO. Establish applicability of ECHO to chosen topic-area.

Year 2
- Develop the knowledge network/ community of practice, involving more disciplines & members.

Year 3
- Well established network and starting to consider how to embed ECHO in their service delivery model. i.e. building into srvice model, job plans, getting ready to be self-sustainable.

Descriptive Overview of Impact across Networks

The Project ECHO Evaluation 101 guidelines highlight three main domains for impact analysis: impact on **Providers**, **Patients**, and the **Health System**. Across all three domains, Project ECHO demonstrated positive impact related to the key objectives of increasing knowledge, confidence and self-efficacy of health and social care providers. Analysis of both quantitative and qualitative data pertaining to these domains indicates the highly interconnected nature of outcomes. Patient and health system outcomes often stemmed from increased knowledge, confidence and capacity gained by health and social care providers. Evidence suggests positive benefits for patients linked to health and social care provider's participation in ECHO, as well as reduced referral and increased confidence to manage patients at primary level.

Analysis of each Network's progress related to self-identified goals and objectives (see Appendix for detail) indicates that most networks demonstrated a high degree of success in achieving short term goals. Progress towards achieving long term goals was more varied across Networks, with higher Level Networks demonstrating most success.

Improved Knowledge, Confidence and Satisfaction

Health and social care providers reported improved knowledge relating to a range of areas including clinical knowledge, symptom recognition, patient management, awareness of up-to-date best practice guidelines and new treatments.

Twenty-four ECHO networks reported results across a Likert-type scale of agreement with statements relating to the impact of ECHO. Participants described benefiting from both access to specialist knowledge, as well as from sharing experiences and peer-learning. **93%** (n=102/110)[13] participants reported improvements to their practice and management of patients as a result of ECHO, while **89%** (n=252/283) reported that ECHO had improved their levels of clinical knowledge, and **89%** of healthcare providers (n=186/208) stated that ECHO had improved their self-efficacy and confidence in managing patients. **89%** (367/413) said they had applied knowledge gained from ECHO in their practice.

Participants across the ECHO networks reported that the information they gained through the sessions would be useful and they had/would apply it within their own practices. The sessions were described as having helped to improve confidence in managing patients and in improving providers' self-efficacy. Positive outcomes described by healthcare providers are likely to be interconnected to positive patient and health systems outcomes such as improving patient experiences and reducing unnecessary referral.

Beyond having access to specialist knowledge and the opportunity to benefit from peer-learning, participants across the networks described the benefits of being part of a community of practice. Particularly for participants working in isolated and remote areas, or working in roles in the community, this virtual community was described as being important in terms of improved practice, improved professional satisfaction, and learning across disciplines and levels of

13 As described in the section on Data Collection, different evaluation questions and metrics were used by different Networks. Number of respondents therefore differed for each metric and are presented in the text.

the health system, and developing a feeling of support and connection between colleagues. **81%** of participants (225/279) reported improved satisfaction, reduced isolation and feeling more supported in work.

Five networks evaluated the impact of the Programme using a retrospective pre/post survey. Across all Networks and metrics participants reported a positive impact of ECHO, ranging from 0.25 point difference to 1.86 point difference, with an average increase of 0.89 across the different networks and metrics.

Quotes from ECHO Participants – Impact on Healthcare Providers

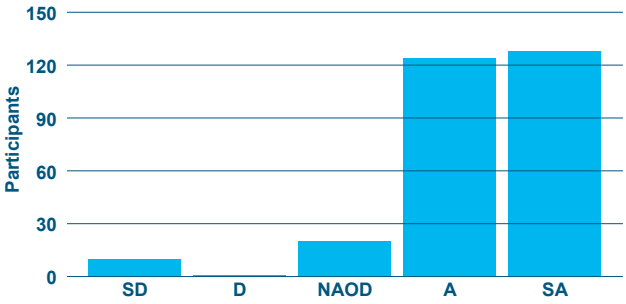
"I wouldn't have felt either confident or competent enough to provide that service if I hadn't have gone those 3 years with the continual knowledge building and that gradual increase of knowledge that I built through ECHO"

"I gained a lot from it, probably more from the experts, but also from hearing other people's problems and how they solved those problems"

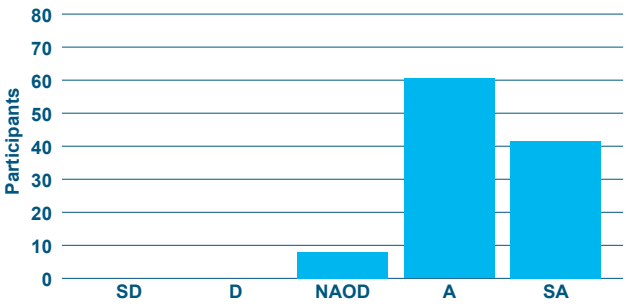
"Speaking with other members in different areas, dealing with the same situation and coming up with solutions whether it be symptom management or breathlessness, bowel obstruction or whatever. It was really honing in on patients similar to mine and maybe things that I hadn't thought about."

"The people we invited to join Project ECHO where the most remote District Nurses teams, with regards to the Peninsula, Donaghadee and Mourne Areas, people at the edge of the trust that still need support"

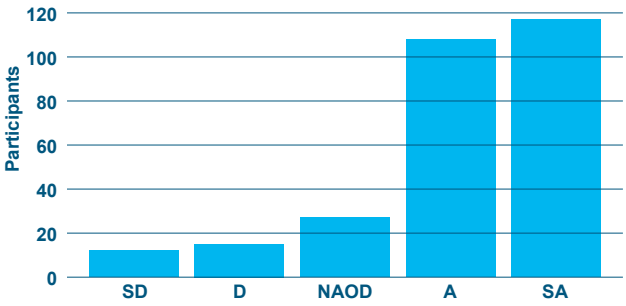
Impact of ECHO: Improved Knowledge



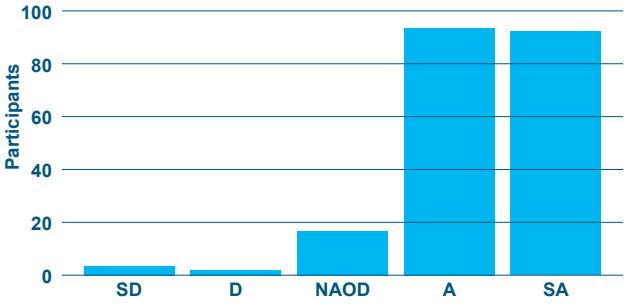
Impact of ECHO: Improved Treatment and Practice



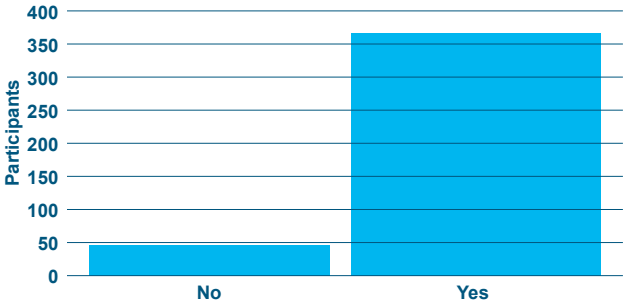
Impact of ECHO: Confidence and Self-efficacy



Impact of ECHO: Improved Satisfaction and Support



Impact of ECHO: Application of Knowledge and Skills



SD – Strong Disagreement/No D = Disagree/No
NAOD = Neither Agree/Disagree A = Agree/Yes SA = Strongly Agreement/Yes

Network	No. Participants	Scale	Metric	Pre-ECHO Weighted Average	Post-ECHO Weighted Average	Point Difference
Diabetes Belfast	11	7 point	Knowledge and Skills	4.18	5.18	+1.00
Diabetes Belfast	11	7 point	Confidence	3.00	4.09	+1.09
Neurology	11	5 point	12 measures related to Knowledge, Skills and Confidence[14]	3.05	4.12	+1.07
Nurse Training Diabetes	4	5 point	Knowledge and Skills	4.25	4.50	+0.25
Nurse Training Diabetes	4	5 point	Confidence	3.75	4.00	+0.25
Positive Behaviour Support	23	5 point	Knowledge	3.50	4.30	+0.80
Positive Behaviour Support	23	5 point	Skills and Practice	3.64	4.16	+0.52
Positive Behaviour Support	23	5 point	Self-Efficacy	3.56	4.10	+0.54
Quality Improvement District Nurses	8	7 point	9 measures related to Knowledge & Skills	2.88	4.74	+1.86
Quality Improvement District Nurses	8	5 point	9 measures related to Confidence	1.94	3.49	+1.55

Benefits for Patients

The impact of Project ECHO on patients was described in terms of improved patient care and experiences. Increased clinical knowledge, self-efficacy and confidence enabled healthcare providers to access to new treatments and therapies, and allowed patients to be managed within their own locality, and to experience reduced waiting times.

Outcomes for patients were described in varied terms. For example, members of the Optometry network described improved outcomes for patients through connecting ophthalmologists and GPs. This enabled GPs sign off on a patient receiving a new treatment in order to prevent sight loss.

One participant described being able to more efficiently access a brain scan for a patient with migraines and other potential 'red flag' symptoms. Through efficiently accessing referral, the patient was seen quickly and avoided a long and potentially worrying waiting period. Participants working in end-of-life care described learning and applying knowledge on best practice regarding managing side effects of pain treatments, as well as how to adapt the physical space around the patient to improve experience and comfort.

Available data only includes feedback from healthcare providers on the perceived benefits for patients. Research involving patients under the care of a healthcare provider participating in ECHO may enable stronger conclusions in the future.

Improved Networks, Relationships and Referral, but limited impact on Changing Policy and Processes

A number of impacts on the **health system** were described. Improved confidence in providers' skills, knowledge and management of patients, resulted in participants describing being more confident and efficient in their use of referrals. At times this was described at helping to reduce unnecessary referrals and ensure patients were treated in primary care, and in other examples this was described as having a better understanding of referral pathways thus allowing more efficient referral and reducing waiting times for patients. **73%** (114/156) of participants said that ECHO had supported them across a range of metrics

14 See Case Study for Further Detail

Quotes from ECHO Participants – Impact on Patients

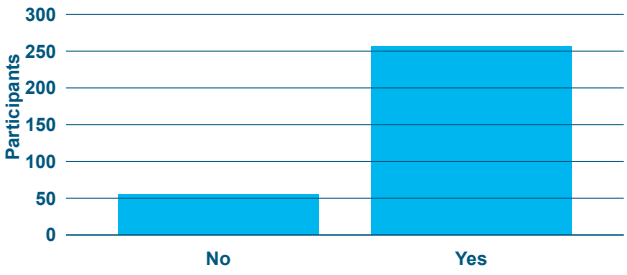
"I had a guy who had experienced exercised induced headaches, which I was putting down to a form of 'migraine'. But through asking questions (I found) there is a potential that this guy could be leaking fluid in his brain. He wouldn't be a true 'red flag' but he definitely needs a brain scan. The thing is I can't access brain scans without a consultant's approval, which meant a referral to the hospital, but anyway (the educator) informed me of the specific guideline that would fit within the Trust which meant I could contact the hospital. Anyway we got the scan done and he has been reassured, I was literally speaking to him 2 hours ago and he is completely fine, but he was looking at going privately or going on a long waiting list".

"It has been very timely for us and really relevant to issues that we are having, things like 'blended diets'. We had a child around the time the ECHO was done and their family had just asked us if we could provide a 'blended diet'. The educator doing the presentation at the session was able to give us some guidance on where to get advice about our policies around 'blended diets' and since then we have done that, our policy is in place that is going through our local government at the moment and then we are going to start doing blended diets".

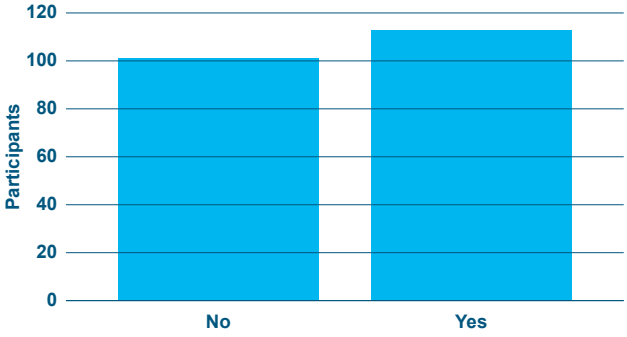
relating to referral, such as being more timely, efficient, and confident in managing patients at primary levels. A total of **82%** (257/312) reported better relationships between levels of the health system, improved collaboration between healthcare providers, and improved knowledge about different services offered within their area.

Results varied on whether ECHO helped to contribute to long-term changes in processes, guidelines or policy, and perhaps reflects the limited embedding of wider systemic changes driven by Project ECHO. A total of **53%** (113/214) stated that ECHO had contributed to changing processes, guidance and policy. For some networks, for example, the Prisons Healthcare Network (see Case Study), long term changes to processes, guidance and policy were described in detail. It should be noted that for some Networks, changing processes, policy or guidance may not have been an explicit objective.

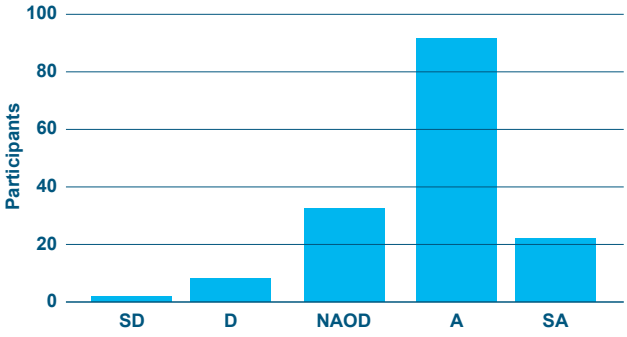
Impact of ECHO: Improved Relationships and Collaboration



Impact of ECHO: Changing Processes, Policy and Guidance



Impact of ECHO: Improved Referral



SD – Strong Disagreement/No D = Disagree/No
NAOD = Neither Agree/Disagree A = Agree/Yes SA = Strongly Agreement/Yes

Quotes from ECHO Participants – Impact on Healthcare System

"It made practitioners more relaxed in their own clinical primary care setting and probably raised the bar for referrals. I imagine a lot of people feel that way as well more responsibility and monitoring situations rather than straight to referral."

"One scenario in particular (was getting) direct access through a specific pathway, which meant that I was able to get things arranged, reassure a patient and he is now no longer on a waiting list."

"Our Minister of Justice at the time had asked for a review of vulnerable prisoners and so that review was on going and documentation was being developed around the pathway for the vulnerable people. Our ECHO fed into that and the educators would bring "Best Practice and Guidelines" themselves the manifestation of that was there was learning and as a result difficult conversations that happened within the ECHO. Then we produced the self-harm framework and that was the time we had collectively looked at what where we doing and what can we do."

Case Study: Optometry/ Ophthalmology Network

The objective of the Ophthalmic Network was to build capacity and capability within primary care optometry to assist in the monitoring and review of patients, with defined clinical conditions, within a robust and quality assured model of service provision; to improve patient experience with regards access to care; and to increase knowledge and self-efficacy of participants. In the long term, the Network sought to embed ECHO into a service specification to provide governance and support for the clinicians involved in co-management schemes delivering enhanced care in the optometric primary care setting. This ECHO supported the development of the Primary Care Optometry Ocular Hypertension (OHT) Review and Monitoring Service provided by primary care optometrists.

The Network has been operating in some form as an ECHO Network for a number of years, initially set up as a pilot to investigate how ECHO could support Glaucoma and Macular pathway reform and decision making in order to reduce referrals to secondary care. Following evaluation of the initial pilot ECHO was adopted as a model and platform to support ophthalmic service transformation. HSCB commissioned the Ocular Hypertension Review and Monitoring regional Optometry-delivered enhanced service. A key component of this service accreditation required attendance and participation at ECHO sessions.

The current optometry/ophthalmology ECHO provides the training, governance and networked approach which underpins service reform and transformation around new models of care in the glaucoma pathway. Without the ECHO knowledge network this transformation would not likely have been possible and may not have been sustainable.

This Level 3 Network delivered 9 sessions within the evaluation period and was attended by 28 participants. 14 participants responded to the evaluation survey, in which they provided feedback on their perceived most significant changes from their involvement in the Network. Participants described increased knowledge, confidence and understanding of pathways, including confidence on referral and reducing unnecessary referral and better understanding between colleagues. 100% of participants said they would like to continue within the network.

A number of participants highlighted most significant change relating to the use of ECHO in supporting the development and implementation of OHT Review and Monitoring service. Participants described feeling more confident in managing patients, and that

patients described the benefit of being treated closer to home. Participants, for example, described having better knowledge of OHT and being more confident in knowing how to differentiate it from Glaucoma, as well as being able to provide earlier referral for patients with suspected OHT and Glaucoma and, fewer unnecessary referrals.

This Network demonstrates significant success in both achieving short term and longer terms goals. A post-project review (at the end of the first year, 2019) of the Primary Care Optometry Ocular Hypertension Review and Monitoring Service stated that the project "demonstrates that overall the OHT Review and Monitoring Service is a safe and accessible service for patients". A total of 450 patients were invited to use access the service by the Belfast HSCT between Jan-Dec 2019, of which 271 patients (60%) took up the offer and were been discharged to access their ongoing review in primary care. In the first year of the service 129 patients accessed their review and clinical care via the OHT Review and Monitoring Service in primary care. From initial implementation in January 2019 to date approximately 1,000 patients have had their care transferred from the hospital eye service to primary care Optometry and, in the time period February 2019 – July 2021, 974 episodes of clinical care have been provided by Optometrists through the OHT Review and Monitoring Service and supported by ECHO.

Through the Network's support for the OHT Review and Monitoring Service, it demonstrates the impact ECHO can have on integrating new pathways and systems into the health service, supporting more effective referrals and better connections between different areas of the health service. Within this Network, ECHO demonstrates that it can provide the opportunity support the learning elements required in new models of care, while also creating an environment which develops a culture of safe learning, psychological safety, and practitioner support and well-being, all of which are essential to supporting service transformation.

"For most of my 28 year career I felt I was talking a different language from Ophthalmologists with regard to Glaucoma- now I have a much better understanding. Thanks to ECHO, I now (mostly) understand why secondary care make the decisions they do. Also I feel that the Ophthalmology specialists involved have been very generous with their time and knowledge and we are more like a team now with a continuum between community optometry and secondary care."

"Our practice can now offer OHT management. All our Optoms benefit from what we discuss in ECHO sessions and would be happy to participate if we could work out how to include more Optoms across the province."

"Confidence- I hated trying to detect glaucoma for years; now I feel I know what I am doing in detection and talking to patients about their eye health."

Equally, ECHO provided a space in which practitioners felt supported and in which relationship development and shared learning were frequently reported.

"Much more open conversation and asking of others opinion. Often subtle change can be hard to pick up and second opinions can be invaluable."

"It's changed the relationship where many of us work in isolation to encourage active discussion of cases in a safe environment."

"I feel more open to ask questions and advice of peers and learn from each other's experiences"

Case Study: Neurology Network

The Neurology network sought to build capacity of GPs to manage more patients within the community and provide higher quality of care through education and improved access to specialist neurological advice. The current neurology service model is largely focused on outpatient delivery. At the end of March 2017 there were 13,522 people on the waiting list for a first outpatient appointment with 5055 waiting more than one year. The Network was initiated within the strategic context of the development and piloting of the Non-Contact Assessment Service (NCAS) in Southern Trust area. NCAS is a method of virtual triage, by a Neurologist, of new GP referrals. An estimated 30% of referrals could be managed in an alternative way at the primary care level. However, preparatory work to develop additional capacity and knowledge at the primary care level is required. ECHO was initiated as a mechanism to support such capacity-building.

In this context, the aim of this network was to improve GP's knowledge of neurological conditions; to improve GP's confidence in the management of neurological conditions; and to improve relationships between primary and secondary care. The intended short-term outcomes included to improve the confidence of GPs to manage neurological complaints and implement first steps in investigation; and to more effectively manage patients while on waiting lists. Long-term outcomes for this network if the objectives were achieved were to review changes in referral patterns: reduce outpatient secondary demand; improve outcomes for patients; and to inform best practice locally through the Development of a GP practice protocol.

The Neurology Network ran for two years during the Evaluation period, delivering 17 ECHO sessions (9 in Year 1, 8 in Year 2), and was attended by 60 participants in Year 1 and 51 participants in Year 2. Of the 11 participants who responded to the final survey, 64% (n=7) had participated in the Network over the two years, while 36% (n=4) had participated for one year. 91% of survey respondents (n=10) had attended nine or more ECHO sessions. Survey respondents worked in the Belfast Trust (n=3), the Northern Trust (n=3), The South Eastern Trust (n=1) and the Southern Trust (n=4). No respondents to the survey worked in the Western Trust.

Results from the Network were overwhelmingly positive regarding short-term of aims of increasing GP knowledge and confidence in managing neurological complaints. 100% of participants reported that participation in the network had helped in their assessment of patients with neurological conditions/symptoms; and 91% saying it had positively impacted on their ability to appropriately refer patients. Participants stated more confidence in diagnosis and management of patients, and improved relationships between primary and secondary care. Retrospective analysis of knowledge on a Likert scale (1-5) indicated improved knowledge and confidence across all 12 assessed domains by +1.07 point (average weighted average prior to participation in the network = 3.05; average weighted average post network = 4.12).

Participants described the most significant changes to their practice as increased confidence in managing patients, as well as understanding and using referral more effectively. Some participants reported improved understanding, knowledge and recognition of different neurological conditions, and that relationships between primary and secondary care had been improved through ECHO. Most significant impact on patients included less referral and better and faster treatment at primary level meaning patients did not have to wait to be seen at secondary level.

These results suggest the benefit of ECHO in supporting management of neurological conditions at primary level and developing stronger relationships between primary and secondary level. The extent to which referral has been reduced would be an important area of further research, as would research on

Domain. Comfort Managing Patients in.	Pre-ECHO Weighted Average	Post-ECHO Weighted Average	Point Difference
Daytime Surgery with chronic headache	3.36	4.27	+0.91
Out of Hours with chronic headache	3.09	4.27	+1.18
Daytime Surgery with dizziness	3.00	4.09	+1.09
Out of Hours with dizziness	3.00	4.09	+1.09
Daytime Surgery with tremor	2.82	4.09	+1.27
Out of Hours with tremor	2.91	4.00	+1.09
Daytime Surgery with transient loss of consciousness	3.09	4.09	+1.00
Out of Hours with transient loss of consciousness	3.00	4.09	+1.09
Daytime Surgery with numbness	2.91	4.09	+1.18
Out of Hours with numbness	2.82	4.00	+1.18
Daytime Surgery with new onset headache	3.27	4.18	+0.91
Out of Hours with new onset headache	3.27	4.18	+0.91
Average Weighted Average	**3.05**	**4.12**	**+1.07**

the degree to which ECHO has supported the development of a Non-Contact Assessment Service (NCAS) and whether this approach and learning from this experience can influence service changes in other areas.

Feedback on the value of ECHO:

"It's great to have this forum to participate in distance learning with our specialists in Northern Ireland."

"The course was excellent. The speakers were excellent teachers and I thoroughly enjoyed the presentations and discussions. It was also very well facilitated."

Case Study: Prisons Healthcare Network

In 2008, the South Eastern Health and Social Care Trust (SEHSCT) started providing the healthcare in Northern Ireland's three prison sites, Magilligan, Maghaberry and Hydebank Wood College. Participants in the Network included frontline staff, management and clinical specialists in SEHSCT and the Northern Ireland Prison Service, a team from the Criminal Justice Inspectorate Northern Ireland, HMP Whatton, a collaboration from the Cardiff Prisons and representation from Health and Justice England.

9 sessions were held and were attended by 90 individuals with a median attendance of 19 attendees per sessions. The ECHO Network set out to provide teaching on the following four themes: Palliative Care; Blood Borne Viruses; Chronic Respiratory Diseases; Sexual Health and Harm Reduction. Focus groups and interviews were held with members of the Network in order to evaluate its impact.

Participants described outcomes that demonstrated changes and improvement for both individuals in the networks and for wider service delivery. Participants reported improved knowledge, upskilling, and an increased awareness of trauma informed practice through having access to both specialised training and to membership in the network. Self-efficacy, confidence, reduced anxiety of prison staff in managing self-harm, and access to new information were all described as beneficial, and participants described broad changes in attitude towards being more supportive for approaches such as harm minimisation.

Wider changes and outcomes in service delivery, catalysed through the relationships developed within ECHO, were described as encouraging a greater focus on client-centred planning, a person centred approach to care and rehabilitation, and a greater recognition of the limitations of a one-size-fits-all approach. An increased emphasis on tailored care, user input, and the need to appreciate individual's specific lived experiences were described by participants across the network.

The ECHO approach was considered effective by participants in terms of sharing knowledge, new information, best practices and experiences. Participants reported benefiting from the conversation, debate and sharing that was generated throughout the network, while also recognising the potential for the network in bridging knowledge gaps between different levels, service providers, and institutions involved in delivering health services in prisons. Access to the knowledge shared by community health providers during sessions was reported as equally beneficial. Relationships developed through the networks allowed participants to better appreciate perspectives of different organisations and to develop a shared language in order to address challenges collaboratively.

The ECHO network, and the relationships developed through it, helped to catalyse the development of a new referral pathway between the Northern Ireland Prison Service and the South Eastern Health and Social Care mental health team, as were new operating procedures for keeping people safe in custody. Health promotion days were initiated, and trauma training was rolled out to all prison and healthcare staff. ECHO was described as important in shaping quality improvement work of the mental health team within the prisons, as well as providing a space to co-produce future aims and objectives. This case study provides an example of the ECHO methodology facilitating a multi-agency approach to collaborating within a complex environment.

The ECHO Approach:

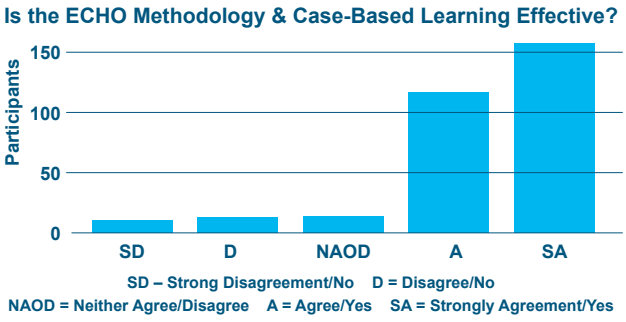
Is the ECHO Model effective; Factors Affecting Impact and Success of Networks; and What makes a 'Good' ECHO?

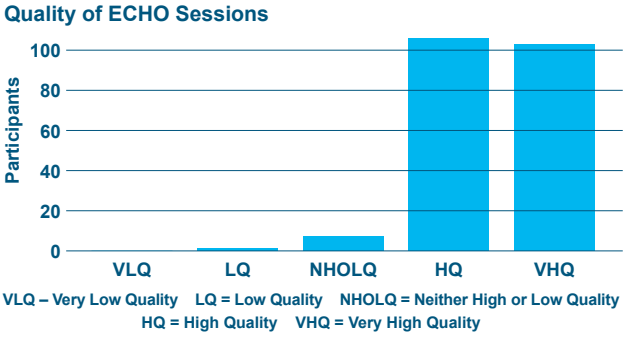
The ECHO approach was considered effective and high quality by participants. Case-based learning, collaborative and facilitated discussion and the ability to meet other healthcare providers in similar fields were described as important and useful approaches to improving outcomes for healthcare providers, patients and the health system more broadly.

88% (274/311) of participants responding to the surveys found that ECHO was an effective approach and that case-based learning was effective in improving levels of knowledge, confidence and support. **96%** (209/217) reported ECHO sessions as either high quality (49%) or very high quality (47%). **96%** (277/290) reported that content delivered in the sessions were relevant to their practice, **92%** (317/343) said they would recommend ECHO to colleagues and **96%** (234/243) said they would participate again if given the opportunity.

Semi-structured interviews were additionally conducted with each member of the Project ECHO Northern Ireland Team to understand and learn from their experiences regarding the implementation of the ECHO programme; to allow team members to describe what factors contribute to a successful ECHO; to enable team members to discuss possible areas for strengthening; and to incorporate this feedback into this 'Lessons Learned' section of the Evaluation Report. This exercise was conceptually informed by Fleming's (2007) typology of reflective practice in health promotion, which focuses on the three domains of the self (individuals and teams)[15], the influence of the planning context (socio-economic and other environmental and political factors) and issues related to the process of planning/ delivery of health promotion programmes.

Reflections from the Project ECHO team were complimented and triangulated with observational data, ethnographic observations from the Report's author, and interview data from Network Leads. Following an analysis of the data, five interconnected common and recurrent reflections emerged:





15 Reflection—a neglected art in health promotion | Health Education Research | Oxford Academic (oup.com)

Reflection 1:
The Importance of Leadership within each Network

Leadership within networks was seen as critically important. A lot is asked of Project ECHO Network leads, including but not limited to the facilitation of sessions, organising speakers, and helping to set curriculum. They provide the anchor within each Network and session. Networks in which participation was greatest and outcome data strongest had leaders who were engaged, open, willing to learn, committed to the principle of fostering a non-hierarchical approach towards building communities of practice, and who had established networks which they were able to utilise for the benefit of the network. Network leads were important for facilitating, keeping to time, encouraging participation, and dealing with any challenges that arise during the sessions. They need to know when to step in, but equally when to step out and leave space for others to contribute. Network leads are able to avail of facilitation training to support them manage these roles, but evaluation on whether additional support would be beneficial Network leads may be useful. Network Leads also have described the challenges on their time and the difficulties of completing the role when coupled with other clinical responsibilities. All these factors have important implications when recruiting Leads for new Networks.

Reflection 2:
The Need for Content to be Relevant

Good speakers presenting information that was relevant and engaging to the Network was deemed essential. Interesting presentations and case studies lead to engaged discussion and participation. Speakers often do not have access or time to avail of the same training and support provided by ECHO to facilitators and Network leads, which may be useful to support presentations being dynamic, engaging and relevant. Delivering relevant content could be challenging in very diverse networks with a large range of levels of expertise and previous training. Curriculum setting days, in which all participants within the Network are invited to join and discuss what topics they would like to see covered, were seen as essential. It was noted, however, that there was a lack of evaluation regarding what worked well or poorly within these important sessions. Reports of Curriculum days being rushed and/or participants feeling flustered or overwhelmed were reported, indicating the need to think creatively about how to adapt the delivery of these sessions if required. Curricula can't be controlled by Leads, but must be co-designed and owned across the whole Network.

Reflection 3:
Getting the 'Right People' in the Room, On boarding and Initiation

On-boarding and Network initiation is an essential part of the process. Networks need to have a shared sense of purpose, a strategic fit, and linked to programmatic change. Leads need to understand the wider context and integrate that into the Network and its curriculum. Recruitment and registration are essential components. It's important to ensure the 'right people' are in the Room. If only managers are in the curriculum setting, but other staff attend the sessions, the Network is unlikely to be successful. If people are told to be there and not interested or engaged it is also unlikely to work effectively. Time needs to be invested to integrate people from the start, make it relevant, and to connect it to their interests and needs. Curriculum setting days allow the participatory development of the network, development of trust and relationships, communication about what ECHO is and what the model is, and identifying relevant topics.

Reflection 4:
The Value of the ECHO Infrastructure and Support

The Project ECHO team and infrastructure is essential and is one of the main elements separating this approach from other types of online and virtual webinars and training. Positive results and impact evidenced within this Evaluation would not be possible without the team (Network coordinators, IT support, managers and research officers) providing support to each Network. The team are essential in supporting the Lead, in developing good relationships, and in injecting informality, lightness and fun into the beginning of sessions. They set the rules clearly in the Introductions section of each session, which in turn allows them to be direct in asking people to turn on cameras and in asking participants direct questions. The ECHO team is there to support Leads who are often busy with many clinical commitments, to provide necessary administrative support, circulating agendas and links to meetings, technological support, and background support such as ensuring registration, recording and uploading sessions onto the online Moodle platform, and providing guidance on important issues such as data security. Zoom and online meetings remain intimidating for many participants; the Team are essential in supporting participants to navigate and use the technology and to ensure everything runs smoothly. Hospice UK staff have provided the operational backbone of the programme as per the HSC contract while the HSC ECHO team have provided the crucial interface with HSC staff to ensure that ECHO networks meet HSC goals.

Reflection 5:
The Development of Trust in Networks

For the type of sharing needed for Networks to be effective, a Network must represent a safe space in which participants feel trust in both other participants, Network Leads and the ECHO team. Trust is developed slowly by ensuring opinions are respected, that the models and principles of non-hierarchical learning are implemented and realised. Having cameras turned on, and this being enforced by the ECHO Team, is one important mechanism for building community, trust and accountability. Smaller networks were described as being easier spaces to develop both trust and participation, with ideal network sizes described as ranging between 15-40 participants (pre-COVID-19). In reality, much of the NHS is not non-hierarchical, and this can be a barrier to achieving trust and participation in Networks. If participants feel their opinions, knowledge and experiences are inferior to other members of the Network this may affect participation. Network Leads and the ECHO are important in actively working to make people feel comfortable and that their engagement is necessary.

Summary

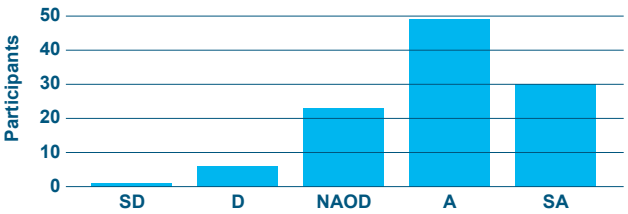
Results from participant surveys suggest that ECHO is both an appropriate and high quality programme to support healthcare providers. There are multiple factors that support ECHO in achieving these results. ECHOs need to be appropriately and collaboratively supported and developed, utilising the diverse knowledge and skills of Network Leads, participants, and the Project ECHO team. The learning from these groups is valuable not just for strengthening Project ECHO Northern Ireland Networks, but also in modelling effective approaches and documenting lessons learned that may be valuable and useful for the ECHO community globally.

Project ECHO and COVID-19: Preliminary Analysis

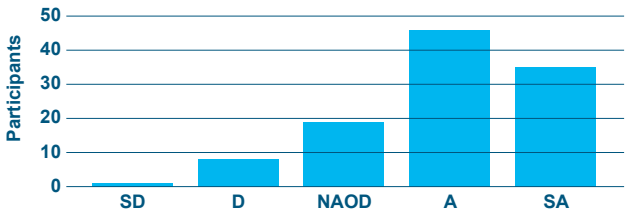
Project ECHO expanded significantly to meet demand during the COVID-19 pandemic. Approximately 15,000 participants took part in an ECHO session between March 2020-March 2021 (against an anticipated number of 7,200) with a total of 350 ECHO sessions delivered (against 240 planned). Preliminary analysis of the impact of ECHO during COVID-19, involving survey responses from 109 ECHO participants across six networks[16], focus group data from 6 networks and 7 in-depth surveys with network leads, indicates the significant benefit of ECHO for supporting healthcare providers during the pandemic. ECHO allowed connections and communities of practice to be developed and maintained when social distancing and remote working may have increased feelings of professional isolation. Participants stated that ECHO "was a brilliant experience to be able to feel supported" and that it was "a good way to keep up with other services and trusts".

Networks that existed prior to COVID described how ECHO had prepared them for online working. Existing networks were already used to online and virtual spaces and were able to quickly adapt to use these to support their response to COVID-19. Participants stated that "ECHO was ahead of the pandemic, and in many ways it was great to know that I could already use the technology and feel confident" and that they "felt it was a real advantage to have involvement in ECHO pre-COVID so we could continue uninterrupted with our network despite the pandemic".

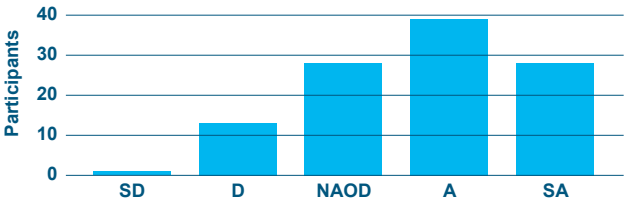
Did participation in this Network support the quality of practice and the care to patients and/or service users during the course of the pandemic?



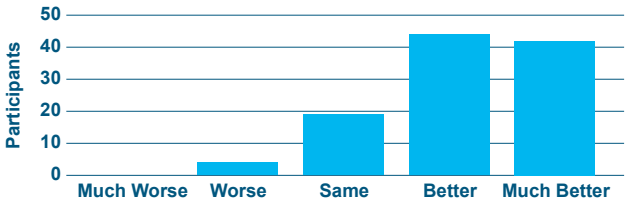
Did participating in ECHO help improve your confidence in keeping up-to-date with the evolving guidelines, processes and changes to practice during the Pandemic?



Did ECHO support adaptation of your practice during the COVID pandemic?

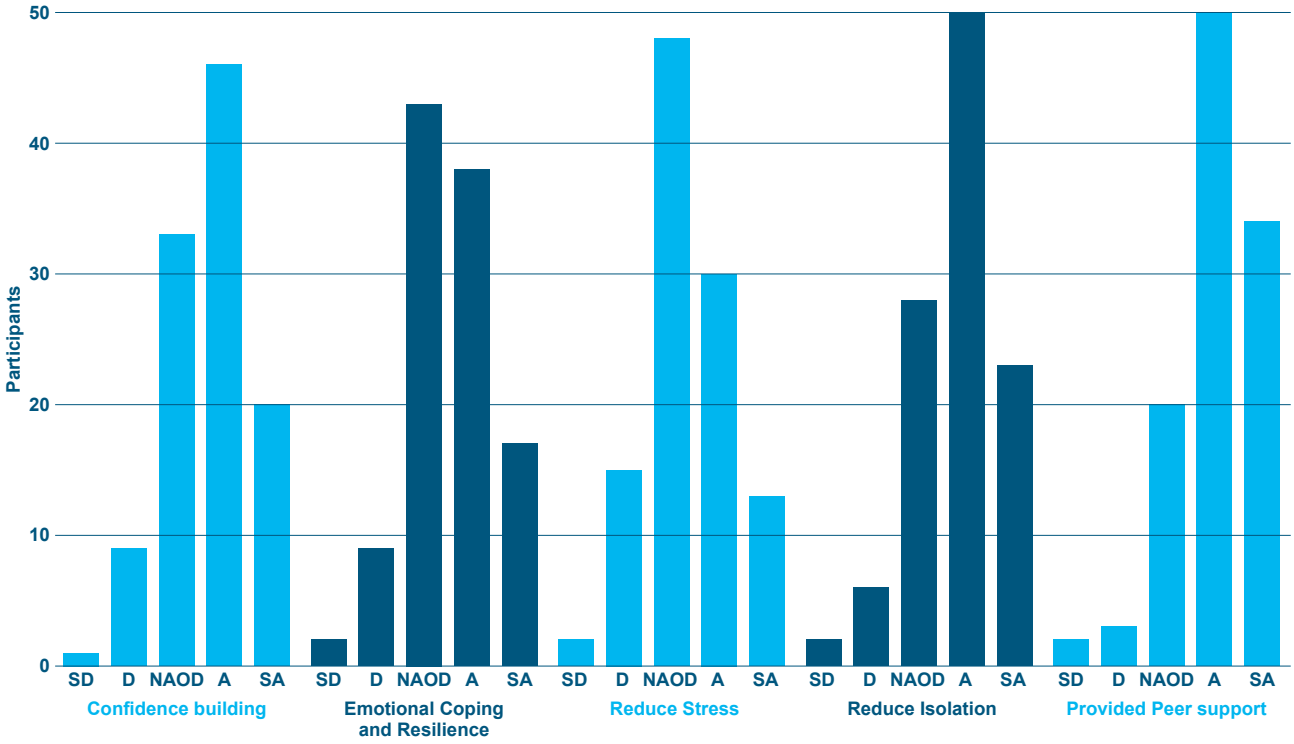


How would you compare ECHO to other online and virtual approaches to learning that you may have encountered during the course of the pandemic (e.g. webinars)



16 SA = Strongly Agreement/Yes; A = Agree/Yes; NAOD = Neither Agree/Disagree; D = Disagree/No; SD – Strong Disagreement/No

Did participating in the ECHO network support your personal/professional wellbeing during COVID pandemic?



There was variation across our sample within this preliminary analysis, suggesting the networks more directly affected by COVID benefited from it to a greater extent. The South Eastern Care Homes Network, for example, reported very strong results suggesting the benefit of ECHO, with 92% strongly agreeing/ agreeing that ECHO supported quality of practice during COVID; 92% strongly agreeing/ agreeing that ECHO supported confidence in keeping up-to-date with changing guidelines; 83% stating that it supported adaptation; and 100% stating that ECHO was more effective compared to other online training platforms.

The challenges experienced by healthcare providers during the pandemic have been well documented. This evaluation indicated that ECHO had a strong impact in supporting staff particularly in terms of reducing isolation and providing peer-support. Given that forms of remote practice are going to be with us for a long time this preliminary analysis demonstrates an evidence base for ECHO supporting practitioners and building communities of practice during a time when providers were physically distanced from each other. Results were less strong regarding the impact of ECHO in reducing stress or supporting emotional coping and resilience, indicating the limits of ECHO in addressing significant workplace stress caused by the pandemic.

Further analysis across on the impact of ECHO in supporting healthcare providers during COVID would be vital across all networks. COVID-19 has demonstrated the importance of having flexible and adaptable systems to support healthcare staff, and has highlighted the value of investing in key supportive infrastructure in advance of a crisis, rather in response to it. Further evidence and analysis from across all ECHO Networks would provide essential information from which to inform future decisions in how to ensure the healthcare system is prepared, flexible and mobile enough to support healthcare providers during COVID-19 and future crises. Understanding variables between Networks and areas for growth would also be of benefit, further necessitating a full review of the impact of ECHO during COVID-19.

Implications of the Report, Strengthening ECHO in Northern Ireland, and Conclusions

Evaluated against the key measures, outcomes and metrics identified by the HSCB, ECHO has demonstrated impact across the vast majority of the Networks initiated in Northern Ireland. Hospice UK fulfilled its contractual obligations to implement and evaluate over 30 Project ECHO Networks across the evaluation period, and those Networks have demonstrated impacts for health and social care providers, patients, and the health system. Using multiple metrics and data sources, this evaluation suggests that the ECHO methodology contributes to key strategic objectives regarding integration of health and care systems, improving quality of care for patients, and supporting the learning and wellbeing of health and social care providers. The diverse case studies presented in this report also highlight the versatility, flexibility, and adaptability of the ECHO methodology to support healthcare providers working in different areas and across various disciplines.

The vast majority of Networks within this evaluation achieved their short term goals, demonstrating the immediate benefit of ECHO for health and social care participants. Networks that had operated for a longer period of time, and were at Levels 2 and 3, tended to demonstrate better progress towards longer term goals of service transformation and integrating systemic changes for service provision. This finding demonstrates the importance of providing long-term support to ECHO Networks in order to enable such long term goals to be achieved.

Networks operating outside of the Evaluation period, and therefore not discussed extensively within this Report, also highlight many of these themes. The Social Prescribing Network, for example, strongly demonstrates the non-clinical application of ECHO with positive results.
In recent evaluations, participants reported that the Network improved knowledge, confidence, adaptation, and partnership building, with high levels of agreement across all evaluated domains. Strong results following the Evaluation period continue to indicate the relevance and benefit of the ECHO approach.

Within the context of COVID-19, preliminary evidence suggests the value of the ECHO methodology in supporting health and social care providers and building communities of practices within a complex and disruptive emergency, and during a time of ongoing social distancing. Further analysis and research on the impact of ECHO during the pandemic would be valuable for future emergency planning and for embedding changes as the health service builds back and recovers from the impact of COVID-19. Operational feedback and learning included within this report, highlighting the importance of factors such as strong leadership within Networks, should be rigorously applied to future applications to ensure impact is achieved across all Networks.

Future strengthening may include integrating the ECHO approach within HSC Quality Improvement to support quality and innovation across the HSC system in Northern Ireland. The ECHO methodology and model is a Quality Improvement tool and has demonstrated its value in supporting shared learning, collaboration, building relationships; empowering health and social care staff, and encouraging innovation and systematic change (as demonstrated by the case studies presented within this report). The ECHO methodology has equally shown its value in providing safe and collaborative environments to solve complex problems, all of which link closely to the approaches and key objectives within HSC Quality Improvement. Given the demonstrable

benefits for healthcare providers, appropriate support should be considered in the future to ensure equity of access and opportunity for healthcare providers to participate in Project ECHO Networks.

Strengthening approaches to evaluation may allow more confident assessment of some of the key measures and outcomes of Project ECHO. More Networks may consider developing pre-post surveys. Data may be gathered at multiple time points e.g. during the curriculum setting days and during final sessions, rather than gathering retrospective data at a single time point. Systematic reviews evaluating other ECHO networks highlight that "evidence is generally low-quality, retrospective, non-experimental, and subject to social desirability bias and low survey response rates"[17]. This evaluation provides a unique insight into how the ECHO methodology can be implemented in a 'real-world' context as opposed to within a research project, but further steps could be implemented to collect high-quality, long-term data which may inform future decision-making. Further data on geographical spread of the programme and the diversity of participants would be valuable in identifying gaps in service provisions and future focus areas. In-depth case studies mapping longitudinal change over time would help in assessing the transformative potential of ECHO.

17 McBain RK, Sousa JL, Rose AJ, Baxi SM, Faherty LJ, Taplin C, Chappel A, Fischer SH. Impact of Project ECHO Models of Medical Tele-Education: a Systematic Review. J Gen Intern Med. 2019 Dec;34(12):2842-2857. doi: 10.1007/s11606-019-05291-1. Epub 2019 Sep 4. PMID: 31485970; PMCID: PMC6854140.

Appendix 1: ECHO Network Attendance and Activity

Network	Network level at time of evaluation	Number of ECHO sessions delivered	Number of 'attenders' (spokes who attended at least 1 session)	Number of 'attenders' registered to network	Median attendance per ECHO session
Belfast Nursing Homes	1	5	21	29	18
Best Practice Governance	1	5	19	11	6
Child and Adolescent Mental Health Services (CAMHS)	1	8	44	24	12
Cardiology	2	9	44	20	13
Dementia	1	13	140	52	22
Dermatology	2	9	36	21	13
Diabetes – Belfast HSC Trust	1	9	37	16	12
Diabetes – Western HSC Trust	1	9	29	30	12
Ear, Nose & Throat (ENT)	1	9	41	28	14
Frailty	1	6	36	45	15
Gastroenterology	1	9	27	15	12
General Surgery	1	5	13	12	13
GP Support Year 1	1	9	32	24	12
GP Support Year 2	1	7	15	19	11
Gynaecology	2	10	48	25	13
Health visitor support Year 1	1	8	74	21	18
Health visitor support Year 2	2	6	33	58	28
Marie Curie Network	1	10	15	12	8
Musculoskeletal (MSK)	1	9	23	14	13
Neurology Year 1	1	9	60	21	22
Neurology Year 2	2	8	51	46	36
Northern Ireland Social Care Council (NISCC)	1	11	59	37	13
Nurse Training Diabetes	1	9	37	17	9
Optometry/ Ophthalmology	3	9	28	28	21
Primary Care and Community Together (PACT) Community Pharmacy and Impact AgeWell Project (Yr1) / Surviving and Thriving (Yr2)	1	8	33	19	10
Paediatric Palliative Care Year 1	1	9	172	63	33
Paediatric Palliative Care Year 2	2	6	30	34	15
Palliative care pharmacy	1	9	20	18	10
Palliative Care South Eastern Trust Year 1	1	9	83	27	11
Palliative Care South Eastern Trust Year 2	2	8	35	43	18
Positive Behaviour Support	1	9	59	51	19
Practice Based Pharmacy Year 1	1	19	174	122	27
Practice Based Pharmacy Year 2 (new cohort)	1	15	115	148	6
Prison Healthcare	2	9	90	19	17
Quality Improvement – District nurses	1	8	32	19	9
Safeguarding	1	8	21	60	12
South Eastern Nursing Homes	1	5	17	26	13
Surviving & thriving in community pharmacy (network renamed for Year 2)	2	8	52	92	12
South Western Acute Hospital (SWAH) 'Minding the Gap'	1	8	113	119	31
Western Nursing Homes	1	8	31	37	19
Western Optometry	1	10	62	58	41
Totals		**357**	**2101**	**2458**	**651**
Average (median)		**9**	**36**	**27**	**13**

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Belfast Nursing Homes	To enable nursing home staff to become more independent in the clinical care of their residents	1. Nursing home staff have increased knowledge, confidence and competence to enable them to make more informed decisions in relation to the care of their residents. 2. Increased number of trained staff 3. Improved relationships between health and social care staff and nursing home staff/ 4. An established community of practice for Nursing homes which encourages learning from each other. 5. ECHO viewed as a suitable model for nursing home education: sustainable and accessible.	1. To improve safety, quality and standards within Nursing Homes, and thus reduce unnecessary unscheduled admissions to hospital and use of Trust services through provision of clinical advice and support	Survey data from the Reporting period was not available. This Network commenced in May 2019 and transitioned in March 2020 to a Covid-19 programme. At the point of their transition they had completed 7 sessions within their original programme. Survey data was completed by the Network in 2021, and has been included in this report due to its relevance and that it was the first data collected since the end of the reporting period. 60 responses were gathered, with 95% stating that the quality of sessions was high or very high, 90% stating that topics covered were relevant, 98% stating that they'd applied knowledge gained through the Network to their practice, and 92% stating that they've shared knowledge with other colleagues. 93% stated that participation had increased their knowledge of other service initiatives across the sector and 77% stated that case-based learning was an effective mechanism for learning and that they'd recommend ECHO to other colleagues. Results indicate progress towards achieving key objectives, however more targeted evaluation metrics to assess progress on key indicators would be beneficial.
Best Practice Governance	To identify what best practice in the HSC looks like	None	None	Evaluation data not available for Network. The Best Practice Governance Network was set up to provide a space for non-Executive Directors within the Belfast Trust to discuss and guide decisions on a range of challenges such as communication and consultation of services. Case study scenarios were presented in 5 different ECHO sessions, but due to challenges with recruitment the Network ceased to continue. Important learning may be taken from this network regarding on-boarding and initiation processes (further highlighted by themes discussed in the main Report).

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Child and Adolescent Mental Health Services (CAMHS)	To help build capacity across children services thereby ensuring safer and more effective interventions for children, young people and their families.	1. Knowledge transfer and the building of capacity across the steps of care in the Stepped Care Model and with key interface services.	1. Effective assessment of young people presenting with complex and high risk behaviour who may need and benefit from the input from an expert panel, thus avoid unnecessary escalation and ensuring more effective management at a local practitioner level.	A total of 18 participants responded to the final survey. Of those who responded 56% (10/18) attended 1-3 ECHO sessions, 33% (6/18) attended 4-6, and 11% (2/18) attended ≥7 sessions. 100% enjoyed participating and would participate in the future. 94% would recommend ECHO to colleagues. Participants cited shared learning and having the opportunity to hear about and discuss complex cases as particular benefits of the sessions. Outcomes of the Network are positive regarding participant enjoyment and engagement with the sessions. Short term goals such as successful knowledge transfer within the network were likely achieved through case presentations and discussion. In this regard, the Network likely has to some extent achieved its key objective of building capacity across children's services, of establishing wider clinical networks and expertise across the region, and in providing advice and support to general practitioners and local practitioners. There is little data on whether the network achieved the longer-term objectives it set out achieve regarding reduced referral and increased management at local practitioner level, or whether the network has supported the development of more standardised approaches to management across the region. It is recommended that more thorough evaluation in relation to knowledge gained through the network and application of that knowledge in practice should be the focus of future evaluation.
		2. Work towards standardisation of practice and more equitable levels of service.	2. Safer and more effective interventions for children young people and their families.	
Cardiology	To build capacity of GPs to manage more patients with Heart Failure within the community	1. Network established & curriculum of relevance to participants.	1. Improved quality of care for patients with HF in the community.	11 participants completed a survey; 91% responded that the network had improved knowledge (over 4 domains/questions); 88% that their confidence had improved (over 4 domains/questions); 77% that they were more likely to seek timely specialist advice and support (over 2 domains/questions); with 100% stating that they had applied knowledge gained from the network in everyday clinical practice (1 domain/question)
		2. Increase in knowledge of management of HF within SPC.		Results related to the key objectives and goals relating to clinical knowledge and capacity were positive, with strong self-reported improvements across multiple domains. Relationship development and the multidisciplinary nature of the network were cited as positives by participants. Further evaluation is needed to determine if increased knowledge and confidence has impacted positively on the quality of the care provided to patients, thus achieving the long-term goals of the network, Little data exists regarding whether patients were being managed in general practice, however survey results indicated participants felt more confident and more likely to seek timely advice.
		3. Increased confidence in management of patients with HF.		
		4. Increased GP contact with cardiologists and palliative care specialists for advice.		

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Dementia	To improve the diagnosis and management of patients with dementia	1. A network established with content that is relevant to participants. 2. Improved partnership working between primary care and secondary care. 3. Improved primary care confidence in managing patients with a diagnosis of dementia. 4. Improved primary care knowledge and confidence to diagnose dementia in non-complex presentations.	1. Improved service user experience. 2. Improved carer experience. 3. Reduced waiting time for assessment, diagnosis and follow on care.	A total of 21 participants responded to the survey. Results indicated that 7 'strongly agree' and 12 'agree' that participation had improved their clinical knowledge of dementia. 5 'strongly agree' and 12 'agree' that participation had developed their clinical skills. 6 'strongly agree' and 12 'agree' that participation had developed their confidence in managing patients with dementia. 81% said they had applied knowledge gained from the network and that their professional satisfaction had increased. Increased knowledge and sharing information and experiences were frequently cited as benefits of the network. This Network achieved goals of successful establishing a relevant Network for participants and progressing short term goals. Little data is available regarding progress towards long term objectives.
Dermatology	Increase confidence in clinical decision making	1. Improved GPs knowledge of dermatological conditions. 2. Improved confidence of GPs to manage dermatological complaints. 3. Enhanced communication between primary and secondary care. 4. To increase awareness of local services and referral procedures.	1. Reduced demand for secondary dermatological care and reduced waiting lists.	13 respondents completed the evaluation survey. 85% felt their knowledge had improved through participation in the network, and that their confidence in managing patients had also improved. 92% felt access to specialist expertise in dermatology benefited their clinical knowledge and practice. 92% applied knowledge gained form the network to other patients. 54% said they were more likely to seek timely specialist advice or input from a dermatology specialist (38% neither agree/disagree; 8% disagree). 46% felt participation helped reduce their referrals to secondary dermatology care (38% neither agree/disagree; 15% disagree). 77% stated participation improved their professional satisfaction; 1 participant (8%) stated strongly disagree). This Network demonstrates positive progress towards short term goals of improving knowledge, but limited impact on whether ECHO has contributed towards reduced demand and referral to secondary services.
Diabetes Belfast	To enhance knowledge of both diabetes and pre-diabetes management and support	1. Participants have increased knowledge in relation to the management of diabetes 2. Participants have increased confidence in relation to the management of diabetes 3. Participants have improved awareness of referral diabetes services available to General Practice and local procedures.	1. Delivery of improved care to patients with diabetes.	11 respondents. Participants stated level of confidence in managing diabetes increased from 3.00-4.09 weighted average prior/post participation in the network (5 point scale). Level of skills, knowledge or competence in managing diabetes increased from 4.18-5.18 (7 point scale). 100% felt their understanding of the local referral processes for diabetes and the services available had improved, and that content delivered through the network was relevant and would recommend to colleagues. This Network demonstrates consistent results, captured in a retrospective re/post survey that indicates success regarding achieving key objectives and goals.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Diabetes Western	To enhance the capacity of GPs, practice nurses and practice pharmacists to deliver diabetes care in the community	1. Participants have increased knowledge and confidence to manage patients with diabetes and have applied lessons learned to practice	1. Improved care provided to patients with diabetes	No survey data available as the Network was paused in March 2020 due to the COVID-19 pandemic and was not completed.
		2. Better and more informed communication within clinical teams and between team members and patients	2. Improved uptake of newer medication groups	
		3. Participants feel more supported and have feelings of reduced isolation		
		4. Increased membership in network compared to original pilot		
Ear, Nose & Throat (ENT)	To develop the capacity to effectively identify common ENT conditions, instigate treatment and manage these long term conditions within primary care, with appropriate specialist input when required	1. GPs have improved confidence with the clinical assessment, diagnosis and treatment of ENT symptoms and conditions through improved knowledge and support.	1. Improved patient experience and overall health through earlier intervention	9 respondents. 56% strongly agree and 44% agree that participation has improved their knowledge of symptoms. 56% strong agree, 33%, 11% naod that their confidence in treating common ENT symptoms had improved. 67% strongly agree and 33% agree said access to specialist experience had improved their skills and practice. 56% felt colleagues in secondary care were more approachable (44% neither agree/disagree). 100% felt ECHO provided them with access to information they otherwise would not have had access to. 78% felt more able to manage patients without referral, and that they understood referral pathways better. Results indicate positive outcomes regarding key objectives and goals of knowledge and confidence in managing patients without referral. Long term goals regarding cost and patient experience were not evaluated.
		2. GPs feel more able to manage patients without the need for a referral.	2. Reduced cost to the system by avoiding expensive secondary care referral where it is clinically appropriate to do so.	
		3. Improving communication between primary and secondary care to include improved awareness of referral criteria.		

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Frailty	To raise awareness of frailty and share knowledge, learning and best practice across a range of disciplines and sectors within Northern Ireland	1. Increased awareness of frailty amongst professionals involved in the network.	1. Increased awareness of frailty amongst the public	10 respondents completed the survey. 100% stated that the sessions were worthwhile and relevant. 20% experienced problems participating the sessions (time and technical problems). 50% have implemented learning from the sessions. 90% felt learning through ECHO was effective in increasing their knowledge (10% strongly disagreed); 70% learned from case presenters (20% neither agree/disagree, 10% strongly disagree). 80% would recommend ECHO to other colleagues (10% neither agree/disagree, 10% strongly disagree). 60% said participation enhanced their working understanding of best practice care in frailty (30% neither agree/ disagree; 10% strongly disagree). 80% said collaboration with other professionals had been beneficial. 60% said there had been no changes to policy, practice guidance, or processes within their work place from the sessions, indicating limited progress towards some long term goals. Shared learning and clinical discussion were cited as benefits of the sessions. Key objectives of raising awareness and learning were achieved by the Network.
		2. Sharing of knowledge, learning and best practice within ECHO sessions helps inform development of the frailty pathway in Northern Ireland.	2. Development of an end to end pathway for frail older people	
		3. A community of practice for frailty which encourages learning and collaboration across sectors is established.	3. Improved care and outcomes for patients who are identified as being frail, or who are assessed as being at risk of frailty	
		4. ECHO viewed as a suitable model to enhance skills and create a learning environment across a range of disciplines and sectors each with a key role in providing care for our more frail population		
Gastroenterology	Improve the delivery of education in the management and referral patterns of Gastroenterology patients	1. Improved GPs knowledge of gastroenterology conditions.	1. Better management of patients on waiting lists.	9 respondents to the survey. 66.67% and 33.33% respectively stating ‘strongly agree’ and ‘agree’ that the sessions had improved their clinical knowledge. 55.56% and 44.44% respectively stating ‘strong agree’ and ‘agree’ that sessions had improved confidence in managing gastroenterology patients. 100% of respondents had applied knowledge gained in the sessions strongly indicating progress towards key goals. 89% and 67% respectively felt their knowledge of appropriate referral processes had improved, and that they were more likely to seek timely specialist advice. This likely resulted in progress towards the key long term goal of better management of patients on waiting lists, however this was not explicitly evaluated. Participants noted improved clinical knowledge and knowledge of referral pathways in qualitative responses, with 100% responding that learning through Project ECHO is an effective way to enhance clinical knowledge and skills. 100% said they’d recommend ECHO to other colleagues and 100% stated they would like to attend future networks.
		2. Improved confidence of GPs to manage gastroenterology complaints.		
		3. GPs make better informed referrals to secondary care.		
		4. Enhance communication between primary and secondary care.		

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
General Surgery	To improve access to timely surgical procedures in general practice	1. Improved GP knowledge and confidence in management of general surgical conditions 2. Improved GP confidence and knowledge in when to refer patients, including red flags, to General Surgery	1. To improve overall patient heath by improving access to timely surgical procedures in general practice earlier, which helps improve the patients journey and may prevent an unnecessary referrals.	13 respondents. 92% felt that the sessions had improved their clinical knowledge; 80% felt participation in the network had improved their confidence in managing general surgical conditions. 92% felt they had increased confidence on when and how to refer patients and more confident to manage patients in primary care both pre- and post-operatively. 46% 'strongly agree' and 46% 'agree' that learning through ECHO is an effective way to enhance clinical knowledge and skills (1 participant, 8% 'strongly disagree' - no reasons given). 92% applied knowledge from the sessions and 100% felt that the network had improved relationships between primary and secondary care. These results indicate success in achieving short term goals, but little explicit evaluation was conducted regarding key objectives and long term goals of improving access to timely surgery, however participants did strongly indicate increased confidence in managing patients and in referral.
GP Support	None	1. GPs have more confidence in their ability to deal with difficult circumstances 2. GPs feel less isolated and more supported. 3. ECHO identified as an educational tool for new GPs/ interested (isolated GPs) who find it difficult to make teaching via traditional model.	1. GPs feel more supported and better able to cope with difficult situations.	16 respondents. 93.75% rated sessions as high quality or very high quality. 87.5% responded that the sessions had reduced professional isolation, and 81.25% said that they had enhanced their professional satisfaction, both indicating good progress towards both short term and long term goals. Positive qualitative feedback included that the sessions allowed networking, communication and experience-sharing; had high quality content; and included practical content and advice. All respondents would recommend ECHO to other GPs. Few negative comments were recorded, although a number of respondents mentioned challenges in making time and sessions being scheduled at inconvenient times.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Gynaecology	To enhance the gynaecology skills and knowledge of GPs	1. GPs have increased knowledge, confidence and skills to manage common gynaecological conditions. 2. GPs improved understanding of what can be achieved in primary care and what should be referred for secondary care. 3. Improved communication between primary and secondary care.	1. GPs have improved capacity to manage primary care gynaecological problems at a local level. 2. Patients receive a higher quality of gynaecological care.	18 participants completed the final survey. 89% either agreed or strongly agreed that their clinical knowledge had improved through participation in the network (5% neutral; 5% strongly disagreed). 94% felt more confident in treating gynaecological conditions. Results from both metrics indicate success regarding key objectives and short term objectives. 78% felt they better understood referral pathways (22% neutral), while 50% stated that their referrals to secondary care had reduced (33% neutral; 17% disagreed), indicating progress towards long term objectives of managing patients at primary care level. 39% of participants reported felt their secondary colleagues were more approachable as a result of participation in the network (56% neutral, 5% disagreed). 100% had applied learning from the sessions to clinical practice and 94% said the ECHO approach allowed them to access learning they otherwise would have been unable to access due to time and/or geography. No explicit evaluation was conducted regarding whether patients received higher quality of care, however other connected metrics indicates progress was likely achieved regarding this goal.
Health visitor support	Increase capacity of Health Visitors to manage patients on waiting lists for child development, ADHD and autism services	1. Health visitors have increased knowledge and confidence in the management of children with developmental, emotional, behavioural and social communication needs 2. Health visitors feel more supported in the management of children on waiting lists 3. Health visitors make more appropriate referrals to specialist services	1. Children have improved access to appropriate levels of care according to their needs	14 respondents completed the survey. 100% felt content was relevant with 86% stating quality of the session was either high quality or very high quality. 86% had applied knowledge gained through the network. 57% stated there had been no changes to policy, practice guidance, or processes within their work place because of the learning through this ECHO network, suggesting limited progress towards long term goals. Participants noted that their knowledge, confidence and understanding of other services in the area had increased, and that they enjoyed and had benefited from the shared-learning approach. Little data was collected on whether referral was improved and whether children had improved access to appropriate care.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Marie Curie	To improve the overall quality of patient care and the efficiency of training delivery to registered nurses	1. An established ECHO network with a curriculum of relevance to registered nursing staff. 2. Increased clinical knowledge of palliative care. 3. Increased confidence in managing patients at end of life. 4. Reduced feelings of isolation amongst staff.	1. Improvements in the quality of the service through improvements in patient care.	11 respondents. 64% 'strongly agree' and 27% 'agree' that participation in the ECHO network developed their clinical knowledge in palliative care; 55% 'agree' and 36% 'strongly agree' that it increased had confidence in dealing with end of life care scenarios; and 55% 'strongly agree' and 36% 'agree' that it helped improve the service provided to palliative care patients and their carers. 100% felt ECHO was an effective way to enhance clinical knowledge and skills and that they would apply learning from the network. 82% felt the network had helped diminish professional isolation and that the network had given them access to learning that would have otherwise been difficult to access due to geography. Participants highlighted the benefits of shared learning, network creation and sharing experiences. All metrics indicate success towards short term goals, and likely improvements to quality of service delivered, however further evaluation on long-term impact would be beneficial.
Musculoskeletal (MSK)	None	1. MSK network echo set up: good level of engagement with participants, and content of value to participants. 2. Increased confidence in managing MSK conditions in primary care.	1. Participants demonstrate engagement with MSK pathways. 2. Improved communication and relationships with SC and AHPs.	10 respondents. 90% felt their understanding of common MSK conditions in primary care has improved as a result of participation in MSK ECHO Network and that it has enhanced understanding between primary, secondary care and allied health professionals taking part. Participants cited increased confidence in diagnostics and in management. Evaluation approaches could be strengthened to provide clearer indications of the long term outcomes of the Network, however survey results indicate that short terms goals have been achieved.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Northern Ireland Social Care Council (NISCC)	To provide support to domiciliary care managers through sharing of knowledge and experience	1. ECHO identified as a suitable model of education and support for domiciliary care managers. 2. Improved engagement and connections between domiciliary care managers. 3. Domiciliary care managers feel better supported. 4. Clear definition of the remit domiciliary care/ support is established. 5. Shared understanding of what is best practice.	1. Improved leadership for domiciliary care managers. 2. Dissemination of knowledge gained to front line staff . 3. Improved experience for service users.	18 respondents. 61% stated that sessions were high quality and 39% very high quality. 94% said sessions were relevant and 67% they had been able to implement learning, indicated success in establishing a relevant Network. 50% agree, 33% strong agree (11% strongly disagree and 6% naod) that participation enhanced understanding of 'good practice' in domiciliary care. 89% would recommend ECHO to other colleagues (11% strong disagree). 67% responded that ECHO helped them feel more supported in their role (28% naod, 6% strongly disagree). 44% felt the network has helped facilitate the development of relationships between domiciliary care managers (33% naod, 11% disagree, 11% strongly disagree), indicating only limited progress in achieving short term goals of improving connections. 83% responded that there had been no changes to policy within their work place because of the learning through this ECHO network, suggesting areas for strengthening the Network. 56% said participation had influenced the strategic direction within their team. Long term goals regarding leadership were not explicitly evaluated, as were metrics regarding experience for service users.
Nurse Training Diabetes	To improve the care provided by practice and district nurses to patients with diabetes	1. Practice nurses and DNs increased confidence and knowledge in management of diabetes 2. Practice nurses and DN increased understanding of medical prescribing for patients with diabetes 3. Change in DNs self-reported referral pattern to speciality services 4. Improved communication between district nurses and primary care	None	4 respondents. 100% felt the felt format and organisation was good, would recommend ECHO to colleagues and would felt content was relevant. 100% felt understanding of the local referral processes for diabetes and the services available improved as a result of participation in this ECHO Network, however the degree to which this improved may have been better highlighted using the pre/post evaluation approach used for other metrics. Skills, knowledge and competence in managing diabetes increased from weighted average 4.25 prior to participation to 4.5 post participation. Confidence increased from 2.75 - 3 pre/post. Both metrics indicate some improvement, but the levels of increase are limited. Some feedback suggested content was pitched at the wrong level and further engagement in curriculum setting days may allow for a more appropriate curriculum to be designed. Communication was not evaluated, and should be an area for future focus.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Nurse Training Diabetes	To improve the care provided by practice and district nurses to patients with diabetes	1. Practice nurses and DNs increased confidence and knowledge in management of diabetes 2. Practice nurses and DN increased understanding of medical prescribing for patients with diabetes 3. Change in DNs self-reported referral pattern to speciality services 4. Improved communication between district nurses and primary care	None	4 respondents. 100% felt the felt format and organisation was good, would recommend ECHO to colleagues and would felt content was relevant. 100% felt understanding of the local referral processes for diabetes and the services available improved as a result of participation in this ECHO Network, however the degree to which this improved may have been better highlighted using the pre/post evaluation approach used for other metrics. Skills, knowledge and competence in managing diabetes increased from weighted average 4.25 prior to participation to 4.5 post participation. Confidence increased from 2.75 - 3 pre/post. Both metrics indicate some improvement, but the levels of increase are limited. Some feedback suggested content was pitched at the wrong level and further engagement in curriculum setting days may allow for a more appropriate curriculum to be designed. Communication was not evaluated, and should be an area for future focus.
Primary Care and Community Together (PACT) Community Pharmacy and Impact AgeWell Project (Yr1) / Surviving and Thriving (Yr2)	To support the education of the community pharmacy network; to support the resilience of the community pharmacy network through shared learning and collaborative problem solving	1. A network established with content that is relevant to participants. 2. Better experience for pharmacists including improved access to training and peer support. 3. Interest in joining network from other pharmacists across NI. 4. Participants accessed Moodle resources.	1. To make older people's lives better and empower a healthier older population. 2. Campaign (e-zine) to share positive news.	14 participants completed the survey. 93% enjoyed participating in the network and would recommend ECHO to other colleagues. 36% experienced some barriers to participation (time, internet speed etc.). Benefits cited included shared learning, opportunities to connect with colleagues and specialists and reduced barriers (e.g. travel) to participation, suggesting success towards achieving short term goals. Some participants reported that content was beyond their comfort-level/capacity. Some participants suggested a preference for evening meetings and suggested participation and membership of the network should be broadened. Evaluation was limited on key objectives regarding resilience.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Palliative Care Paediatrics	Improve collaboration around children approaching end of life	1. Participants have improved knowledge on how to manage complex symptoms. 2. Participants have increased confidence in managing complex symptoms. 3. Participants have a shared understanding of the disparities in care. 4. Participants feel more supported and less isolated. 5. Moodle is a useful resource for participants.	1. Standardisation of pathways across the region. 2. Equality of access to services. 3. To reach more families who are not in receipt of services.	16 respondents. 56% and 44% respectively rated sessions as very high quality or high quality. 94% said sessions were relevant to their practice. 88% said they'd applied knowledge gained from the sessions to the care of their patients (communication, end of life plans, information on blended diets and/or cannabinoids), suggesting success in achieving short term goals. 94% stated increased knowledge of service initiatives across other organisations, related to the key objective of improving collaboration, however this was not explicitly evaluated. 69% stated no changes to policy, practice guidance, or processes within their work place, indicating limited progress towards long term goals of standardisation. Further benefits cited included having space to reflect and learn, confidence in communication, and awareness of new approaches to care. Participants also highlighted reduced isolation and opportunities to network and build relationships. 88% wanted to continue with network. Connectivity problems cited as one reason for not wanting to continue. No evaluation was completed on progress towards long term goals regarding equality of access.
Palliative Care Pharmacy	Reduce pharmacist's anxieties around dealing with EOL care scenarios and patients	1. Improved knowledge in palliative care guidelines and palliative medicines/ treatments for pharmacists. 2. Improved confidence for pharmacists in communicating with patients/carers receiving palliative care. 3. Improved networking opportunities. 4. ECHO viewed as a useful model for community education.	1. Improved communication between pharmacist and patients/carers	12 respondents. 58% strongly agree and 33% agree that participation has improved their clinical knowledge and their confidence in dealing with end of life care, indicating success in achieving short term goals. 67% strongly agree and 33% agree that participation has improved the service they provide to end of life patients. 83% strongly agree and 17% agree that ECHO was an effective tool for enhancing clinical skills. 67% strongly agree and 17% agree that ECHO gave them access to information they otherwise would not have had. 100% stated they would use the learning gained from the network and would recommend ECHO to colleagues. Participants described being more knowledgeable and confident in their approach to care, and benefiting from networking and meeting and learning from colleagues indicating success in progressing towards long term goals.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Positive Behaviour Support	None	1. Evidence of change in: Knowledge, Skills, Confidence, Competence 2. Evidence of practice leaders emerging in PBS. 3. Networking and peer support for staff implementing PBS practice.	1. Improve quality of care provided for people with learning disability.	23 respondents. 96% felt content delivered through the network was relevant to their work. Knowledge in caring for people with behaviours of concern increased from weighted 3.50 - 4.30 prior/post participation in the network. Skills to care for people with behaviours of concern increased from 3.64 - 4.16 prior/post. Confidence increased from 3.56 - 4.10 prior/post. All metrics indicate success regarding short term goals. 61% had been able to implement learning gained from the network. 91% said there had been no changes to policy within their work place because of the learning through this ECHO network, and 61% said it had not influenced the strategic direction of their team. However, 87% stated that participation in the network met their original expectations. Participants reporting benefiting from the networks and relationships created, and from learning from shared experiences.
Practice based Pharmacy	To develop the knowledge and capacity of practice based pharmacists	1. PBPs have increased confidence in management of a wider range of clinical issues and ability to carry out a range of different tasks 2. PBPs have improved knowledge and capacity in relation to prescribing optimisation and discharge prescribing 3. PBs feel better supported 4. Improved working relationships between PBPs & GPs 5. Use of Moodle resources by PBPs as educational resource	1. GPs released to take on different and more complex care	18 respondents. 61% stated that sessions were high quality and 39% very high quality. 100% said content was relevant and 89% said they had been able to implement learning from the networks. 72% said there had been no changes to policy, practice guidance, or processes within their work place because of the learning through this ECHO network. 66% strong agree, 22% agree and 22% disagree that ECHO provided opportunities to access education that they otherwise would not have had. 50% strongly agree, 33% agree and 17% naod that participation improved their knowledge. 56% strongly agree, 33% agree, 6% naod and 6% disagree that their confidence in managing a wider range of clinical issues had improved, demonstrating success in achieving short term goals and key objectives identified by the Network. 44% strong agree, 44% agree, 6% naod and 6% disagree that they felt more supporting in their roles. Participation was restricted due to time and other commitments. No data was collected to allow assessment of progress towards long term goals.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Quality Improvement	Enhance district's nurses knowledge of QI methodology	1. District nurses will have improved knowledge of QI methodology 2. District nurses will feel more confident in initiation/ management of QI projects 3. District nurses will feel more supported	1. Improve patient care	8 respondents to the survey answered retrospective pre/post questions related to 9 measures on Knowledge and Skills, and 9 measures related to confidence. On measures related to Knowledge and Skills there was an increase from 2.88 to 4.74 representing a +1.86 increase on a 7 point scale; while on measures related to Confidence there was an increase from 1.94 to 3.49 representing a +1.55 increase on 5 point scale. Measures included knowledge/skills/confidence on developing and setting aims for QI work; competence in relation to diagnostic tools (process mapping, fishbone etc.); competence in relation use of driver diagrams; in developing measures for QI work; and Communication among others. These results strongly suggest the benefit in achieving both key objectives and short term goals set by the Network. Whether these benefits have extended to patient care has not been assessed or evaluated.
Safeguarding	To standardise practice and responses to neglect across the network	1. Increased communication between participants across multiple agencies with regards neglect 2. Increased understanding of the roles and responsibilities of professionals across multiple agencies 3. Increased understanding of the latest guidelines and resources in relation to neglect. 4. Increased working knowledge of the neglect strategy 5. Knowledge transfer: participants share new learning with colleagues 6. Participants feel more supported and have increased confidence in making difficult decisions, including decision to refer to social services 7. Case based learning identified as a suitable model of provision of education	1. To standardise practice and responses to neglect across the network and create a trauma informed workforce 2. A community of practice which advocates for service improvement 3. To improve outcomes for children and young people by ensuring prevention, early recognition and improving agency responses to children, young people and families affected or potentially affected by neglect	69% (9/13) felt their levels of knowledge regarding neglect had improved through participation in the network. 46% (6/13) felt better supported because of the network. 85% found the sessions relevant to their practice, 46% said they'd share learning with other team members, and 62% had implemented learning gained from ECHO in their practice. These results suggest a moderate success in achieving short term goals. 100% said they'd recommend ECHO as an online learning tool and that case-based learning and presentations were an effective way of learning. No data, however, was collected on most of the objectives set by the Network, e.g. standardising practice; creating a community of practice, representing areas for future focus and evaluation.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
South Eastern Nursing Homes	To enhance the knowledge, confidence and competence of those managing Palliative and End of Life Care within the nursing home setting	1. Nursing home staff have increased knowledge, confidence and competence to enable them to make more informed decisions in relation to the care of their residents. 2. Hub members have increased understanding of the learning needs of nursing home staff 3. An established community of practice for Nursing homes in the Southern trust area which encourages learning from each other. 4. ECHO viewed as a suitable model for nursing home education: sustainable and accessible.	1. To improve safety, quality and standards within Nursing Homes, and thus reduce unnecessary unscheduled admissions to hospital and use of Trust services through provision of clinical advice and support.	Survey data from the Reporting period was not available however data collected in 2021 was included within this report as the most recent and relevant data related to activities occurring within the reporting period. 13 participants responded to the survey. All respondents to the survey had participated in 7 or more ECHO sessions. Responses were universally with positive with all respondents responding either strongly agree or agree to metrics on the impact of ECHO related to the ECHO approach and methodology; its impact on improving knowledge; and its impact on improving support and satisfaction. Further benefits were qualitatively described related to improving patient care in the community and developing greater understanding of the needs of palliative care patients. 70% described changes to policy or practice concerning safeguarding and care planning. Progress was reported related to key objectives and long term objectives, but specific evaluation questions on e.g. safety, community of practice, may enable more thorough evaluation.
South Eastern Palliative Care	Improved patient care and staff support	1. Increased knowledge of community nurses in relation to management of complex conditions 2. Increased confidence of community nurses in relation to management and decision making around complex conditions 3. ECHO identified as suitable model for delivering education – to include moodle as a resource.	1. Increased capacity of community nurses to safely manage patients with complex conditions in the community. 2. Help prevent unnecessary admissions to hospital.	37.5% (3/8) of the 8 respondents to the survey 'strongly agreed' and 62.5% (5/8) 'agreed' that participation in this ECHO network developed their clinical knowledge in palliative care. 62.5% (5/8) of respondents indicated they were 'strongly likely' and 37.5% (3/8) indicated they were 'likely' to use the new information they learned in their ECHO network within the next 3 months. 25% (2/8) of respondents 'strongly agreed' and 75% (6/8) 'agreed' that participation in this ECHO network increased their confidence in dealing with end of life care scenarios. 37.5% (3/8) of respondents 'strongly agreed' and 62.5% (5/8) 'agreed' that participation in this ECHO network helped improve the service they provide to palliative care patients and their carers. These positive responses suggest success in achieving short term goals. Further research and monitoring of progress towards long term goals and reducing hospital admissions would be useful.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
South Western Acute Hospital (SWAH)	To create a regular virtual meeting place to share key learning, provide support to isolated practitioners and improve communication and understanding between primary and secondary care	1. Participants have improved understanding of the services within the hospital 2. Participants have improved understanding of referral and discharge processes 3. Primary care staff report improved relationships with hospital care staff 4. ECHO identified as suitable model for education for rural staff and as a means for bringing primary care staff and secondary care staff together to learn 5. Participants use ECHO sessions in CPD portfolio 6. Isolated participants feel more supported in their role	1. Build a community of practice – Through sharing real life examples it is hoped the community of practice will form and recognise the need for collaboration	31 participants responded to the survey, 100% said content was relevant and sessions were enjoyable. 23% noted challenges to participating in the sessions (mainly related to time commitments). 83.87% had applied knowledge from the networks. Weighted average of 4.48 for feeling more supported in their role, and 4.45 for enhancing relationships between primary and secondary care. 42% reported changes to policy, practice guidance, or processes within their work place because of the learning through this ECHO network, suggesting areas for future strengthening particularly related to referral and/or discharge processes set out in short term goals. Data strongly suggests that this network achieved its goals of reducing isolation of practitioners and improving relationships and building a community of practice.
Western Nursing Homes	To enhance the knowledge, confidence and competence of those managing Palliative and End of Life Care within the nursing home setting	1. Nursing home staff have increased knowledge, confidence and competence to enable them to better manage people with Palliative and End of Life needs. 2. Nursing home staff feel more supported to manage people with Palliative and End of Life needs. 3. A community of practice for Nursing homes which encourages learning from Specialist Palliative Care services and each other is established. 4. ECHO viewed as a suitable model for nursing home education: sustainable and easily accessible	1. A reduction in unnecessary hospital admissions for residents of Nursing Homes, especially those nearing End of Life, through improved education and support	10 respondents completed a survey. 40% 'strong agree' and 50% 'agree' that participation has improved their knowledge, while 50% 'strongly agree' and 40% 'agree' that participation has improved the care they provide to patients. 70% felt more supported in their roles (30% neither agree/ disagree)/ 100% would recommend ECHO to other colleagues and said it had impacted on their daily practice. Only 30% had accessed resources through Moodle and 40% experienced technical difficulties (e.g. sound quality). 90% rated their ECHO experience as good or excellent, and 10% as fair. 100% would participate in future sessions. These results suggest success in achieving short term goals such as improving knowledge, however there is little data on the impact or progress of the network in achieving long term goals of reducing unnecessary hospital admissions.

Appendix 2: Evaluation Results and Assessment of each ECHO Network (excluding Case Studies presented in main Report)

Network	Key Objective	Short Term Goals	Long Term Goals	Evaluation Results and Assessment
Western Optometry	To optimise the value and input of Primary Care Optometry in the care provision for patients across all eyecare pathways through improved knowledge and confidence and a reduction in professional isolation.	1. Enjoyable, relevant and valuable interaction at each ECHO session with 50-60 participants.	1. Improved knowledge about the wider HSC system, transformation and the integration of Ophthalmic services within the HSC system, including scoping of opportunities to innovate and transform care.	44 respondent to the surveys. 68% of respondents 'strongly agreed' and 27% 'agreed' that participation in this ECHO network improved their clinical knowledge in ophthalmic assessment and clinical decision-making. With regards the application of this new knowledge, 55% 'strongly agreed' and 41% 'agreed' that they applied knowledge learned through the ECHO sessions. 56% 'strongly agreed' and 43% 'agreed' that their confidence in assessing and managing a range of ophthalmic conditions improved as a result of participation in this ECHO Network. 43% 'strongly agreed' and 36% 'agreed' that they feel more connected to their Optometry peers within the ECHO network. Across all these metrics, success was therefore evident and shows progress towards key objectives and goals. 93% of respondents agreed that the topics covered with the ECHO sessions were useful to their clinical practice. 100% would like to continue to be involved in this ECHO network and 100% would recommend participation in this network to other community optometrists. Data was not collected on longer terms goals related to service transformation and reducing waiting lists, representing areas for future focus.
		2. Strengthened relationships and improved communication between Optometrists in primary care and with secondary care Ophthalmology.	2. Formation of foundations on which opportunities can be developed and built through the network and Community of Practice – reduce waiting lists and demand, increase capacity.	
		3. Quality Improvement in eye care provision – better informed clinical decision making, management and in referrals.		

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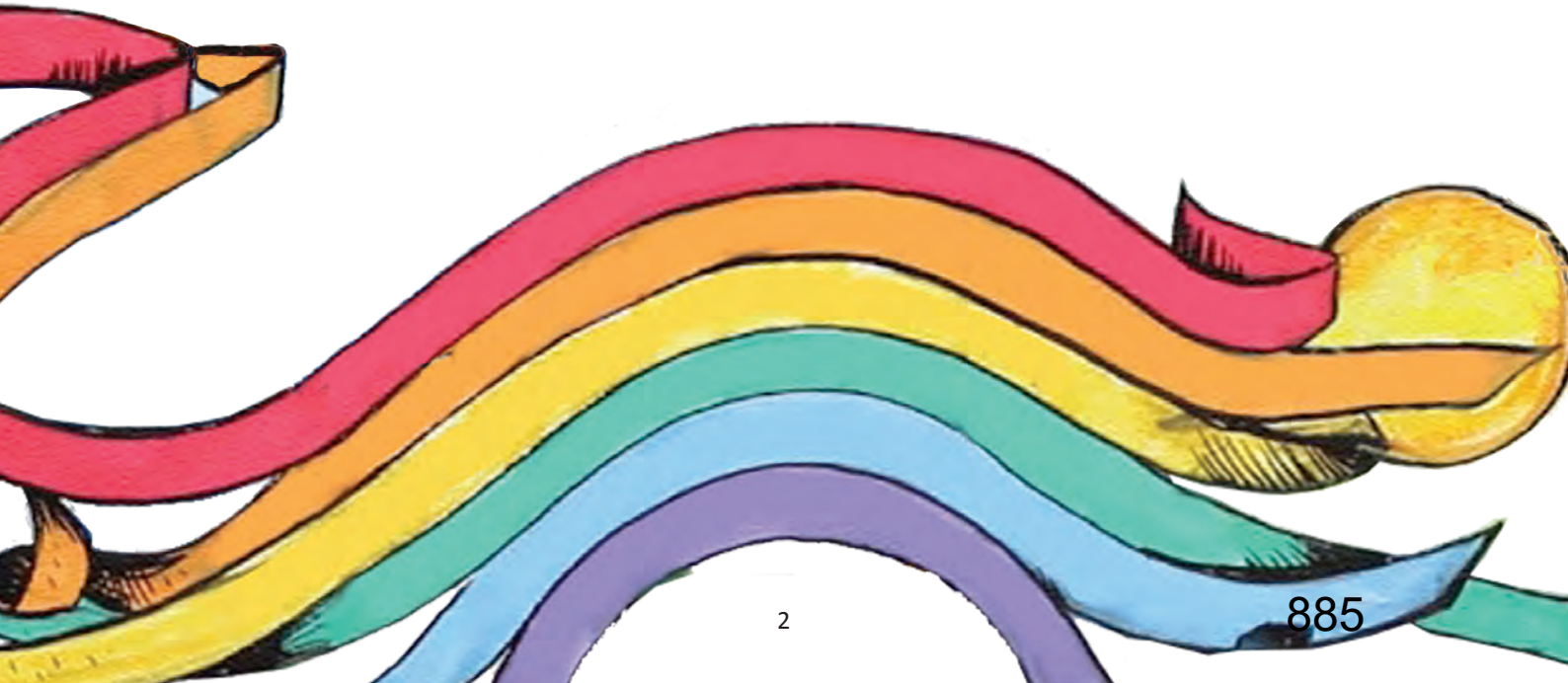

Creating Caring Cultures: Getting Started

Second edition

Authors
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For further information, please contact admin@fons.org

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Acknowledgements
We would like to offer our thanks to the nurse-led teams we have worked with over the past 15 years as part of our programmes of support and development. The learning from this work has contributed greatly to the development of this booklet and the associated animation and web-based resources.

We are grateful to the Department of Health for supporting the production of all the resources and to Creative Connections for working with us to create the animation and the images used in this booklet. Our thanks also go to all the FoNS Friends and Associates who provided feedback during the development of the animation and resources.

Finally, as members of the International Practice Development Collaborative, we acknowledge its role in contributing to greater understanding regarding practice development, workplace culture and facilitation.

Production: Jonathan Lalljee **Printers:** Kingsmead

Contents

Note on terminology:
When we use the term 'patient' in this resource, we include service users and residents.
When we use the term 'staff', we are referring to anyone who is involved in providing care and/or services.

Authors' foreword to the second edition

Since the first Creating Caring Cultures booklet was published in spring 2015, its popularity has required us to do several more print runs. As we move into 2019 with supplies again running low, we decided it was time to revisit and review. And so here we are with the second edition. Perhaps not surprisingly, we found very little needed to be changed as it still feels as relevant now as it was when first published.

Our continued work with team leaders in health and social care shows us that, while many acknowledge the need for culture change, knowing where to start is still difficult. Although we hear person-centredness spoken about more, this is often not something experienced in reality, by staff or those using services. And as demand on services continues to increase, we recognise more than ever the need to focus on staff wellbeing for its own sake, to create cultures within teams and workplaces where staff feel valued, respected and engaged.

If you haven't yet read the booklet, watched the associated animation, or explored the freely accessible online resources, we would like to share with you the words of some who have, from across the world:

'It was so helpful! It grasps all the essentials together – from what workplace culture is, up to celebration and the purpose of the facilitator. The resources on your website were helpful in more than one way and I am so glad that I came across them.'

'The animation and resources are great. I used them as part of a workshop I was delivering to a group of ward sisters to facilitate reflection and discussion about what culture is, what we can all do to look at our culture, begin to improve our culture, the impact of poor culture, etc… Having access to the resources certainly enabled me as a facilitator.'

'It's been my handbook this last year, easy to dip into.'

'Gives great tips of how to encourage #CaringCultures and #PersonCentredness.'

'I think the animation is especially useful in helping people understand why values matter… always great feedback from the participants. I also use the resources to support new facilitators to understand their role and identify strengths… The resources are very helpful, not too wordy and as handouts they are attractive and well received.'

Introduction

The Creating Caring Cultures resources are based around a model in the form of a rainbow because like rainbows, it is difficult to see/find the beginning or end of culture change. The model has been developed using our experiences over a number of years of working with health and social care teams and our theoretical understandings of practice development[1] as an approach to enabling change and transformation, towards the development of person-centred practice and cultures.[2]

The rainbow model is created using six colours, each representing a different intention or focus, to:

- Explore values and beliefs and agree a shared purpose
- Look at what is happening in practice and identify gaps between what we say and what we do
- Develop action plans through shared decision making
- Enable team working and staff wellbeing
- Commit to learning in and from practice
- Celebrate success and continue momentum

The seventh colour represents the fact that culture change is a continuous process that needs to be facilitated, preferably by clinical leaders, with the support of others within the organisation.

While we suggest that you ideally start by exploring values and beliefs, the model is not intended to be prescriptive or linear. It may be more appropriate to first spend time talking to staff, understanding their experiences, helping to promote engagement and to enhance their wellbeing. The model is intended as a guide and each team will find its own way of using it.

In the next section, we will talk more about culture and then in the following sections, we will explain the elements of the model in more detail and how you might use it to get started.

PEOPLE MAKE CULTURE

What is culture?

What exactly do we mean by culture?

Put simply, culture is 'how things are done around here'[3] – the patterns, habits and routines of practice. Each one of us makes up the culture and so whatever our role, it's important for everyone to know that as individuals our ideas and actions can change things.

Why do we need culture change?

One of the most significant influences on the quality of care is workplace culture.[4] This has been highlighted by several reports into significant failures in health and social care, which have identified the need for change.[5-8]

Although it is often organisational culture that is spoken about, organisations are made up of many smaller cultures, for example within departments and teams and at ward and unit levels (workplaces). It is these cultures that have the greatest influence on the experience of patients, families and staff.[4]

A caring culture makes things better for everyone. Patients, service users, residents and their families and carers experience good care. Staff feel valued and supported, which helps them to provide the care patients want with compassion and confidence.

How do you know if your culture needs to improve?

The complex nature of health and social care means that wherever you work, there will be aspects of care that can be improved, even if there are no specific concerns. As patients' needs change, services reconfigure or staff join, it is valuable to reflect continuously on practice to ensure the care being delivered is safe, effective and person-centred.

You could also look at audits, dashboards, the Friends and Family Test, staff and patient surveys, compliments and complaints and exit interviews, or use tools such as the 15 Step Challenge[9] and the 'Culture of Care' Barometer.[10] All of this will help you to develop a better understanding of your workplace culture, by identifying:

- What is working well and how you could make this happen more often
- What needs to be improved and where you might need support

Here are some questions that may help you to begin to think about the culture in your workplace:

- What do patients and relatives say about their experiences of care?
- What do staff say about what it is like to work here?
- What do students say about their experiences of learning in your workplace?
- What aspects of care (if any) do you think need to be improved?
- What concerns (if any) do you have about patient safety – falls, pressure ulcers?
- What gaps are there between what people say they do and what actually happens in practice?
- What are the recruitment, retention and sickness rates like?
- How open are staff to change?

Facilitating culture change

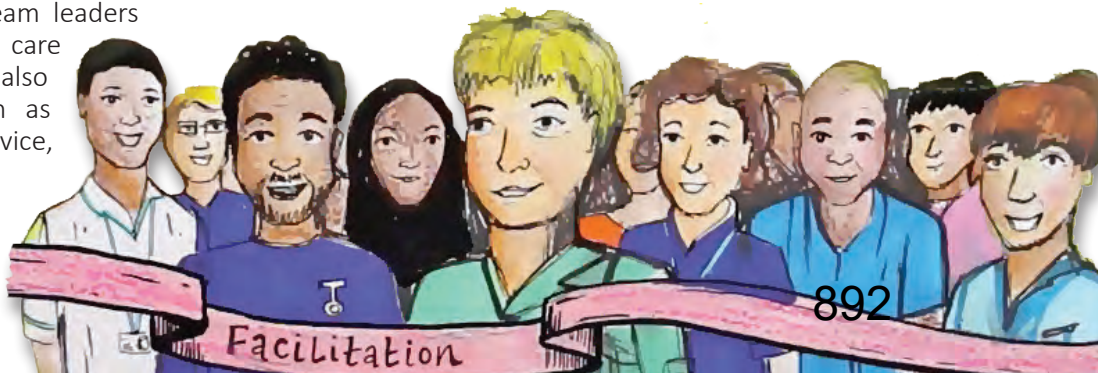
MAHI - STM - 308 - 891

Although culture change is not quick and easy, a planned approach helps and it is important that there is someone to guide the process- someone who is enthusiastic, persistent and willing to listen. Maybe this is you.

Because culture is about people, it is important that you work with people, not on your own. If you work alone, you are more likely to take a directive role and to work in a task-focused way, often ending up doing things for staff. However, by adopting an approach that involves using more coaching or facilitation skills, your focus will be on helping staff to become more involved, enabling them to take action and responsibility for improving practice. This may feel harder and more time consuming at first, but we know that skilled facilitation and transformational leadership help to create more effective workplace cultures.[4]

It is therefore useful to think about the people that are affected by the culture and/or can affect the culture. For example, patients, service users, residents, families, carers, staff (nursing, medical, therapy, pharmacy, ancillary and so on) and managers. Ideally all of these people should be involved, however you may find it easier to begin by working with a small team of interested staff.

There are also other people that can help you. Perhaps there is a practice development team in your organisation or a learning and development department. Your patient experience lead, quality improvement team or research and development department may also be able to offer advice and support. Alternatively, you could start to work with other ward managers or team leaders or make contact with other care home managers. There are also external organisations such as FoNS, that could offer you advice, help and support.



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Enabling team working and staff wellbeing

There are strong links between staff engagement (such as staff feeling connected with each other and the organisation) and patient outcomes, and staff wellbeing and motivation and patient experience.[11-15] Staff wellbeing is not only important in its own right, but also because it is an antecedent to good patient care.[13]

Leadership plays a vital role in staff engagement and wellbeing. 'If leaders and managers 'want staff to treat patients with respect, care and compassion, all leaders and staff must treat their colleagues with respect, care and compassion'.[15]

It is therefore important to prioritise staff engagement and wellbeing if you want to create a caring culture. Increased staff engagement can be achieved by nurturing positive staff relationships[12], and through developing well-structured teams that have 'clear shared objectives, work interdependently and meet regularly to discuss effectiveness'.[14] Supportive line management is crucial to the leadership of such teams.[14]

A great place to start creating a positive environment is by talking to staff – asking them 'what is it like to work here, what's good, what could be different?' Don't assume that you already know – ask them and really listen. When staff feel listened to and valued, they feel happier at work and we know that if staff are happy then patients are happier too.

You could use existing opportunities to get staff together – team meetings, handovers, huddles during the shift? Or could you be courageous and create new ones – extended coffee breaks, away days, conversation circles? Just do it!

Leaders can create positive and supportive environments by:

- Understanding the staff experience – asking them what it is like to work here
- Acting on staff feedback – helping with ideas for making improvements
- Supporting staff development through well-structured appraisals, mentorship, clinical supervision and ongoing learning and education opportunities
- Developing well-defined teams that:
  – have shared goals
  – are clear about their roles and responsibilities
- Creating space for staff to:
  – get to know each other as people
  – reflect on goals, effectiveness, team working, patient care challenges and innovations

Exploring values and beliefs to create a shared purpose

Why are values and beliefs important?

'How things are done around here' (our behaviour) is influenced by our values, beliefs and attitudes. This is often taken for granted, not challenged or spoken about.

Talking to the people who receive care (patients, service users, residents, families and carers) and the people that give care (nurses, multidisciplinary team, ancillary staff, managers, and others) about what they see as important (values) and what they feel should happen (beliefs) is therefore an important first step in the process of culture change – helping everyone to think about how they would like care to look and about how to transform the way things are done to achieve this.[16]

This information – about what matters to people – can be used to create a shared purpose.

What is a shared purpose and who should be involved?

A shared purpose sets the direction, aims and objectives or goals, helping you and your team to identify what you want to move towards. A shared purpose should represent the values and beliefs held by the people you care for and those you work with. The more people involved in creating it, the stronger it will be. While acknowledging differences, it should be able to:

- Help people to see what connects them – shared ground and common interests, such as everyone agreeing mealtimes are an important part of the day – rather than the differences – between patients and staff, or different job roles, for example
- Create a personal connection to the change or transformation you are trying to achieve

How do you do this?

The starting point is getting to know the values and beliefs that people hold about the aspect of care or work that you want to focus on, for example, being caring and compassionate, person-centred care, team work, pain management and so on.

First, start with yourself – what is important to you and what do you think should happen – what really matters?

Then, invite others to think about their values and beliefs and share them. Perhaps you could use some time in a scheduled meeting and use picture cards to prompt discussion; or maybe you have team days or could allocate some time during education or training. Alternatively you could put up some posters in the office and encourage people to contribute.

Once the values and beliefs have been collected, they can be used to create a shared purpose – providing a focus and energy for any changes or transformations in practice. This is done by finding common values and beliefs, turning these into statements and using these statements to create a shared purpose. At every stage, information should be shared and feedback encouraged.

Looking at what is happening in practice and identifying gaps between what we say and what we do

How do I use the shared purpose?

The shared purpose can be used to reflect on or evaluate your current practice – helping you to look at what is happening in practice to identify gaps between what you and your team say and what you do. In effective workplace cultures, the values and beliefs that people hold and talk about are reflected in their behaviour and put into action every day.[4] That is, what people say is what they do. For example, if a nursing team agree that it is important to know 'patients as people':

- You should see staff spending time with patients – asking them about what matters and what is important
- You should hear staff talking about patients as people, not bed numbers or diseases
- Documentation should reflect patient preferences and involvement in decision making

A shared purpose offers a baseline against which to evaluate your practices and cultures, helping you to think about and identify:

- What you are doing well and could build upon
- What you might need to create, develop, change or improve to achieve your purpose

How do I do this?

Describing and measuring where you are starting from helps you to identify what you need to change or develop:

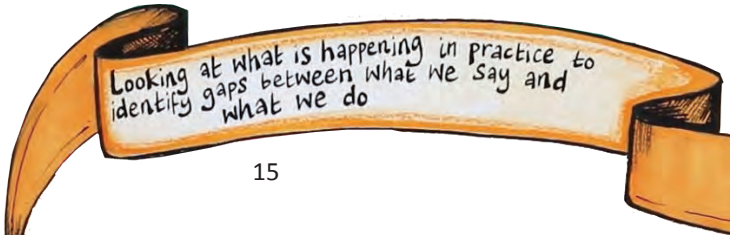
- In yourself
- In your team
- In your workplace setting

In most organisations, there is already a lot of activity to 'measure' aspects of care and practice, often using audit tools. While this information is useful, it tends to focus on 'what' has or hasn't been done/happened rather than the 'why' or 'how'. For example, a safety cross for pressure ulcers or falls, identifies how many people have acquired a pressure ulcer or fallen, but it does not highlight what is being done well to prevent pressure ulcers, or the circumstances under which people are falling – missing an opportunity to learn in a way that can inform future practice.

Additionally, this activity is often done by only a few people, for example senior members of the team or staff from other departments, who take the data away and interpret it for the team. This can make the activity and information that it provides less meaningful to those that it primarily relates to.

To enable the transformation of cultures and practices it is essential to involve all staff in evaluating practice against your shared purpose. You can do this by looking at what is happening and how things are done through: observing practice – thinking about what you see, hear and feel; listening to the experience of patients and staff- asking what has been done well and what could be improved; and collecting stories using emotional touchpoints.[17] You can then discuss what you find, helping staff to:

- Gain new insights
- Deepen understanding
- Identify actions



Developing action plans through shared decision making

Shared decision-making involves frontline staff in decisions about their practice.[17] They are experts in their area and so are well placed to identify solutions to clinical problems and to implement meaningful changes for patients.

Information that is collected about practice should be shared with staff as soon as possible (audits, compliments, complaints, observations, stories and so on), helping them to think about:

- How does current practice relate to the shared purpose?
- What is good/working well and how could this happen more often?
- What are the areas for improvement and ideas for taking action?

Approaches such as a SWOT analysis (to identify strengths, weaknesses, opportunities and threats) or claims, concerns and issues[19] (to identify positives, concerns and questions) can aid the planning process by identifying potential barriers but also people and resources that may offer help and support. It can also help you to think about how your plans fit the strategic goals of your organisation to encourage support and recognition from your senior team.

Creating an action plan

Action planning is a process that will then help you to identify clear objectives and the steps needed to achieve them, considering who should be involved, the resources you will need and the timescale that you should be working towards. When creating action plans, a useful approach is to ask yourself if your objectives are SMART. In other words, are they:

- Specific
- Measurable
- Achievable and Action-orientated
- Relevant and Realistic
- Time-based

Committing to learning in and from practice

Culture change requires a change in the way things are done – transformations in people and their practice. Learning is crucial to this transformation and the development of caring cultures because it helps us to develop a deeper understanding about ourselves and our practice and we can use this to plan actions.[20]

There are a variety of opportunities to access training and education within health and social care; however many of these are pre-planned by others and often focus on the development of knowledge and skills. It is also not unusual for them to take place away from the workplace.

While these opportunities are essential for the development of competencies, the nature of these approaches may mean that the learning tends to be more general and not specific to the context within which staff are working. This can make it more difficult for staff to translate what they have learnt into their everyday practice – thereby reducing the impact on culture change.

What is not so often recognised is that the clinical area itself makes a great classroom because learning can be facilitated using opportunities arising from everyday practice.[20] This can make the learning more specific to individuals and teams, and to the context within which they are working – perhaps helping people to connect emotionally with the learning, to become more fully engaged and take responsibility for identifying their own actions.

There may already be formal systems in place to facilitate learning in and from practice, for example clinical supervision, preceptorship and mentoring. These can be strengthened and built upon in a number of ways - you can use the shared purpose as a focus. For example, by:

- Involving staff in the collection and analysis of audit data
- Involving staff in observing practice, for example, observing mealtimes or the way people speak about each other. It might be helpful to ask people to use their senses: What do you see, hear, smell, feel?
- Asking staff to listen to patient's experiences of care using:
  – Short questions, such as: What did we do well? What would you like us to do more of?
  – Emotional touchpoints
- Encouraging staff to use reflective models

Staff should then be supported to reflect individually on what they have seen or heard and to share with their team to gain other perspectives, celebrate success and to identify actions.

Celebrating success and continuing momentum

Why should we celebrate success?

Celebrating success is one of the simplest ways to keep teams engaged and motivated. Staff who feel appreciated are more likely to work effectively. We've all heard the term 'success breeds success'; teams that focus on and celebrate success create more success, making it part of the culture. Staff want to work in this type of team.

Celebrating success is also a good way of remembering a shared purpose, helping teams to unify around agreed objectives/goals. It can reinvigorate energy levels and help to continue momentum. Leaders have a key role. They can facilitate staff engagement and wellbeing by having conversations that focus on the positives, strengths and accomplishments. By role modelling praise and recognition in meaningful ways, they can encourage peers to acknowledge each other; peer-to-peer praise can create a thriving and innovative workplace.

What should you celebrate?

The most important thing is getting started. If you wait to celebrate something that you think is really significant, it may be a long time coming and opportunities and momentum could be lost.

You could start by recognising people. Think about what is important to you and start to notice it. Giving feedback that is well prepared, motivating and developmental is an effective way of celebrating success. It must feel genuine to the person receiving it, and so should be specific and sincere, for example: 'I saw you communicating effectively with Mr Brown during his discharge planning. You listened actively and showed kindness and compassion'. You could do this face-to-face or by sending a thank-you card or an email. Compliments from patients should always be noticed and shared with individual staff and at handovers or team meetings. If staff are named personally, copies of thank you cards can be created for them.

Work with your team to identify small targets – these could be related to your action plans. When these are reached, small celebrations could be planned. For example, create a poster for display in the staff room, which identifies the people involved, and what they have achieved. You could celebrate with cake or a fruit basket, and invite your communications department to write a short article about what has been achieved for inclusion in newsletters. Involve the staff in identifying how they would like to celebrate – they may come up with some new and interesting ideas!

We know that in caring cultures, patients experience safe and effective care and staff feel valued and engaged. We can achieve this by working together, talking, listening and taking action, helping us to provide care that is the best it can possibly be. If you would like further help and support, we encourage you to access our short animation and online resources, at **fons.org/learning-zone/culture-change-resources**

Wherever you are working in health and social care, we hope this has inspired you to get started today.

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Workplace Training Solutions

Proposal

CRISIS PREVENTION INSTITUTE™

906

Company Overview

MAHI - STM - 308 - 906

- Established in 1980
- Over 17,000 customer organizations worldwide
- 38,000 work-based Certified Instructors worldwide
- 15 million trained participants worldwide

Customers

- Healthcare (including Mental Health) 20%
- Social Care (including Learning Disability) 47%
- Education (Mainstream and SEN) 20%
- Other
  (including Dentistry, Housing Associations etc) 13%

907

Programmes: Sector and Topic Specific

MAHI - STM - 308 - 907

- Management of Actual and Potential Aggression (MAPA)
  - *Health & Social Care*
  - *Education*
- Clinical Holding
- Prevention First
- Prepare Training
- Dementia Capable Care
- *Consultancy*

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Flexibility: Training Delivery Options

Online

Blended

Face to Face

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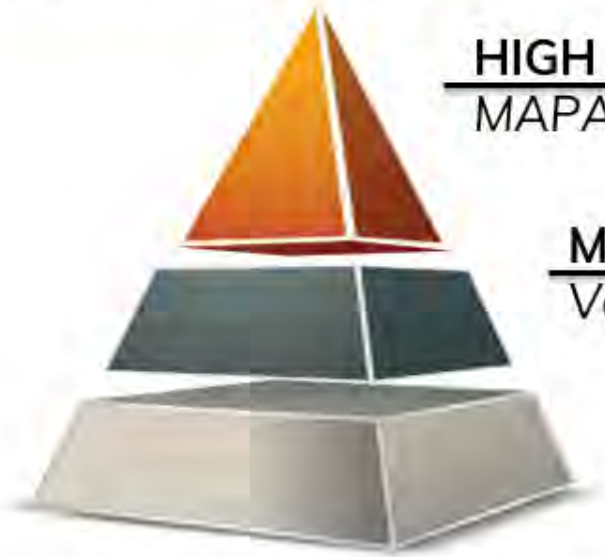
Programmes: Risk-Based Approach



HIGH RISK
MAPA Advanced Course

MODERATE RISK
Verbal Interventions & MAPA Foundation

LOW RISK
Prevention First

- Driven by Training Needs Analysis.
- Organisational authorisation and approval.
- Prevention compulsory.
- Safety interventions (Non-restrictive and Restrictive) optional.

Training – Stage 1 MAHI - STM - 308 - 910

Prevention First Training

- All 1st Year Nursing Students approx. 3,000
- Academic Year 20/21
- 100% Online Training
- Awareness of Workplace Violence
- Identify Potential Crisis Situations
- How to Address the Crisis Situation
- Interactive
- Case Studies – Hospital Based

911

Training - Stage 2 MAHI - STM - 308 - 911

MAPA - Blended

- Year 3 Students – Mental Health & Learning Disabilities
- Approx 200 Students
- 100% Online
- Approx 2 hours
- Teaches the Fundamentals of MAPA
  - Identify Challenging Behaviour
  - Assess The Level of Risk
  - Identify the Impact of the Crisis Event
- Physical Skills – CEC/Trusts

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Training Stage 3

MAHI - STM - 308 - 912

MAPA Instructors

- Group Of Instructors to be Trained
- Based at CEC & Universities ? Trusts
- Foundation & Advanced Level
  - 16 Foundation Instructors (8 per course)
  - Advanced Instructors

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Outline Costs

MAHI - STM - 308 - 913

Undergraduate Students -		
All 1st Year Students Intake (approx. 3000)	• All student nurses to complete Prevention First Training	£7.50 per seat x 3000 = £22,500
3rd Year Students (180-200) aiming to work in MH & LD	• MAPA Blended (existing version) – 2 hours	£14.00 per seat x 200 = £2,800
Total		£25,300 (24 months) - £9,570 Annually

Post Graduate Programme – Building Capacity Across University's, CEC and HSC Trusts		
Foundation MAPA Instructors	• 2 groups of 8 staff members to attend the Foundation MAPA Instructor course. This can be delivered face to face or we can deliver via the blended route	£1,755 per person x 16 = £28,800 Annual Renewal Cost:- 16 X £500 =£8,000
Advanced MAPA Instructors	• Unsure of your numbers but should your MAPA Foundation Instructors wish to progress and complete the Advanced certification we can deliver via 5 days Face to Face training	£2,407 X 5 People £= £12,035 Annual Renewal Cost:- £1,200 X 5 =£6,000
Total		£40,835 / £14,000

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Next Steps....

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1. MAPA Revised Curriculum –March 21 – *Trauma Informed – Human Rights. 'Safety First Programme'*
2. Secure Agreement on Model Programme Board. (April 21)
3. Establishment MAPA Partnership Implementation Team. (May 21)
4. Develop services level agreements for undergraduate programmes. (June 21)
5. Commissioning for Sept 2021- (picking up year 1 (20/21) 21/22 Students) (July 21)
6. Commission through ECG –Foundation and Advance MAPA Programme

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Safety First Intervention Task and Finish Group

Terms of Reference

July 2021

Version 4

1.0 Background and rationale.

At the Future Nurse Future Midwife (FNFM) Programme Board meeting on the 4 March 2021 the Public Health Agency (PHA) was tasked with establishing an implementation group for Safety First Intervention Education and Training with the intention that roll out would begin from September 2021.

FNFM Programme Board recognised the need for a regional model to ensure consistency between education, training and practice. This will be achieved through the delivery of evidence based proactive, preventative strategies that underpin safe and effective practice whilst ensuring the safety of both patients and staff.

Pre-registration nursing and midwifery students will undertake *Prevention First and Safety First Intervention* Education and Training to ensure that they have the necessary knowledge and understanding that will create the potential to make a meaningful difference to all fields of practice in both hospital and community settings.

The recent review of Mental Health Nursing (DoH) has recommended that mental health nursing students should have an agreed level of competence in relation to Prevention First and Safety First Interventions at the point of registration with the expectation that they can acquire the additional practical skills when taking up employment within HSC Trust Hospital and Community settings post registration. To support the delivery of practical skills and expertise post registration it is envisaged that a cohort of staff from practice and education will undertake Advanced CPI education and training. The Department of Health has recently developed a new Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedures for the Use of Seclusion which will require changes to current practice and will also require an update on Safety First Training to reflect a more person centred therapeutic approach. The new Regional Policy is now out for public consultation.

Learning from Serious Adverse Incidents has identified a need to ensure a standardised approach to Safety First Intervention training and practice across all HSC Trusts and education providers in Northern Ireland. The aim is to ensure that nurses take a trauma-informed approach to managing challenging events and circumstances.

The Public Health Agency with support from the Department of Health, QUB, UU, OU, CEC, and NIPEC wish to establish a Task and Finish Group to oversee a regional plan for the implementation of Safety First Intervention Education and Training in Northern Ireland.

2.0 Objectives and Responsibilities;

- To set the direction, for Prevention First and Safety First Intervention Education and Training for pre-registration and post registration nurses and midwives in Northern Ireland.
- To agree a funding plan for the implementation of Prevention First and Safety First Intervention education and training
- To agree a delivery plan for 2021/ 2022
    - **Phase One** will focus on pre-registration Nurse and Midwifery programmes beginning in September 2021
    - **Phase Two** will focus on Advanced Education and Training for a cohort of staff from Universities and Trusts to support the delivery of practical skills and expertise post registration
- To monitor progress on implementation of Prevention First and Safety First Education and Training in 2021/2022 Academic Year
- To engage with pre and post registered Nurses and Midwives who have undertaken the training in order to establish learning and inform future developments
- To identify and resolve implementation challenges as they emerge
- To ensure regional standardisation of Prevention First and Safety First Intervention education and training in line with existing structures within HSC Trusts and aligned with the “Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and regional operational procedure for the use of Seclusion”
- To establish a Community of Practice (CoP) for Prevention First and Safety First Intervention Education (Longer term objective)
- Agree a timeframe for completion of the project and provide a summary report to the Department of Health on progress with recommendations on the way forward with regards to future developments and long term sustainability.

3.0 Membership

- PHA Interim Assistant Director of Nursing: Mental Health and Learning Disability (Co-Chair)
- Co-Chair to be nominated from the members of the group (July 2021)
- Project Lead Nurse for Mental Health Strategy
- DoH Divisional Nurse
- DoH Project Lead for Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion.
- QUB
- UU
- OU
- CEC
- NIPEC
- Safety First Intervention Leads from all 6 Trusts including NIAS.

A separate meeting will be held with Workforce Leads for Mental Health & Learning Disability from all 5 HSC Trust areas and Public Health Agency to agree representation on the Task and Finish Group. (PHA) – July 2021

4.0 Frequency of meetings:

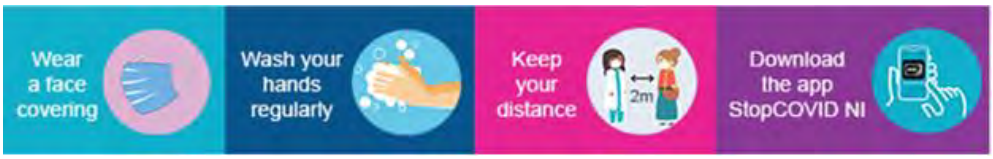
- The Task and Finish Group will meet monthly for 4 months initially. This will be reviewed in October 2021.
- Meetings will be held via Zoom.
- PHA will provide secretariat support to the Task and Finish Group.

From: Rodney Morton (PHA)
To: MORTON, Rodney (NHS ENGLAND - X24)
Subject: FW: Costs for Prevention First Training
Sent: 28/05/2024 14:54:12

From: McManus, Mary Frances <MaryFrances.McManus@health-ni.gov.uk>
Sent: 19 January 2022 20:19
To: Rodney Morton <Rodney.Morton2@hscni.net>
Subject: FW: Costs for Prevention First Training

Rodney
FYI
MF

Mary Frances Mc Manus
Deputy Chief Nursing Officer
Department of Health DoH
C4.21
Castle Buildings
Stormont Estate
BT4 3SQ
MaryFrances.McManus@health-ni.gov.uk
Tel: 02890 520795



From: McManus, Mary Frances
Sent: 19 January 2022 20:19
To: 'Deirdre McNamee' <Deirdre.McNamee@hscni.net>; Rogan, Siobhan <Siobhan.Rogan@health-ni.gov.uk>
Subject: FW: Costs for Prevention First Training

Deirdre Siobhan
Funding approved by WPD.
Mary FRances

Mary Frances Mc Manus
Deputy Chief Nursing Officer
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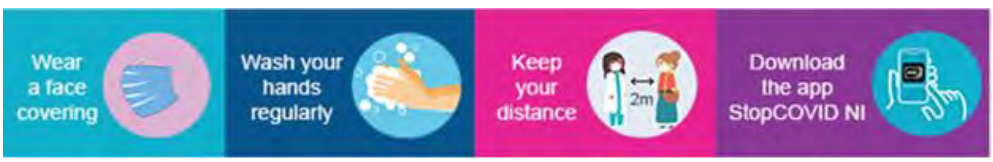

From: Browne, Mark (DOH)
Sent: 18 January 2022 11:36
To: McManus, Mary Frances <MaryFrances.McManus@health-ni.gov.uk>; Barbour, Peter <Peter.Barbour@health-ni.gov.uk>
Subject: RE: Costs for Prevention First Training

Hi Mary Frances,

Many thanks for this. We are content to approve this funding, for the first year of this training (2021/22).

Regards

Mark

From: McManus, Mary Frances
Sent: 13 January 2022 16:03
To: Browne, Mark (DOH) <Mark.Browne@health-ni.gov.uk>; Barbour, Peter <Peter.Barbour@health-ni.gov.uk>
Subject: RE: Costs for Prevention First Training

Hello Peter and Mark
As the Prevention First Training was a new area to me, I asked Heather Finlay for her views on the Business Case. Heather confirmed that the Business case reads well and it is for WPD to approve the funding.
Are you content to approve this training?

Phase 2 will be via ECG
Heather

Many thanks
Mary Frances

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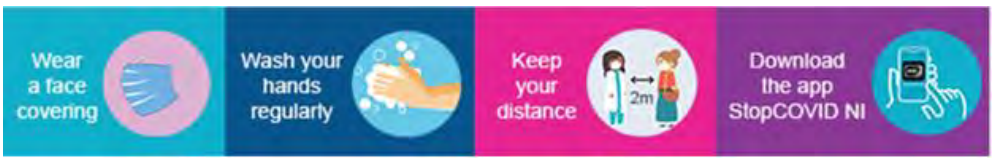

From: Browne, Mark (DOH)
Sent: 23 November 2021 09:41
To: McManus, Mary Frances <MaryFrances.McManus@health-ni.gov.uk>
Cc: Barbour, Peter <Peter.Barbour@health-ni.gov.uk>; Gilmore, Raymond <Raymond.Gilmore@health-ni.gov.uk>
Subject: FW: Costs for Prevention First Training

Good morning Mary Frances,

I hope you're well. WPD will be able to cover the costs for this proposal in 2021/22, however Peter has asked me to clarify a couple of issues with you first, as follows:

1. Given that WPD were not involved in this working group or the project to date, I'd be grateful if you (or other Nursing colleagues) could confirm that you are content with these proposals and with the business case

2. We would need clarity on what the plans are for future years, i.e. how future students will receive this training, if they are required to. We would need to know this for budget planning purposes, if there is an expectation that recurrent funding will be required for this.

3. We would also need a process for confirming numbers of students requiring this training each year – perhaps through the PHA as with this year?

I'd be grateful for your views on this.

Many thanks

Mark

Mark Browne
Workforce Development Unit
Department of Health NI
(028) 9052 0036

Mark.Browne@health-ni.gov.uk

From: McManus, Mary Frances
Sent: 19 November 2021 16:29
To: Barbour, Peter <Peter.Barbour@health-ni.gov.uk>
Cc: Cosgrove, Patricia <Patricia.Cosgrove@health-ni.gov.uk>; Gilmore, Raymond <Raymond.Gilmore@health-ni.gov.uk>
Subject: FW: Costs for Prevention First Training

Hello Peter
For your consideration
Mary Frances

Mary Frances Mc Manus
Deputy Chief Nursing Officer
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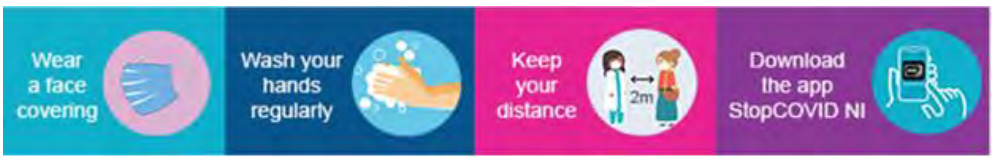

From: Deirdre McNamee [mailto:Deirdre.McNamee@hscni.net]
Sent: 17 November 2021 13:23
To: McManus, Mary Frances <MaryFrances.McManus@health-ni.gov.uk>
Subject: RE: Costs for Prevention First Training

Mary Frances this is the Business Case that was referred to below.
Prevention First is for all pre-registration students so this would not be something that Trusts would be providing as part of their support for students on placement.
There is no recurrent tail for Prevention First.
The Safety Intervention will be targeted at Year 3 MH and LD Students, will be Phase two and this will have a recurrent tail.
The Business Case only covers Phase One.

Hopefully this answers the questions raised but happy to have a meeting if required Mary Frances.
D

Deirdre McNamee
(Interim) Assistant Director of Nursing: Mental Health and Learning Disability
Public Health Agency (Southern Area)
Tower Hill
Armagh

BT61 9DR

Telephone: (028) 95 363 444
Email: deirdre.mcnamee@hscni.net

From: McManus, Mary Frances [mailto:MaryFrances.McManus@health-ni.gov.uk]
Sent: 17 November 2021 12:14
To: Deirdre McNamee
Subject: FW: Costs for Prevention First Training

HI Deirdre
Please see Peter queries below?
Thanks
MF

Mary Frances Mc Manus
Deputy Chief Nursing Officer
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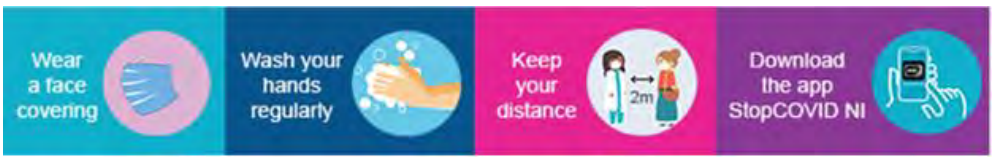

From: Barbour, Peter
Sent: 17 November 2021 12:01
To: McManus, Mary Frances <MaryFrances.McManus@health-ni.gov.uk>
Cc: Browne, Mark (DOH) <Mark.Browne@health-ni.gov.uk>
Subject: FW: Costs for Prevention First Training

Mary Frances

I would need to see the business case alluded to by Deirdre McNamee.
My initial observation is why this cost of this to be a call on the pre-reg budget and not the Trusts?
Also is this to be a recurrent cost?
Presumably these issues are covered in the business case?

Thanks

Peter

From: Finlay, Heather
Sent: 25 October 2021 17:09
To: Rodgers, Philip <Philip.Rodgers@health-ni.gov.uk>
Cc: Barbour, Peter <Peter.Barbour@health-ni.gov.uk>; McManus, Mary Frances <MaryFrances.McManus@health-ni.gov.uk>;

Cosgrove, Patricia <Patricia.Cosgrove@health-ni.gov.uk>
Subject: FW: Costs for Prevention First Training

Hi Phil,

As discussed and agreed at FNFM Programme Board there are costs to be met to deliver the *Prevention First and Safety Intervention programme* from the Crisis Prevention Institute (CPI) to all pre-registration nursing and midwifery students.

£28,027.50 is the one off cost for this year to enable all undergraduate Nursing and Midwifery students across all fields of practice to undertake the training, a total of 3737 students.

The PHA (Rodney Morton's team) are happy to provide the necessary detail to inform a business case. Emails below refer.

Can I please leave this with you to progress/advise further?

I finish in DoH on Wednesday so copying in Mary Frances McManus who is taking over from me from next week.

Many thanks
Heather

From: Deirdre McNamee [mailto:Deirdre.McNamee@hscni.net]
Sent: 21 October 2021 10:08
To: Finlay, Heather <Heather.Finlay@health-ni.gov.uk>
Subject: FW: Costs for Prevetion First Training

Dear Heather
I understand that your time at the Department is coming to an end and I am sure you are up to your eyes trying to get finished up.
I wanted to ask if you would be able to update on the position regarding the funding request for the Prevention First training as per email below?
I have a Business Case drafted but need you to confirm if the additional funding would be available for Phase One. This would now be for 3737 students as QUB had underestimated their numbers.
Give me a call if you need to discuss.
Kind regards
Deirdre

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Telephone: (028) 95 363 444
Email: deirdre.mcnamee@hscni.net

From: Deirdre McNamee
Sent: 08 October 2021 17:02
To: Finlay, Heather
Cc: Owen Barr (UU)
Subject: Costs for Prevetion First Training

Dear Heather
We had a workshop on Wednesday to discuss the Action Plan for the Task and Finish Group so we are continuing to progress with our plans for Prevention First and Safety Intervention programme.

Regarding the proposed costs we had forwarded to you after our discussion with Rodney, it has come to light that QUB had underestimated the numbers of students requiring the Prevention First training in Phase One.
The new figure for QUB is 1872 students so this will increase the overall costs for CPI.
The revised total figure would therefore be **£28,027.50.**
Can you please advise if this is still within your budget Heather?
As you are aware this is a one off cost for this year to enable all undergraduate Nursing and Midwifery students across all fields of practice to undertake the training, a total of 3737 students.
If you need to discuss please do not hesitate to give me a call.
Kind regards
Deirdre

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Rapid, focused external review of the Public Health Agency (PHA) for Northern Ireland's resource requirements to respond to the COVID-19 Pandemic over the next 18 - 24 months

Dr R Hussey CB, OBE, DL

Dec 2020

Acknowledgements

I am grateful for the support provided by the PHA to conduct the review in a short time frame. Staff and stakeholders gave freely of their time. I am particularly indebted to Libby Jones and Christine Thompson for administrative support and to Dr Paul Mc Gurnaghan for the comparison of Public Health Agencies.
Olive MacLeod, Hugo Van Woerden and Stephen Bergin provided valuable advice and support.

Context

The SARS-CoV-2 pandemic has impacted global society both in terms of the direct disease but also the social and economic consequences. There will be much for Governments and Public Health bodies to reflect on as the pandemic recedes. For now, the pandemic continues and sustaining an effective response whilst preparing for the post pandemic phase is crucial.

This rapid review arose from a desire to plan for the next phase, informed by the events of 2020, with the aim of securing a sustainable and strengthened Public Health function in Northern Ireland (NI).

The Terms of Reference of the review are at appendix A. Specifically, I was asked to provide a concise report to identify the short term (18-24 months) actions necessary to respond to the Covid-19 pandemic.

Background

The PHA in NI was established in 2009 under section 12 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

As stated in the Management Statement – *"The overall aim of 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:*

1 *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,*
2 ***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*
3 *providing professional input to the* ***commissioning of health and social care services which meet established quality standards and which support innovation.***

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."

This rapid review is set in the context of the scope of responsibility of the PHA and consideration of the response to the Covid -19 pandemic so far.

During the rapid review, conducted between mid-November and mid-December 2020, I interviewed a wide range of staff and stakeholders. In total I conducted 25 staff, individual or group, interviews including Board members and Directors and I undertook 12 external, individual or group, stakeholder interviews. In addition, I contacted senior public health officials in other United Kingdom (UK) / Republic of Ireland (RoI) Public Health organisations. In total, I spoke with around 50 people. All interviews were conducted by Zoom or telephone.

In addition, I reviewed PHA reports and drew from comparisons with Public Health Agencies across the UK and RoI, completed as a desk top exercise by Dr Paul Mc Gurnaghan, Registrar in Public Health.

The aim was not to conduct a detailed review of pandemic management but to use the experience gained during 2020 to inform future plans.

Findings

As the Regional Public Health organisation, the PHA has mounted an unprecedented health protection response in support of the direction set by the Northern Ireland Executive to manage the pandemic. The agency provided a range of services, including specialist public health advice, data and epidemiology, public information and established a new Contact Tracing Service.

So far in the pandemic, Northern Ireland has the lowest death rate of the four UK countries, at 59.6 per 100,000 population for deaths within 28 days of a positive test (Table 1) and also where Covid-19 is mentioned on the death certificate as one of the causes of death.

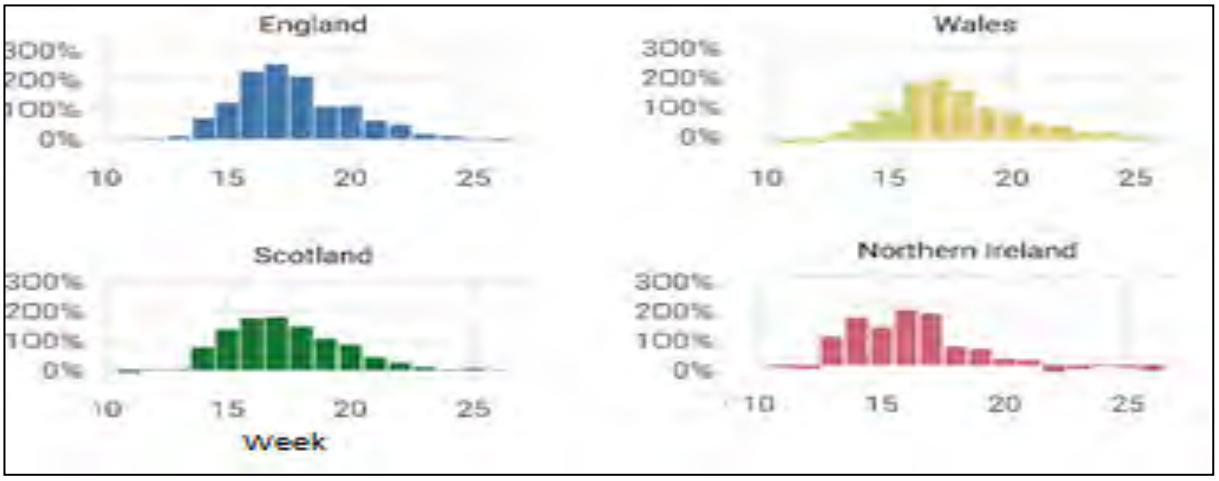
Table 1: Cumulative deaths within 28 days of a positive test, for the four UK countries per 100,000 population, to 14 December 2020

Country	Rate per 100,000 population
Wales	91.4
Scotland	75.2
Northern Ireland	59.6
England	100

Source: Deaths in the United Kingdom.
https://coronavirus.data.gov.uk/details/deaths

It was reported that Northern Ireland made a concerted effort to reduce Covid-19 care home deaths. When the rise in care home deaths was first identified, staff described how the PHA worked intensively with the care home sector on a wide range of measures to contain the spread of the virus and prepare care homes. Research shows that after week 17 there was a notable fall in death rates in Northern Ireland, which coincided with strong collective leadership efforts to protect the care home sector co-ordinated by the PHA (Figure 1).

Figure 1: Death Rates for England, Wales, Scotland and Northern Ireland during the first wave of the pandemic.



Source: Bell D, Comas-Herrera A, Henderson D, Jones S, Lemmon E, Moro M, Murphy S, O'Reilly D and Patrignani P (2020) COVID-19 mortality and long-term care: a UK comparison. Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, August 2020.

Additionally, Northern Ireland was the first of the UK nations to develop and put into operation a new Contact Tracing Service after wave one. An IT support system was designed from scratch, and Northern Ireland was also the first country in the UK to have a functioning proximity app.

The PHA has expanded the Contact Tracing Service at a rapid pace over the last four months, almost doubling the workforce, in terms of headcount.

Although vaccination against Covid -19 started in Dec 2020, the PHA will continue to be in incident response for many months to come and will have a role in the recovery phase as the wider impacts of the disease on health and wellbeing emerge.

The PHA has had temporary leadership arrangements for some years. A new interim CEO and a new Director of Public Health came into post as the first wave of the pandemic took hold. They faced a substantial challenge to pick up the reins of the organisation at such a crucial time and when the organisation had to embrace remote working at speed whilst mounting an effective response. There were vacancies in senior posts and a number of temporary appointments. For example, the Health Improvement function had 46% of its staff in temporary posts, as a result of delays to approval mechanisms at regional level.

The pandemic response has involved mobilising all staff in the health protection function as well as drawing on staff from across the agency to provide surge capacity. This has involved staff working well outside their comfort zone to help the response to the pandemic.

Staff were pleased with many aspects of their response, describing it as a supportive team in health protection. Others reported having been able to develop new data analyses and learning new methods 'on the job' had been pleasing.

Staff felt that they had done their best in the circumstances and were proud of many achievements. Examples cited included the education cell to support schools, data and professional support for care home outbreak management, testing co-ordination, contact tracing, communications and the work on case definition for children. Staff stepped up to help from across the organisation, though some said they didn't immediately feel welcomed. Training was necessary to work in the Duty Room and this added to the pressure, even if it ultimately helped provide support. Many described individual staff as 'very able'. The PHA employed a significant number of locum junior doctors to increase the capacity of the Duty Room, which helped to manage the rapidly expanding workload.

However, it is evident that the prolonged incident has put substantial strain on many of the staff involved. This effort has come at the expense of personal and family time with the added impact of new ways of remote working, adopted at pace. Some have found home working acceptable and effective, though IT support was critical to this.

Staff spoke of working 7 days a week for months during the first wave, with no let up. Public Health Registrars were at the front line of response in the Emergency Operations Centre for much of the early weeks in Feb – March 2020. They describe feeling under supported and overwhelmed with demand. Others also described the demands as being unmanageable and therefore giving rise to tensions and frustrations for both stakeholders and the service when the expectations were not met. Some staff are tired, frustrated, and anxious about blame. At times staff felt undermined when their professional advice was questioned by key stakeholders. Stakeholders understand the pressure but expected a more pro-active response to their needs – there was reported to be a strain, at times, in the relationship with some external stakeholders.

The most consistent, and widely mentioned, term used to describe working practices in the PHA was 'silo working', although some staff have felt that Covid-19 has had the converse effect and helped to reduce the silos. Staff from all parts of the organisation wanted more 'joined up effort' with better use of skills. In particular, staff felt there could be more use of project management support.

More generally, strategic planning was needed both in the pandemic response (which was described as reactive not proactive) but also in the PHA as a whole. Work was undertaken early in the pandemic, through a series of workshops, to develop multidisciplinary, multi-agency 'cells' to support more effective horizontal working. These cells operated across the PHA/HSCB under the SILVER tier of the national emergency response and were recognised as making a beneficial impact. A Business Continuity Plan was also rapidly developed and has been reviewed regularly by the senior management team. Work to produce a strategic plan is underway though not all staff were aware of this.

Feedback on service areas

The next section summarises some of the issues reported by participants in response to the specific areas of the terms of reference.

Health Protection Service and Emergency Preparedness

There was consistent reporting that the health protection service was under resourced to sustain the emergency response in the duty room; in providing specialist advice; and for emergency planning and response.

Specific points raised:

- Whole organisation surge capacity was not historically planned and trained for
- Overstretched staffing and insufficient training budget in Emergency Prevention, Preparedness, and Response (EPPR)
- Insufficient capacity to manage NHS / Care home outbreaks
- Duty room model changed – needs evaluating
- Strategic work paused
- Staff need a recovery period – 'no time for leave as no-one else to do the role'
- Lessons learnt so far not yet undertaken – no time to reflect
- Stretched business management / project management support– staff working below skill level
- Limited capacity to keep documentation and standard operating procedures up to date
- Limited supervision and support of Registrars
- Many temporary appointments – 'takes time to train them'
- IT inadequate – hardware and software, phones and internet crashing
- Working environment poor (Under discussion with landlord for some time)

➢ **Infection Prevention and Control**

- Capacity severely overstretched
- Pressure to service all Outbreak Control Teams
- Need access to sufficient genome sequencing and epidemiology to investigate nosocomial spread
- Roles and responsibility blurred between respective agencies (RQIA/HSCB/Trusts) especially for care homes
- Limited cross-divisional working/ support for professionals without relevant health protection qualifications
- Working environment poor – IT and accommodation

➢ **Contact Tracing Service (CTS)**

- Initial service extremely stretched by demand
- Insufficient project management in initial phases
- Pleased been able to get new CTS up and running quickly
- New IT system established at pace
- Links between Health Protection Service and CTS unclear initially but improving

- Strengthened leadership in place and business case for sustainable resource developed
- Need to further evaluate the model for CTS

The effective use of evidence, health information, epidemiology and research

The need for *timely* surveillance and epidemiology data to support decision making has far exceeded capacity. The response has also required rapid *new* surveillance analyses. Other essential surveillance schemes will have been impacted, having diverted all available resource to Covid -19. This risks missing other infectious disease outbreaks or changes to the incidence of other important infections. Staff recruitment was attempted with limited success, due to a lack of sultably qualified staff existing in Northern Ireland. A range of extenal staff were brought in to provide support including around six academic staff and two veterinary epidemiologists.

Specific points raised:

- Epidemiology and surveillance team overwhelmed with multiple demands and criticised / challenged
- Some of the skills and software needed for analysis were not available
- IT equipment inadequate e.g. 2 hour run times for analyses
- Analysts spread across the organisation with different priorities
- Short term funding for posts e.g. Antimicrobial Resistance
- Limited modelling skills available in PHA (despite some academic supplementation)
- Research was commissioned in support of the clinical and public health response (behaviour change advisory group established)
- Unclear publication policy and approach to open data
- Opportunity to further develop data science and modern data approaches
- General lack of awareness of plans to develop science and evidence capability – does not drive the work of the organisation
- PHA does not have direct access to the data in record linkage system and access to primary care data needs to be improved
- Reports could be more tailored to the audience and their desired impact

Communications including social media and online communication to enhance public messaging

There was general support for the way communications had been managed both with the public and professionals.

Specific points raised:

- Generally, thought to be a good response though severely over stretched

- Good collaboration with Department of Health
- Mainstream media expectations substantial
- Relied heavily on a few individuals as spokespeople
- Social media methods used but could do more segmentation and behaviour change work
- Website not easy to navigate – not 'click through' nor up to date
- Could have anticipated what information different sectors needed and made them accessible for direct access or download – some felt they were answering the same questions repeatedly
- Good engagement with voluntary sector – desire to build new relationships post pandemic and focus on community assets
- Public and professional awareness of PHA has increased significantly during the pandemic and this should be built upon.

Ensuring a strong and vibrant professional public health community in Northern Ireland.

The health protection service has been under strength for some time and is currently supported by a number of locum consultant posts. A minimum number of consultant posts is needed to deliver a 24/7 service and therefore more staffing pro rata is needed for a smaller population. The Faculty of Public Health has recently made a case for 30 consultants per million population. Northern Ireland currently stands at an estimated 15.3 consultants per million, whereas similar public health agencies such as Wales and Scotland stand at 24.8 and 22.7 respectively. This suggests that NI is under resourced at present and some way from the Faculty's future staffing goal.

Specific points raised:

- Many temporary posts
- Opportunity to strengthen multidisciplinary public health skills
- Limited succession planning
- Limited academic links
- Silo working between some professional groups
- Specialised functions with result that drawing in more skills for the surge response was difficult
- Working below skill level due to lack of support staff
- Training & career development needed
- Public Health training impacted by supporting the service response
- Masters programme for public health affected by availability of staff in PHA
- Good operational / individual links across UK agencies and some developing ones with RoI
- Some strategic development and training links outside NI

General comments

- **Context**

A comparison of the 5 agencies in UK and ROI showed that, up to 2020, all had responsibility for the 3 elements of public health (health protection, health improvement and service development). The creation of the National Institute of Health Protection (NIHP) in England will change the system but is still in development. Public Health England has an UK wide remit and it will be important for NI to clarify how the new arrangements in NIHP will continue to provide specialist support for NI.

The governance arrangements differ in each country but Public Health Scotland and Public Health Wales are similar to PHA NI.

Funding is not easily compared as each agency has a different mix of services and hosted functions. However, as stated earlier, it is clear that PHA NI has the lowest specialist public health staffing rate per million population in the UK. (A more detailed paper has been developed by Paul McGurnaghan and a summary page is included at Appendix B)

Organisational issues

Many of the points raised on the specific areas of the terms of reference have implications for the whole organisation.

- **Strategy** – Interviewees were keen to have a shared vision for the organisation and a clear strategic direction. Some raised concern that the PHA would become focused solely on health protection in future. There was a recognition that data and evidence are crucial to public health practice and that further strengthening of the strategic approach is needed to develop effective use of data science.

- **Governance** – issues raised with regard to governance included:

- It was suggested that the structure of the organisation might better follow key functions and thereby align to strategy
- Information governance - needed to review systems, especially in light of new data collection systems and need for data sharing.
- Multiple Freedom of Information requests – opportunity to further strengthen publication policy and management of FOIs
- The business continuity plan was insufficient for the pandemic response, given the substantial nature of the pandemic
- The agency has a range of ‘hosted services’ – respondents wanted clarity about the interface with such services, for example, related to child protection
- It was not evident that a stakeholder survey had been undertaken in recent times to inform partnership working

- The Board is undertaking development work in line with the new handbook on Arms-Length Bodies. The role of the Board during a prolonged Civil Contingencies emergency incident merits exploration.
- There was a desire to have more outcome / impact focus to Board reports and stronger performance monitoring against an agreed strategy

- **Workforce -** Many of the issues raised with regard to specific services were in relation to workforce.

  Specific points raised:

- It was reported that the PHA has an out of date workforce plan
- Substantial concern was expressed about staff wellbeing in an overstretched system
- It was felt that the agency needed more HR support to recruit staff in a timely way
- A cultural assessment survey, reported in Feb 2020 showed the PHA to be mid-range on most scores but with lower scores on 'Vision, Quality and Innovation'
- A new survey will be completed in Dec 2020
- An organisational development plan was produced in early 2020 but not progressed because of the pandemic. Many of the areas identified for development work have been magnified negatively during the pandemic response.
- There is an appetite for leadership development at all levels and a recognition that there is a need for more succession planning
- Specific skills gaps were noted such as behavioural science (for which a business case has been developed), health economics, data science
- There is a need for more project management capacity to support delivery
- Public Health training has been disrupted because of the pandemic
- Staff across the agency wanted the opportunity to develop their skills
- It was reported that more in-house IT support was needed as well as up to date IT systems.
- Office accommodation was described as unsuitable and overcrowded
- Remote working had been established quickly and some would like it retained

- **External partnerships**

There was consistent evidence that there had been good collaboration with other Public Heath institutions, both before and during the pandemic, especially at individual and operational service levels. Strategic links had fallen back a little because of the pressure of the pandemic.

The interrelationship with the Health and Social Care Board (HSCB) ensures that public health is able to contribute to improving population health outcomes through health needs assessment and service planning. This is valued by the health and care system. The proposed changes to the HSCB, provide an opportunity to re-think

how public health inputs to community planning, integrated care partnerships and any future commissioning arrangements.

Despite the strain on the whole system, the NHS felt supported by the PHA. Information had been accessible and there was good communication with professionals. Also recognised that there was much to learn and incorporate into future plans e.g. roles and responsibility in regard to care homes, rapid communication of guidance, emergency plans etc. Specific, practical, issues also merited reflection such as staff needing Fit test assessments for different masks and ways this could be streamlined in future.

Local Authorities valued the work of the PHA. Outside the pandemic, there was joint working at local level on health improvement but less so on health protection. Relationships at a strategic level had been less actively managed by the PHA in recent years.

During the pandemic response, public health input at incident meetings was essential. More could be done to provide tailored public health support to LAs especially when guidance changes. LAs have a role in the recovery phase and early engagement to consider wider health impacts would be valuable.

The Department of Health is the strategic sponsor of the PHA. There is regular interaction between staff in both organisations and regular high-level monitoring. During the height of the pandemic there was a mismatch in expectation and available resource to deliver, which at times led to strain.

The Voluntary and Community sector supported the pandemic response in several ways such as when the contact tracing app was being developed and at community support level. The importance of using the experience of public involvement and connecting with community assets was emphasised. (The PHA provides regional leadership for PPI across Northern Ireland via the Nursing Directorate).

The academic sector was able to mobilise staff with specific skills to support the pandemic response. It was noted that more could be done to support staff development such as joint appointments and research development.

Conclusions and recommendations

The PHA has been subject to temporary leadership arrangements for some years and this, along with resource constraints, has slowed the development of the organisation. Covid-19 has challenged the health and care system and affected the whole PHA. There is an opportunity now to learn from the experience and design a public health system able to respond to future health threats. Although the Terms of Reference for this rapid review were focussed on the immediate challenge of Covid-19, it is apparent that action is needed at a number of levels to address the longer-term strategic challenges faced by the organisation.

Recommendation 1

Strengthen the public health system in NI

1.1 The PHA has a broad remit to promote and protect the health of the public – this should continue with a strengthening of the agency's capability and clarity about its roles and responsibilities, especially in relation to partner agencies such as health and social care and Local Government. The planned changes to the Health and Social Care Commissioning Board provide an opportunity to create a stand-alone, independent PHA, focussed on protecting and improving the public's health and wellbeing, and which continues to provide an effective population health input into service development and quality improvement.

1.2 The PHA should aim to be a modern, effective Public Health organisation. In order to do this, it must set out a clear vision and ambitious strategic direction in collaboration with the DoH. **A strategic plan is needed in order to set priorities and develop organisational capacity and capability.** It is recommended that the strategic plan is supported by a three-year investment programme with senior transformational change management support.

1.3 A modern public health system encompasses 10 essential public health services (appendix C). The PHA should self-assess its capability to deliver these services. The International Association of National Public Health Institutes has a range of tools and resources that could help to guide development as well as a peer support network. It is important that the Agency looks ahead to plan for global health challenges. For example, further pandemics, impact of climate change, antimicrobial resistance and delivering the UN Sustainable Development Goals. These issues should be set in the context of delivering the Northern Ireland Executive's ambitions for health and wellbeing.

1.4 It is unlikely that the Agency will be able to access all the necessary skills and should therefore seek to strengthen strategic and operational networks with the relevant UK agencies, in line with existing Memoranda of Understanding. It should continue to develop academic networks and strengthen all Ireland collaboration.

1.5 The interim CEO has been able to steer the Agency through the pandemic response but has made it clear that the interim role will come to an end in mid 2021. However, the transformation programme will require sustained leadership and

therefore the recruitment of a permanent CEO to lead the development of the agency for the longer term should be commenced now in order to ensure an effective handover.

The incoming CEO should have substantial strategic transformational skills, be an outstanding communicator and have a clear understanding and commitment to protecting and improving the public's health.

1.6 In the context of the pandemic and its aftermath, the Agency's strategy should address the following areas:

1 Strengthen health protection capability.
2 Assess health impacts arising from the pandemic and seek to address them, drawing on research, intelligence and international evidence.
3 Reactivate core public health services affected by the pandemic, taking the opportunity to refresh models of delivery where needed.
4 Develop the Organisation.

The wider health inequality impacts of the pandemic will require a range of policy and service responses over the short and medium term. There is also a requirement to restart core public health services as soon as practicable. These areas are not within the scope of this report but are, nevertheless, an important part of pandemic response and recovery.

There is a need to act now to improve specific functions. The rest of the report will focus on this and the 4th objective of organisational development.

Recommendation 2

Strengthen health protection capability

2.1 There is an urgent need to expand the current capacity of the specialist health protection team, infection prevention and control capacity and emergency planning functions. A business case has been prepared for consideration and this should be negotiated and implemented as soon as possible in order to ensure a sustainable service and allow staff time to reflect and refresh following a prolonged period in incident response.

2.2 The Associate Head of Health Protection has a large number of direct reports. Additional staffing will add managerial workload. Management arrangements could be strengthened, in line with existing plans, to ensure optimal staff support, whilst enabling leadership development and succession planning.

2.3 The duty room staffing arrangements have been adapted during the pandemic. These should be evaluated from a staff and user perspective to inform ongoing and future needs. There should be clear accountability for quality assurance of processes and advice. The education cell provided an effective model of support for the sector. The model could be replicated to provide tailored advice and support for other key sectors.

2.4 The Contract Tracing Service will need to be sustained for months to come. Leadership and accountability for the service is in place. Consideration of how best to sustain a flexible response is needed and confirmation of the appropriate resources. Further evaluation of the current system will enable strategic consideration of requirements for ongoing contact tracing systems and how to scale up capacity in future incidents.

2.5 Lessons learnt from the spread of Covid-19 in health and care settings should inform a refresh of approaches to prevention of health and care acquired infection. Review of roles and responsibility for action in these settings is needed with sufficient capacity to provide a preventative approach and to service outbreak control teams.

2.6 The sustained operational incident response has led to deferment of strategic work. Steps should be taken to re-start strategic health protection work as the pandemic response allows. Job roles may need to be reviewed to consider the balance of operational and strategic work in a future prolonged incident. Environmental health protection should continue to be developed along-side infectious disease prevention and management.

2.7 Modern public health practice relies, increasingly, on genome sequencing to enable tracking of spread in time and space. The HSCB should strengthen capacity and capability for genome sequencing and ensure it is strongly linked to health protection activity. Strengthened public health links to microbiology services are needed.

2.8 Learning from the pandemic incident response should be captured and used to inform and strengthen EPPR arrangements. Surge capacity was provided from across the organisation. This should be documented and codified into a business continuity plan with systematic training and development for the relevant roles. All relevant staff should have a minimum standard level of health protection training and knowledge of systems and processes.

2.9 IT systems and accommodation require attention and will be covered in the general section later.

Recommendation 3

Develop science and intelligence capability

Evidence and data are the ‘life blood’ of public health practice. The PHA should be a leader in developing and using science and intelligence to inform its work. Modern public health practice requires access to a broad base of sciences, such as epidemiology, microbiology, behavioural, economic and data sciences to name a few.

Data sources should include quantitative and qualitative methods. New methods of analysis should be developed as well as using record linkage opportunities. Digital

Health and Care Northern Ireland has an ambitious programme to enhance digital systems and PHA should ensure that it participates fully in exploiting the opportunities of this work. There should be a focus on 'horizon scanning' to anticipate future health trends and active participation in research & development.

3.1 The PHA should develop a strategic ambition, and plan to be, an evidence and data driven organisation to inform policy and practice. A science advisory board would help to bring a range of inputs to developing the strategy.

3. 2 In order to deliver such an ambition, there is an immediate need to develop analytical capacity and invest in skills such as behaviour change, data science, modelling and health economics.

3.3 The PHA already has a range of analytical skills and these should be brought into one team to enhance the overarching capability of the function. This will require strong leadership and a Chief Information Officer should be appointed to lead the function with alignment to the proposed Director - Research & Intelligence (see later 4.8).

3.4 The PHA should invest in digitising its collection, storage and processing methods. The emphasis should be on real time data collection and analysis. Data flows should be reviewed. For example, there was reported to be limited access to primary care data. The epidemiological surveillance function is an important asset which needs development.

3.5 Reporting of data should be reviewed against 'best in class' and with user feedback to ensure that products and publications are achieving maximum impact on public health outcomes.

3.6 The UK government has a new digital strategy with an ambitious goal to *encourage innovative uses of data by making it easier where possible to access and use data held by both government and businesses, within new legal frameworks and to ensure data is used to its maximum potential within government to provide more efficient and responsive public services*. The PHA should consider how best to develop an open data approach to its work and review its publication scheme to support openness and transparency.

3.7 Information governance is crucial to ensure high standards of data storage and usage. Some data sets are held by the Business Support Organisation and PHA should review access arrangements to these essential data sources as well as ensure all personal data in the PHA are held securely.

3.8 There is scope for the PHA to be a more research active organisation, both in identifying research questions and encouraging staff to engage in active research. A Northern Ireland public health research network already exists and staff should be enabled to participate fully in such work. Existing proposals for a Public Health R&D Director should be accelerated in line with para 4.8

3.9 At a basic level, analytical staff need higher computing power to do their work – this is covered in a later section.

Recommendation 4

A modern, effective and accountable organisation

4.1 The PHA has a substantial opportunity to learn from the pandemic as a whole organisation. No part of the organisation was untouched by the experience. It is important that the whole organisation undertakes a 'lessons learnt' debriefing exercise as soon as practicable to capture the experiences and learning in real time.

4.2 As part of its strategy to protect and improve the health and wellbeing of the population of Northern Ireland the PHA should optimise the use of scarce skills and resources and aim to create the best working environment.

There is much to be done to maintain the Covid-19 response and recover from the prolonged incident.

In terms of Organisational Development (OD), the areas that need early attention are:

- Culture
- Accountability
- Capacity and capability
- Working environment
- External relationships

➢ Culture

4.3 The health and wellbeing of staff has been impacted. There was evidence of severe pressure on individuals, some of whom also felt disempowered and undermined at times. These concerns should be addressed.

4.4 An organisational development (OD) plan was started and this should be activated as soon as possible. The second cultural assessment survey, due to be completed in Dec 2020, should be used as a platform to drive change.

➢ Accountability

4.5 Structural form should follow function. The organisation's core business is public health (covering health protection, health improvement and service quality development) and this should be centre stage in all its strategy, systems and structures.

4.6 There is an imbalance in the organisation's leadership team. The DPH role spans 2/3rds of the budget of the PHA and acts as Medical Director in the HSCB. This is a very wide role for one person and should be reconsidered.

4.7 The directorates should be arranged around the key functions to be delivered. Accountability should align with strategic objectives, with more visibility of health protection at Board level.

4.8 The DPH role will need to focus on strategic development of the public health function and external relationships. In order to strengthen leadership, support effective delivery and succession planning, I recommend three deputies to lead the respective functions of:

- Health protection director
- Health improvement director
- Health research & intelligence director

4.9 There are a number of hosted functions within the PHA which should be reviewed in due course to ensure they align with the Agency's core purposes. However, in the short term more collaboration with hosted functions would bring benefits. For example, with R&D to further support evidence-based practice and innovation and with the Quality Improvement function to drive innovation and improvement in public health services.

- **Capacity and capability**

4.10 The PHA should update its workforce plan so that it is aligned to its strategy.

The workforce plan should cover the development of current staff to upskill in their specific roles and ensure a basic level of public health skills for incident response and collaborative working. The plan should include an ambition to be a learning organisation.

4.11 The plan should ensure that ways of working within the agency address concerns about professional silo working, for example, by ensuring that all senior staff have adequate public health training. There should be more cross fertilisation of roles and ideas as well as joint project working focussed on shared outcomes. A leadership development programme is essential. Use of mentoring and coaching should be encouraged.

4.12 Specific public health, epidemiology and analytical training will need to be increased to replace staff as they retire / leave. The current public health training programme is recruiting and the PHA should seek funding for a one-off increase in multidisciplinary recruits as well as develop a longer-term plan for future numbers of specialist staff needed to be sustainable.

4.13 The epidemiology Fellows scheme should continue to be supported.

4.14 The training programmes should seek to maximise placement opportunities within and outside NI to ensure public health registrars are exposed to a wide range of approaches and areas of practice that may not be available in house. These could include placements in the Northern Ireland Executive and with local government to help develop public health practice in support of policy development and decision-making. Academic research opportunities should be readily available.

4.15 Joint service-academic appointments can help to attract candidates for roles, support research and innovation in practice and strengthen the training programme.

More should be done to enhance links with Universities. Similarly, joint appointments with other public health agencies would foster collaboration and make best use of scarce resources.

4.16 Public health centred communications and engagement is a vital part of delivering improved health outcomes. There was a call from stakeholders for more engagement. The communications function should be supported and enhanced. The appointment of a Director of Communications and Engagement would provide the leadership needed to develop this capability.

4.17 More use should be made of digital communication and behaviour change expertise. The website requires an upgrade to be more 'user accessible'.

4.18 There was a call for more overarching co-ordination within the organisation and a need to enhance strategic and operational planning. The recently retired Director of Operations role should be replaced to encompass these functions and support the CEO in the daily running of the business. Project management and business support roles should be reviewed to ensure sufficient capacity and focus on programme delivery. The high level of temporary posts should be reviewed to ensure retention of necessary skills.

4.19 The IT and HR functions should be enhanced to support efficient and timely recruitment as well as an upgrade of IT functionality.

- **External relationships**

4.20 Partnerships are a crucial part of public health practice. As recommended above, a Director of Communications and Engagement would bring strategic leadership to this work.

A stakeholder survey should be undertaken to identify areas of strength and areas for improvement.

Whilst there is local engagement for health improvement activity in community planning, it should also be strengthened for health protection as well as for involvement in Integrated Care Partnerships, and including primary care.

- **Working environment**

4.21 The working environment needs improvement. An estates plan is underway and this should be underpinned with a strategic approach to future working methods. A survey of how people want to adapt their working arrangements after Covid-19 should inform decisions. Even before the pandemic, other public bodies have achieved substantial transformations in creating flexible, 'location agnostic' ways of working which enhance staff engagement and wellbeing.

Implementation

The four high level recommendations in this report are supported by detailed actions that are necessary to re-invigorate the public health function in order to continue the response to Covid-19 and prepare for future health threats. Further work is underway to re-start other public health services which was not in the scope of this report.

The immediate priorities are to:

- Finalise and agree relevant business cases to ensure current service sustainability
- Commence appointment of the CEO
- Agree an investment and transformation plan

My recommendations constitute a major change programme which requires investment and leadership. The interim CEO should be supported to start the delivery of this programme forthwith, with assurance provided by PHA non - executive Board oversight.

Appendix A

Terms of Reference for a rapid, focused external review of the Public Health Agency for Northern Ireland's resource requirements to respond to the COVID-19 Pandemic over the next 18 - 24 months

Background

1. The Public Health Agency for Northern Ireland (PHA) is facing an unprecedented COVID-19 pandemic. Rapid, focused advice on the resource requirements to respond to the current situation over the next 18-24 months would be valuable.

2. Whilst the Agency has clearly responded well to most of the issues raised by the pandemic, it is also clear that the scope, scale, pace and complexity of the challenges will only increase and the Agency must be ready to respond with agility and with the capacity and capability required.

3. Furthermore, it is more than ten years since the Agency was established under the second phase of Review of Public Administration and such a review would be timely in any case.

4. An investment in public health – particularly in health protection – is likely to be required if we are to ensure a Public health Agency fit to deal with future challenges over the next decade. These include, but are not limited to:

- Pandemic threats such as COVID-19;
- The effective use of evidence, health information and epidemiology in a digital age;
- Analytical and epidemiological work including research
- Infection Prevention and Control
- The best use of public engagement, co-production, communications including social media and online communication to enhance public messaging; and
- Ensuring a strong and vibrant professional public health community in Northern Ireland.

Proposed Approach

1. The rapid review will be led by Dr Ruth Hussey, OBE, a previous CMO in Wales.

2. The recipient of the review will be: The Chef Medical Officer for Northern Ireland, the Chair of the Agency, and the Chief Executive of the Agency.

3. The Chief Executive of the PHA will ensure, with the support of the Director of Public Health, that Dr Hussey is provided with all the practical help required to undertake the review.

4. The review will aim to provide a concise report that can rapidly be undertaken to address the COVID-19 pandemic over the next 18-24 months.

5. The report will aim to have a draft available for comment by 31 December 2020.

6. Dr Hussey will be free to develop and structure the review as she sees fit, in discussion with the three recipients of the report and to engage other external advice, if she deems this advisable.

Appendix B

Information available online was used to describe the public health service arrangements across the five nations of Northern Ireland, Scotland, Wales, England, and Ireland. Each nation is set within its own context and subsequently direct comparisons between them are not easily achieved.

All of the services are explicit in stating their focus on protecting and improving the health and wellbeing of the population, and on reducing inequalities. The provision of each nation's service is also broadly framed around the three main domains of public health practice (health services, health improvement, and health protection). All services exhibit cross-sectoral and multi-disciplinary working. The systems in Ireland and England are undergoing periods of significant transition. Scotland's public health service - in its current form - was only created in Spring of this year.

There are differences in the organisational models adopted by each service - but, when each nation's service is taken as a whole (including any delegated public health functions), the types of output are similar. In turn, with regards to the scope of their Health Protection work, the composite functions appear comparable between nations. Close partnership between Microbiology services and Health Protection services is a feature for all nations. In Wales and England some Microbiology services are managed by the Public Health organisation.

The size of the population is likely to be a significant factor determining the scale of the service available. Funding is not easily compared as each agency has a different service mix. However, it is clear that Northern Ireland has the lowest specialist staffing rate in the UK, including having fewer Directors of Public Health per head of population.

All nations have responded to the pandemic by adapting pre-existing models of service delivery. During the pandemic, there has been close co-operation between all of the five nations. Collaboration between the agencies was also an important feature prior to COVID-19.

Selected elements of the five public health services

	Ireland	Wales	Scotland	England	Northern Ireland
Population	4.9 million	3.2 million	5.5 million	56.3 million	1.9 million
Number of specialists / consultants (per million)*	-	79.4 (24.8)	125 (22.7) *estimated*	1007 (17.9)	29 (15.3)
Directors of Public Health (per million head of population) &	8 (1.63)	7 (2.19)	14 (2.55)	134 (2.38)	1 (0.53)
Budget / expenditure 2018-19[ł]	Euro 241m (2019)	£135m *Includes all Wales' microbiology services*	£71m *This is an 'opening budget' for the new organisation, Public Health Scotland*	£4,013.0m *This represents net expenditure for Public Health England - about ¾ of funding is for local government public health*	£113m *Includes hosted services such as R&D for health and social care*

[ł] Note that each agency's budget may not be comparable due to differences in their functions.
*Figures taken from Representation to the Comprehensive Spending Review 2020 (Faculty of Public Health)
[&] Figures taken from Association of Directors of Public Health (UK) (www.adph.org.uk/). National Directors may not be included in figures.

Appendix C

Essential Public Health Services (Revised, 2020)

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities.

1. Assess and monitor population health status, factors that influence health, and community needs and assets
2. Investigate, diagnose, and address health problems and hazards affecting the population
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
4. Strengthen, support, and mobilize communities and partnerships to improve health
5. Create, champion, and implement policies, plans, and laws that impact health
6. Utilize legal and regulatory actions designed to improve and protect the public's health
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy
8. Build and support a diverse and skilled public health workforce
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
10. Build and maintain a strong organizational infrastructure for public health

https://www.ianphi.org

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

REBUILDING HEALTH AND SOCIAL CARE SERVICES

STRATEGIC FRAMEWORK

DEPARTMENT OF HEALTH

JUNE 2020

CONTENTS

MINISTERIAL FOREWORD

Before the introduction of social distancing almost three other people were infected by each COVID-19 patient in the community. As a result of social distancing and other restrictions, each COVID-19 patient now infects less than one other individual in the community. The result of this is that we are now seeing a slow decline in the number of community acquired COVID-19 cases, hospital admissions, ICU occupancy and deaths.

This Strategic Framework for Rebuilding Health and Social Care (HSC) Services will only be successfully implemented by ensuring that the number of Covid-19 infections remains at the current level or less in the future. If this increases above one there will be the risk of a second wave of the pandemic. Consequently, our ability to rebuild HSC services will be derailed by having to divert HSC resources to manage the impact of a second wave of the pandemic.

My position as Minister of Health has given me a particularly privileged vantage point to witness the impact of this terrible virus on our community. This has both humbled me and sharpened my determination to ensure that we use every available measure we can to keep the rate of infection below one.

The number of our fellow citizens who have been infected or sadly lost their lives has already been too great. As of 2 June 2020, over 76,000 people had been tested. Sadly, 705 COVID-19 related deaths had been registered up to 22 May. I send my sincere condolences to the families and loved ones who have suffered the loss of their family member. I pray that those who are recovering from COVID-19 will make a full recovery and return to a happy and healthy life. The impact of COVID-19 on our older citizens living in care homes has been particularly devastating and my thoughts are with their families and friends at this difficult time for them.

I am immensely proud of the response to COVID-19 of everyone involved in our health and social care sector. Our nurses, midwifes, allied health professions, doctors, pharmacists, care workers and other front line health and social care workers and those individuals who volunteered to return to work have bravely and tirelessly put themselves at risk to save the lives of others. In addition, staff in our arms-length bodies and in my Department have put in many long hours planning for and managing the emergency response. I know that I can rely upon their continuing commitment to deliver the highest quality health and social care services across the community as we begin the task of rebuilding the HSC.

COVID-19 has presented our HSC system with its biggest challenge since inception. We faced huge strategic challenges prior to COVID-19, which included an ageing population, increasing demand, long and growing waiting lists, workforce pressures, the emergence of new and more expensive treatments and ongoing budget constraints. These challenges have been compounded by COVID-19.

I am deeply concerned about the impact of this activity downturn on long term health outcomes across the population. In total, 643 excess deaths have occurred up to 22 May 2020. Throughout the pandemic the HSC has continued to provide high priority and urgent services such as emergency care and many cancer treatments. Despite the action I took to protect our highest priority services, a terrible consequence of the pandemic is that for some people conditions will have gone undetected or untreated longer than they otherwise would have. I am also deeply concerned about the impact of the pandemic and the lockdown on mental health, especially for our most vulnerable citizens.

We are now emerging from the peak of the first COVID-19 wave and we must now seek to rebuild services as quickly as possible in that context. My immediate focus will be on supporting services where further delay would seriously risk the condition of patients worsening. As we do so, patient and staff safety will remain an absolute priority. We will therefore create an environment where it is safe for patients to attend appointments in both primary and secondary care settings.

I conclude by again thanking all health and social care staff for the incredible efforts to date. We will not be able to return to business as usual as quickly as we would want to and some services will take a considerable period of time to return to activity levels similar to those prior to COVID-19. At the same time we need to mainstream the important innovations that have emerged, we must retain flexible capacity to continue to manage COVID-19 patients and we must plan for the future, all at the same time.

This Strategic Framework that I have published is an honest attempt to plot the way forward to rebuilding HSC services. Because of the uncertainty about our ability to control further outbreaks of the virus our planning horizon will look no further than three months ahead as we seek to rebuild service capacity over the next 2 to 3 years. The road to achieving full recovery of services will be long and testing for all involved.

I am convinced that as a system we will rise to this complex challenge.

Robin Swann
Minister for Health, Northern Ireland

1.0 INTRODUCTION

1.1 COVID-19 has posed unprecedented challenges for the Health and Social Care (HSC) system, which already prior to COVID-19 was facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments as outlined within *'Health and Wellbeing 2026: Delivering Together'*. This is against a backdrop of financial constraints and single year budgets. Elective and diagnostic services have had to be curtailed with adverse impacts on existing waiting lists. At the end of March 2020 there were some 307,000 patients on the outpatient waiting list, almost 94,000 waiting for inpatient and day case admissions and more than 131,000 patients waiting for diagnostic tests. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic.

1.2 The impact of COVID-19 on HSC will be profound and long lasting. Services will not be able to resume as normal for some time due to the continued need to adhere to social distancing and for Personal Protective Equipment (PPE) at volumes not required prior to the pandemic. In addition, the resilience of the HSC workforce is likely to have been eroded and will continue to be impacted with pressures from parts of the social care sector, with care homes still managing a significant number of COVID-19 outbreaks, for instance. This could require the continued deployment of additional staff into the independent sector, which, if delivered, will further constrain staffing capacity to fully resume other HSC services. Ongoing pressures and the need to operate in new ways will likely impact the pace of stabilisation across primary, secondary, community and social care services.

1.3 Whilst the restrictions imposed by The Health Protection (Coronavirus, Restrictions) (NI) Regulations 2020 ('the Regulations') were necessary, they have impacted on the wider economic and social environment, with both long and short term effects on population health. Emerging research indicates that population health is, on balance, likely to be negatively affected by the wider impacts of COVID-19. Furthermore, the greatest effects are likely to be felt by our most disadvantaged citizens.

1.4 In addition, given the very significant downturn in HSC services, many people have not had access to the screening, testing or treatments that they otherwise would have had. In that context, the Department took action to preserve the highest priority essential services to mitigate this impact. Inevitably, however, the downturn in normal business will have resulted in some diseases going undetected or untreated longer than is desirable, with potential impact on long term health outcomes. The uncertainty and concern about the pandemic combined with the impact of the lockdown will also likely have had an adverse

impact on mental health, especially for the most vulnerable in society. Additional support for mental health and resilience have been provided, however it is likely that there will be significant need coming forward as we emerge from the lockdown. Delivering on the mental health action plan launched on 19 May 2020 will be essential if we are to meet this particular challenge.

1.5 COVID-19 has disrupted the clinical education and progression of a number of health professions resulting in a disruption in progression and future workforce supply. This disruption has been particularly acute in elective services which have been stood down, multidisciplinary community teams and district nursing teams where student training would have generated additional footfall. The third sector has also been negatively impacted by COVID-19 and HSC are reliant on the sector to provide support.

1.6 Careful consideration will also need to be given to the delivery of long term support for people in the community, including that provided through HSC domiciliary, residential and nursing home care and through the vital support provided by informal carers. There will need to be a careful balance struck between continuing to protect people and ensuring that other aspects of people's health and wellbeing – and their rights – are respected and looked after.

1.7 A further issue that will increasingly come into focus during 2020 is the need for readiness for EU Exit, ahead of the end of the transition period on 31 December 2020. This includes understanding the implications for the HSC sector of the implementation of the Northern Ireland Protocol and ensuring that the sector is prepared and risks are managed in areas such as workforce, health security and healthcare supplies.

1.8 The Department's budgetary position continues to be hugely challenging, with the Department facing a funding shortfall in respect of forecast inescapable pressures necessary to maintain existing services. Rebuilding HSC services whilst simultaneously dealing with the ongoing COVID-19 pandemic will require additional sustained funding and investment.

2. COVID-19 IMPACT ASSESSMENT

2.1 The Department has collated a comprehensive assessment of the impact of COVID-19 across primary care and community services; secondary care; and a wide range of programmes and projects. This detailed assessment has been published in three separate Appendices[1], alongside this Strategic Framework. This section summarises the key impacts across these areas and also highlights some of the emerging wider population health impacts.

2.2 It is important to stress that the information included in this section and in the separate appendices was collated quickly with the intention of providing a high level illustration of impact. Please note that waiting time figures only include data that was available on the Patient Administration System at the time of reporting, with some data excluded[2]. Given the urgency in developing this Strategic Framework and associated service rebuilding plans, the data in this section and in the appendices has not been subject to any detailed data verification processes. The data is therefore provisional only and is subject to change. It has nevertheless been published in the spirit of openness and transparency.

Primary and Community Care

GP / Dental / Ophthalmic Services

2.3 COVID-19 has had an adverse impact across primary care and community services. GP appointments have reduced by 19.4% compared to last year. In addition to normal business, GP practices are receiving large numbers of COVID-19 related queries.

2.4 There has also been a marked reduction in the availability of dental and ophthalmic services with a minimum service focused on emergency care. In respect of emergency dental care this is provided through the Urgent Dental Care Centres that have been established in each HSC Trust. The net impact of the restrictions is that whilst 50,000 patients would have visited a dental practice each week in normal circumstances, this has reduced to around 2,000 (a 96% reduction) currently whilst there has been a 72% reduction in sight tests.

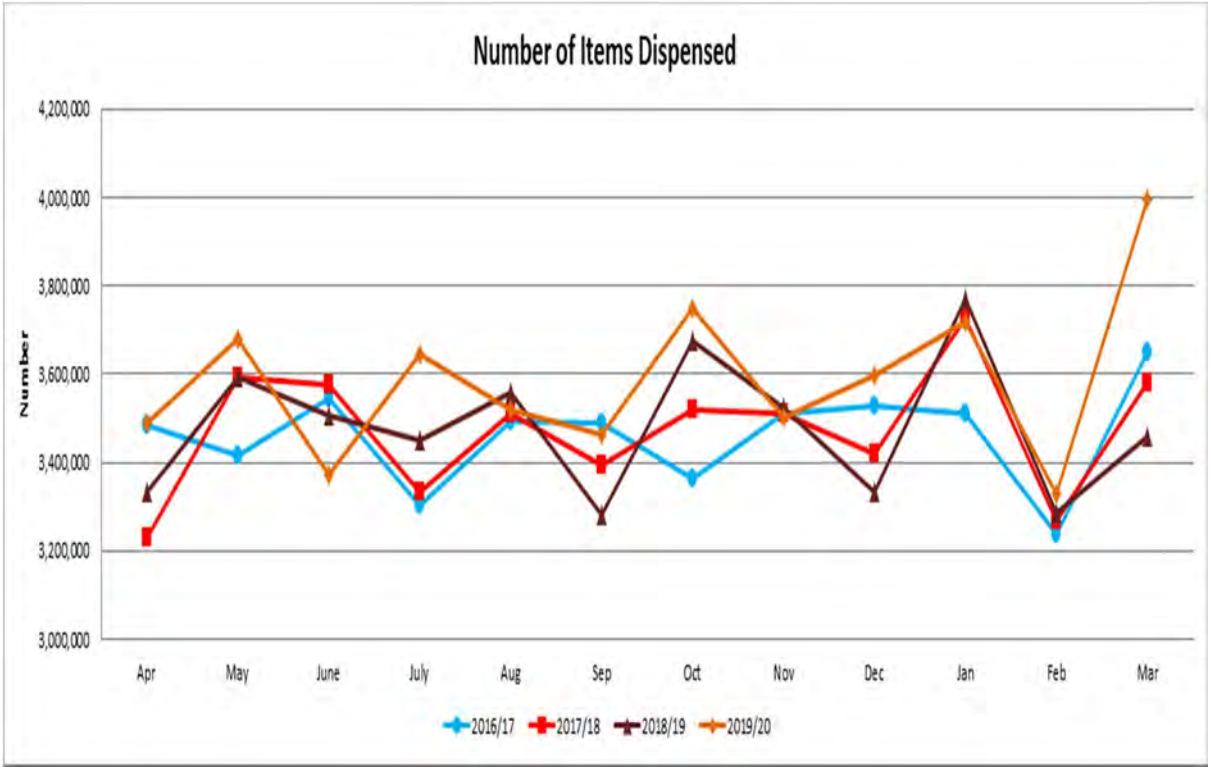
[1] Appendix A: Impact on HSC Services, excluding secondary care.
Appendix B: Impact on secondary care.
Appendix C: Impact on programmes and projects.

[2] The following Trust data is not included: Belfast - Community Paediatrics, Rehabilitation, Learning Disability, Old Age Psychiatry, Genito-urinary Medicine; Northern – Community Paediatrics; Southern – Genito-urinary Medicine; and Western – Learning Disability, Genito-urinary Medicine.

Community Pharmacy Services

2.5 Information is only now emerging on the impact of COVID-19 on community pharmacies. This is exemplified in prescription volumes which show an increase of 15.2% in total prescription items dispensed, which exceeded 4 million items in March. In reality, community pharmacies across the country experienced a huge surge in demand for prescription and over the counter medicines from mid-March (figure 1 below), placing acute strain on pharmacy staff and business owners.

Figure 1: Prescription Volumes by Month



2.6 A number of rapid interventions were needed to sustain the service through the initial emergency phase. These interventions saw the standing down of non-essential services and commissioning of new services to meet emerging population health needs.

2.7 Additional pressures also emerged. The high numbers of people shielding, self-isolating and the government message to “Stay at Home” resulted in an increase in requests for prescription deliveries. General practices encouraged the public to use prescription collection services to reduce footfall through GP practices. This resulted in a greater expectation from the public for collection and delivery services for prescription medicines, none of which was

commissioned. Against rising demand, community pharmacy experienced significant pressure in relation to workforce resilience. In the earlier stages of the pandemic response, staff capacity fell to below 70%. In recent weeks, it has improved to 80%.

Community teams

2.8 Community Allied Health Professional (AHP) services and community nursing services have been severely disrupted, negatively impacting patient access to community rehabilitation and recovery; assistance to support and maintenance of independent living; and the management and control of long term conditions. The demands on community teams has increased with district nursing and acute in-reach teams supporting vulnerable clients in care homes.

2.9 Health visitors have been relocated to provide care and services where needed resulting in a reduction of the number of health assessments and home visits which means issues in relation to health and development of children may not have been identified early. Closure of the schools has meant the school vaccination programme and health appraisals have been unable to be completed. This will need to be addressed when schools reopen.

Screening Programmes

2.10 Many adult screening programmes were paused from the second week of March 2020 in response to the COVID-19 pandemic. The purpose in pausing these programmes was to reduce the risk of COVID-19 infection in people eligible for screening programmes and to ensure that adequate healthcare and laboratory resources could be redirected to the pandemic response. As a result, the number of screening tests carried out in the adult programmes which were paused has fallen very significantly since the middle of March 2020.

2.11 Screening has continued to be offered for people who require higher risk breast screening, diabetic eye screening for pregnant women, newborn blood spot screening, newborn hearing screening, antenatal infections screening in pregnancy and ‘smear’ tests for non-routine cervical screening such as repeat tests requested by colposcopy or the laboratory.

2.12 Breast assessment clinics for women who have previously been recalled for assessment following mammography continue to be held within our screening centres.

2.13 Colposcopy clinics offering further assessment following a cervical screening test are also still being held where possible and tests for people who have recently been screened will continue to be processed and results sent to GPs for onward communication to patients.

Mental Heath

2.14 The impact of COVID-19 on mental health is expected to be severe. International evidence indicate short and long term direct effects on mental health and psychological wellbeing, and in some cases increased suicide and posttraumatic stress disorder (Lancet 2020; 395: 912–20). The causes of the direct effect on psychological wellbeing are identified as social distancing and isolation, bereavement, unemployment, financial hardship, inability to access health and social care services and increased stress due to work pressures. Further it is expected that the prevalence of mental disorder and mental illness will increase. Evidence from World Health Organisation (WHO) and academic research indicate that the pressures are expected in already vulnerable groups, with an increase of depression in women, increased rates of depression and anxiety in the older population, and those with severe mental disorders felt to be especially vulnerable during emergency situations.

2.15 Early indications in Northern Ireland support this research. Whilst most early intervention, prevention, mental health and suicide services reported an initial decrease in demand, this has now turned into an increase in pressures. Mental health in-patient bed occupancy (for those with the most severe mental illness) showed a 15% drop in demand between middle of February and end of March. However, since the second half of April demand has increased significantly and the daily bed occupancy levels are now around 95%.

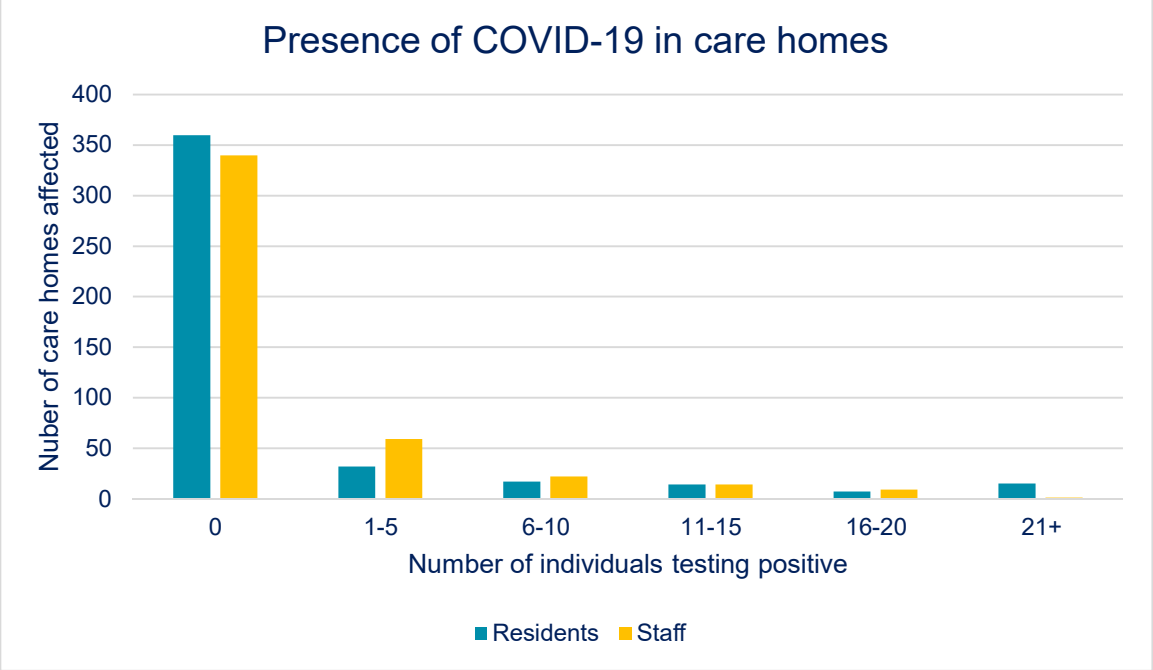
2.16 Anecdotal evidence from clinicians also indicates an increase in acuity of those presenting with severe mental health problems, and a larger number of new presentations, previously unknown to mental health services. Early indications links this with the effects of reduction in face to face contacts, in the health services and wider society, and stress related to the pandemic.

Social Care

2.17 COVID-19 has highlighted the fragility of the adult social care sector and a wider and fundamental reform of adult social care will be required. In contrast to other areas of the health system, the ongoing nature of the service limits the potential to create capacity by reducing or restricting access to the service. In particular, care homes remain in the surge period of the pandemic with pressures evident in the presence of COVID-19 among care home residents and staff.

2.18 A recent survey of care home providers indicated that 19% of providers who responded were caring for a resident who had tested positive, while 23% of providers who responded had employees who had tested positive. The chart below shows both the number of care homes affected by COVID-19, and the extent of COVID-19 presence within those homes through analysis of the number of positive tests within each home:

Figure 2: Number of homes affected by COVID-19 - May 2020



2.19 The provision of domiciliary care has also been affected, with many recipients choosing to rely on informal care due to concerns about the transmission of COVID-19 by domiciliary care workers entering their home. Anecdotally these concerns have also impacted on the way some direct payments are used. The long term impact of this is difficult to forecast but, anecdotally, demand for formal care packages is returning. There may be a requirement for increased levels of care – whether in care homes or in people's own homes – where individuals have suffered from COVID-19 and their longer term care needs are more acute as a result.

2.20 A number of other important support services have been affected by COVID-19. For instance, Trust day centres and respite services have generally stopped. The staff and resources associated with those services have been redirected to provide more intensive support to families in their own homes. Trusts are currently discussing how services can be restarted in a way that provides much needed support and respite but also minimises infection control risks.

Vulnerable Children

2.21 The lockdown regulations and public health restrictions have created new, or exacerbated existing challenges and risks for many vulnerable children, young people and their families. Children and young people are potentially at a greater risk of harm in the home, as evidenced by increased domestic abuse rates. They are also exposed to risk from outside the home, including the risk of online grooming and exploitation. Lockdown restrictions have created a

range of pressures, including financial pressures. Many families, including those with a child with a disability or complex health problem, are not able to access the same level of support from services as pre-lockdown. Access to health services has been more limited and school closures have created particular challenges for families as they try to balance home life and online learning. Families are more isolated, prevented from accessing the support of wider family networks. Children generally have been less visible than before and this was reflected in a reduction in the number of referrals in the early stages of the pandemic. However, the number has steadily increased over time and now exceeds the number received during the same period last year; this is likely to be as a result of building pressure and challenges within the family home.

2.22 Since the introduction of stay at home policy, leading to school closures, there has been a shift in the source of referrals. Referral sources (from three HSC Trusts for which we have information), show half (47%) are from police, compared with 31% in year ending 31 March 2019. Referrals from schools are down from 9% to 1%.

2.23 Throughout the period Social Services Gateway Teams have continued to operate in line with normal operating arrangements and statutory duties, maintaining contact with families, using technology where face-to-face visits were not possible. Social Work Managers have closely overseen all cases to ensure appropriate risk assessments were carried out, taking full account of public health advice and guidance relating to COVID-19.

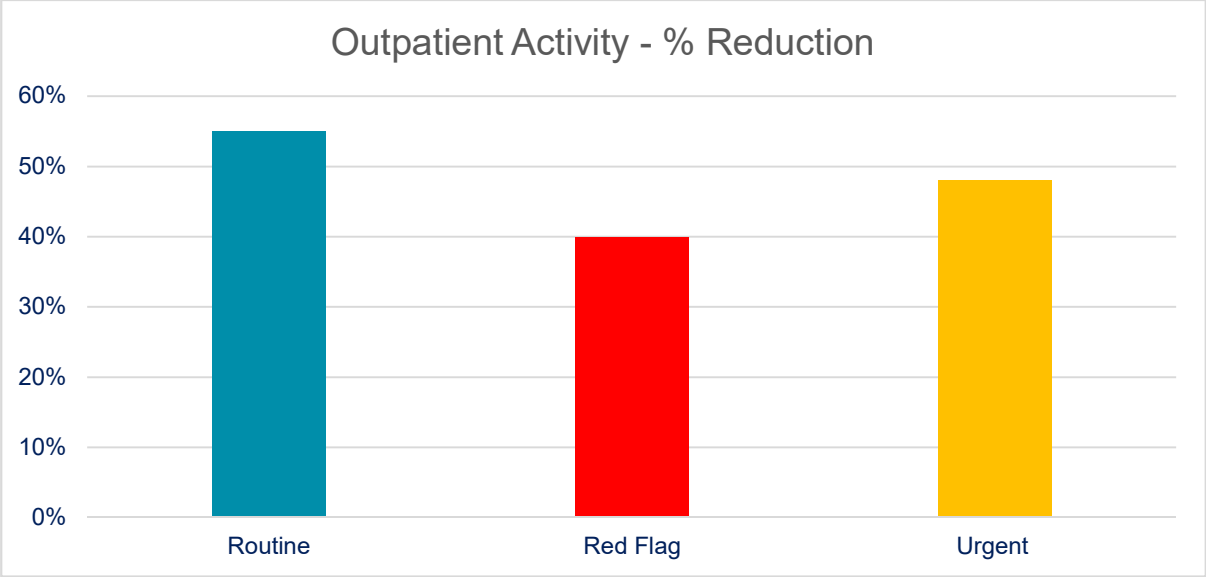
2.24 It is anticipated and evidence is beginning to emerge that that the prolonged period of lockdown will result in increased demand for children's social services.

2.25 The Department is leading on the development of a cross-departmental plan that reflects the activities that will be or have been undertaken across government to meet the needs of vulnerable children, young people and their families during this time and to prepare for service recovery.

Secondary Care

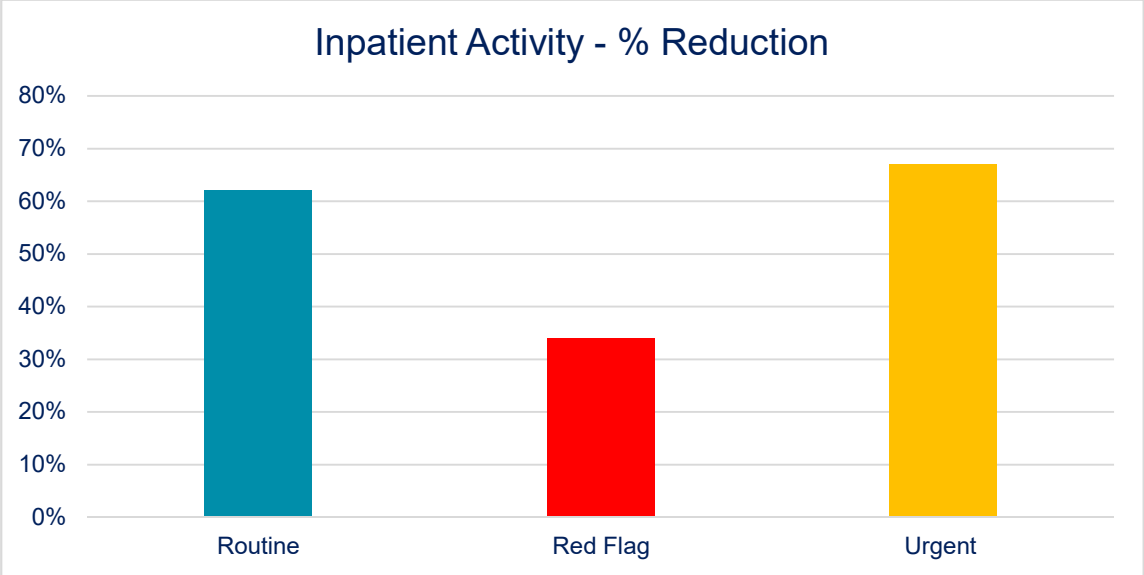
2.26 The pandemic has had a devastating short term impact on secondary care activity, particularly elective care. Figure 3 below shows the reduction in outpatient activity, compared to same 6 week period last year:

Figure 3: Reduction in Outpatient Activity 9 March – 13 April 2020



2.27 The situation is similar for inpatient activity, with severe reductions in activity compared to the same 6 week period last year:

Figure 4: Reduction in Inpatient Activity 9 March – 13 April 2020



2.28 The very significant downturn in secondary care activity has also, as expected, impacted on waiting lists (except for the urgent inpatient waiting list, which has reduced marginally compared to 1 April 2019). As of 1 April 2020, compared to 1 April 2019, waiting lists were impacted as follows:

- Routine inpatient waiting list grew by 5%.
- Urgent inpatient waiting list grew by 31%.
- Routine outpatient waiting list grew by 4%.
- Urgent inpatient waiting list reduced by 1%.

2.29 Projections by the Trusts suggests that the 6 weeks to June resulted in similar reductions in activity. This will further impact adversely on the waiting lists. Also, since the latest available comparable waiting list data is as of 1 April, waiting lists will already have increased in the intervening period.

2.30 Urgent and Emergency care has also been impacted with a 47% reduction in Emergency Department activity across Northern Ireland, compared to the same period in 2019 (9 March – 13 April).

Cancer Services

2.31 The down turn in red flag demand through April and into May means that all Trusts outside of Belfast currently report that all patients who are suitable to be listed for surgery have a scheduled date, either locally, or within the Independent Sector facilities secured by HSC. However, red flag demand is starting to increase again and this will result in an increase in the demand for surgery.

2.32 The development of the Nightingale Hospital on surgical and ICU capacity across the Belfast Trust has inevitably impacted on specialist surgical provision. The Belfast Trust has introduced measures to mitigate against this. The Belfast Trust recommenced specialist surgery w/c 25 May 2020 in Belfast City Hospital now that the Nightingale Hospital has been stood down.

Programmes and Projects

2.33 COVID-19 has curtailed a large range of projects and programmes across the Department, as staff have been redeployed to manage the pandemic. Of particular note is the impact on delivery of the priorities set out in the New Decade New Approach document. These are summarised below:

Table 1: NDNA Priorities

NDNA Priorities	Risk Rating – Anticipated delay in Delivery
Extend publicly funded IVF Cycles from 1 to 3	Amber
Develop Cancer Strategy by December 2020	Red
Improvements will be made in day case elective care by the end of 2020	Red
Improvements will be made in Urgent and Emergency care by the end of 2020	Red
Improvements will be made in stroke by the end of 2020	Red
Improvements will be made in breast assessment by the end of 2020	Red
Deliver reforms of health and social care as set out in Bengoa, Delivering Together and Power to People Reports	Amber
Mental Health Action Plan within 2 months.	Green[3]
Mental Health Strategy by December 2020.	Red
Successor strategy and action plan to the Strategic Direction for Alcohol and Drugs Phase 2?	Amber
An extra 900 Nursing and Midwifery undergraduate places over three years	Green
Introduce a new Action Plan on Waiting Times	Red
No one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021	Red
Build capacity in general practice through the ongoing rollout of Multi Disciplinary teams to cover a further 100,000 patients by March 2021.	Amber
The Executive will provide increased investment to fully implement service improvements for palliative and end of life care including enhancing the contribution of hospices; and to increase support for palliative perinatal care.	Red
The Executive will expand university provision at Magee in line with commitments made by the previous Executive, including through the establishment of a Graduate Entry Medical School.	Amber (from DoH perspective - cross cutting issue)

Key: Red: High Risk of Delay; Amber: Medium risk of delay; Green: On target for delivery.

[3] Mental Health action Plan published on 19 May 2020.

2.34 As well as recognising the impact of COVID-19 on these projects and programmes, it is also important to record that the Department's Budget 2020/21 outcome did not provide any additional funding to support the delivery of these priorities. Public expectations were raised considerably by the New Decade New Approach document, but the accompanying financial settlement did not provide the funding necessary to deliver these priorities.

2.35 The ability of the Department to re-engage and deliver on these projects will continue to be constrained against the backdrop of COVID-19 and in the absence of additional funding.

Population Health Impacts

2.36 The introduction of the lockdown regulations was essential in controlling the spread of COVID-19. However, they have impacted on the wider economic and social environment, with both long and short term impacts on population health. Emerging research indicates that population health is highly likely to be negatively affected by the wider impacts of COVID-19, with the greatest effects felt by the most disadvantaged. There is emerging evidence that many key health behavioural risk factors, such as consumption of alcohol, are likely to be worsening. In addition, public health surveillance has been disrupted and emerging evidence also suggests that the disease burden from conditions such as mental health is already rising. The development and management of long term mental health conditions is also likely to be negatively affected.

2.37 The Department commissioned an initial analysis of the wider impacts of COVID-19 and the associated regulations on population health outcomes. This has been supplemented with analysis at the UK level. This analysis considered economic factors; reduced access to public sector services; interrupted access to social/family networks, and reduced access to other goods and services. While there are both positive and negative impacts of the regulations on wider public health, overall the analysis suggests that the net effect of the measures (excluding direct COVID-19 related mortality and morbidity) is negative. There is comparatively little research into the longer-term health impacts of economic crises. However, it is widely observed that structural changes and/or deep economic downturns tend to have very strong impacts, mainly through deprivation, which can be very long lasting. The literature also points to long term impacts on chronic disease prevalence due to recessions.

2.38 It is therefore likely that any growth in life expectancy will stall and perhaps even flatten in the wake of COVID-19. In terms of the social determinants of health, there are likely to be negative impacts on poverty, employment, economic security, and potentially educational attainment. The impact on housing and

social capital is unclear at this stage. There are likely to be positive impacts on air quality and water quality, which will counterbalance some of these impacts.

2.39 There have also been changes emerging in terms of health related behaviours, such as smoking, alcohol consumption, physical activity and road safety. While these impacts differ for each behaviour, again the net effect is likely becoming increasingly negative the longer the restrictions remain in place. The biggest negative impacts on disease outcomes are likely to be in respect of mental wellbeing and the development and management of long-term mental health conditions.

2.40 The analysis also highlights that the wider impacts of COVID-19 are likely to increase health inequalities, with those who live in the most deprived communities most at risk.

3. MISSION

3.1 The impact of the pandemic across HSC services, programmes and projects has been devastating, as resources have rightly been focused on the required emergency response. COVID-19 will be with us for some time and will continue to constrain service delivery across the HSC sector. In that context, the following mission statement will apply as an overarching principle:

To incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing COVID-19 conditions. The aim will be to maximise service activity within the context of managing the ongoing COVID-19 situation; embedding innovation and transformation; incorporating the Encompass programme; prioritising services; developing contingencies; and planning for the future all at the same time. Specific service activity targets will be developed for each programme of care.

3.2 The remainder of this document sets out a road map on how this mission will be achieved. Service innovations that have emerged in recent months are set out in Section 4. In addition to those innovations, the intention is to, where possible, incorporate 'quick wins' from the transformation programme that had been gathering pace until the pandemic emerged, with the purpose of increasing service capacity. It will also be important that the ongoing Encompass programme is at the heart of rebuilding services.

3.3 Section 5 sets out the overarching approach to developing service stabilisation plans, with the aim to maximise activity in the context of the constraints and issues that COVID-19 presents. This will lead to incremental service activity plans and targets being developed for each programme of care / specialty to be updated in three monthly cycles for the period June 2020 to March 2022. If possible, the planning cycles will be extended if the prevalence of COVID-19 in the community improves. Section 5 also includes information on the regional approaches taken to treating COVID-19 patients; guidance on prioritisation of surgery; and the Testing Strategy, amongst other things.

3.4 Section 7 presents some early example demonstrators indicating what service delivery might look like in the next three months. These demonstrate that services will only be able to be switched on slowly and incrementally. Given the huge amount of uncertainty around the continued spread of the pandemic, it is only considered feasible to take a 3 month planning horizon at this stage.

4. SERVICE INNOVATION

4.1 The emergency response across primary, community and secondary care services has resulted in innovative new practices that could potentially be mainstreamed as normal services are resumed. Innovation has emerged across all services and some examples of these innovations are described in this section.

4.2 Embedding recent innovations, along with transformation activities already underway, into service delivery will be an important strand in achieving the mission set out in Section 3 above.

Primary Care

COVID-19 Centres

4.3 Eleven Primary Care COVID-19 Centres have been established across Northern Ireland. Between 9 April and 6 May 2020, GP practices dealt with 23,441 COVID-19 related queries. A total of 3,702 patients who contacted their GP, or out of hours service, were triaged and referred to one of the COVID-19 Centres. 75% of these patients were provided with advice on self-management; 15% were referred to secondary care; and 10% were referred to other services.

4.4 The COVID-19 Centre model has been successful in separating Covid and non-Covid services, reducing the risk of infection and allowing GPs to protect and continue a range of ordinary primary care services such as vaccinations. The COVID-19 Centres have also proved highly effective in dealing with a high level of demand and in effectively triaging and advising patients. This has undoubtedly reduced pressures on our Emergency Departments.

4.5 In view of the potentially lengthy timescales before a vaccine is available, it is likely that COVID-19 Centres will continue to be needed in the short to medium term. However, some changes in configuration may be required in response to the emergent contours of the pandemic. Given the clear benefits of the approach, consideration will need to be given to what can be learned from the model and what elements ought to be retained to support longer term transformation of the HSC. In particular, the effectiveness of the primary care partnership with HSC Trusts and the benefits of greater joint working and resource sharing between primary and secondary care.

4.6 The model has also demonstrated the value of an independent, federated primary care sector. With strong leadership from the Health and Social Care Board (HSCB), the British Medical Association (BMA) and the Royal College of General Practitioners Northern Ireland (RCGPNI), GPs were able to move quickly to establish and operate the COVID-19 Centres. The first centre

opened within 12 calendar days of the first discussion of the potential for the model. This swiftness was made possible by active and committed leadership in the sector capable of bringing GPs with them.

4.7 The Department and HSCB will now consider the future use of COVID-19 Centres in discussion with BMA and RCGPNI.

Telemedicine / Video Consultations

4.8 The use of telephone triage and video consultations is now widely embedded within the primary care sector. All patients are now subject to telephone triage for around 5 minutes. Whilst exact figures are not available, it is clear that this triage addresses issues for a significant number of patients, thereby reducing numbers needing a more detailed consultation. This consequently reduced pressures on GP surgeries. The outcome has delivered a transformational impact and there are therefore clear benefits to continuing this operating model.

4.9 Video consultations, which were previously only carried out in very low numbers, are now also widely embedded within the service. Where a face-to-face appointment is not necessary, video consultations provide a more efficient model of GP to patient contact and the widespread use of technology should be incorporated into the service going forward. It is recognised that for some patients, face-to-face consultations remain the most appropriate model and will be retained in those cases. Looking ahead, there is also the potential to use this technology to work more closely with secondary care, for instance with video consultations between patients, GPs and hospital specialists.

4.10 The primary care sector will now consider the continued and expanded use of telephone and video technology in delivery of GP services. The sector will also consider ways to integrate more effectively with other sectors.

4.11 Face-to-face interpreting involving deaf service users also virtually stopped except in very exceptional cases. By way of mitigation, a new temporary free remote interpreting service for British Sign Language (BSL) and Irish Sign Language (ISL) users to access NHS111 and HSC services was procured. This was funded by the Department with support from the Department for Communities and ensures that deaf people can access vital information and support during the COVID-19 pandemic.

Multidisciplinary Teams (MDTs)

4.12 During the pandemic, MDTs including nursing, physiotherapy, mental health practitioners and social workers have emerged as an essential part of the primary care response, delivering essential support to vulnerable people at a

time of extreme need in the community. Anecdotally, GPs report that access to these workers has demonstrated significant benefits for the wellbeing of patients and for the effective delivery of primary care services in relevant practices.

4.13 In view of the substantial mental health challenges that are evident, there is a strong argument that MDTs could form part of the recovery effort in this regard, bringing mental health support to the community level, accessible directly through GPs. As COVID-19 Centres have demonstrated, when properly resourced, primary care can successfully reduce demand on secondary care services. Indeed, more broadly, there is clear potential in the MDT framework to improve access to patients for a range of services and to further reduce demand on secondary care. On this basis there is clear merit in exploring the role that MDTs and primary care could play in reshaping the system during the rebuilding phase.

4.14 The primary care sector will be asked to produce proposals for the role of MDTs in the future delivery of health services.

Allied Health Professional (AHP) Workforce

4.15 During the pandemic the value of skill mix and staff working at the top of their professional licence in advanced and extended roles has enabled primary and secondary care services to be responsive to the emerging complexity and volume of demand. There is clear potential to extend the role and scope of advanced nurse practitioners, specialist AHP's and consultant nurse and AHP roles to maximise the capability and flexibility of the workforce to aide rebuilding of services.

Pharmacy

Community Pharmacy Services

4.16 Community pharmacies adapted their working practices and many introduced technology to streamline prescription ordering and collection services and reduce waiting times for patients. A new emergency supply service was introduced which provided access to prescription medicines in the event that a patient had run out of their repeat medicine and they could not access their GP. Pre COVID-19, this would have been a key component of the GP Out of Hours Services workload. An enhanced on-call palliative care medicines service was also provided to support end of life care for patients at home and in care homes. To manage some of the demand on pharmacies for medicines deliveries, the HSCB worked with the Community Development Health Network to incorporate the use of volunteers to support deliveries of medicines from pharmacies. By

the end of May a total of 252 pharmacies and 120 community groups had registered for the scheme and over 33,000 prescriptions have been delivered by volunteers registered on the scheme.

Pharmacy Services in Trusts

4.17 Pharmacists and pharmacy teams in Trusts adapted their working practices and introduced new and innovative solutions to ensure that their patients received the right medicines, safely and effectively. This included a wide range of initiatives across all sectors, developed in collaboration with a wide range of stakeholders.

4.18 In Intensive Care, clinical pharmacists and clinical technicians joined their colleagues in critical care teams. Aseptic services in hospitals produced batch IV medicines to meet rising demand. Processes for the standardisation of critical medicines and a dedicated COVID-19 Kardex were introduced. Trusts skilled up their clinical pharmacy teams to provide seven day services. Pharmacists used technology to hold virtual clinics to maintain contact and support for patients taking specialist treatments including anticoagulants, ESA, chemotherapy and rheumatology. Renal transplant education for carers was provided for 42 transplant patients via Zoom. Specialist medicines home delivery systems, using Trust transport, were implemented to ensure that patients in high risk shielding groups received their treatment without interruption. Rapid sequence induction packs were introduced in ED and changes introduced to addiction services and to introduce in-possession medicines in prisons.

4.19 New regional systems were established to model and monitor critical healthcare supplies essential for the COVID-19 response including critical care medicines, oxygen and clinical consumables. Victoria Pharmaceuticals worked with the HSCB to supply medicines to COVID-19 and Out of Hours Centres. New systems were developed to monitor stock remotely and conduct stock checks in COVID-19 Centres and action cards and standard operating procedures for medicine management were established.

Pharmacy support for care homes

4.20 Pharmacy teams from the HSCB implemented a system to provide anticipatory care boxes to care homes for palliative care and to provide increased access to oxygen. Consultant pharmacist team members in Trusts joined with practice based pharmacists to participate in virtual ward rounds for care homes. Training sessions were provided by pharmacists to care homes staff on swallowing, pandemic packs and palliative care. Trust pharmacy teams supported the

establishment of the community hospitals at the Ramada and Everglades hotels.

Ophthalmology

4.21 Ophthalmology is a high volume specialty and one which is particularly susceptible to demographic pressures. As a specialty it currently accounts for 10% of all outpatient appointments, and, in elective care, cataract surgery is the highest volume surgical procedure in the developed world, and one which scores highly in terms of quality of life benefits. COVID-19 has given an opportunity for ophthalmology teams to take forward significant innovations such as:

- reviewing care pathways;
- reviewing referrals and patient notes;
- carrying out risk assessments and prioritisation in preparation for re-engagement of services;
- validating waiting lists, discharging where appropriate; and
- a move to virtual video and telephony consultations where possible.

4.22 Throughout this process ophthalmology has focused on its communications with patients, with many being contacted by telephone to discuss concerns and arrange appointments as required. Approximately 75% of urgent appointments were converted to telephone or video reviews. A video was produced to inform patients of safe practices in the Macular Unit to encourage attendance, as most patients are at increased risk due to age and diabetes. The short video clip, which has been shared on social media, reassures patients attending appointments about the measures put in place to best protect patients attending the unit.

4.23 The Belfast Trust Cataracts Team has maintained approximately 15% of cataract surgical activity through Lockdown, focused on patients most in need. This allowed the service the opportunity to test the cataract surgery pathway in the COVID-19 climate. The diabetic eye service has continued to provide treatment (laser and injection) appointments for the most urgent of patients at high risk of irreversible sight loss.

4.24 The Belfast Trust identified hundreds of review patients on glaucoma waiting lists who required only a check of their intraocular pressure. The Trust wanted to offer patients a way of getting their pressure checked without needing to attend the clinic. They developed the concept of a ‘drive thru’ where the patient gets a pressure check with the new ICare device whilst they remain in their car.

4.25 During the COVID surge, the Paediatric Eye Team ran all day clinics and accepted all paediatric eye emergencies from A&E. Across ophthalmology the

focus is now on incrementally rebuilding services taking account of the constraints arising from COVID-19 and ensuring that the new and innovative practices are permanently embedded.

Secondary Care

Use of Technology

4.26 The secondary care sector has, like primary care, now adopted use of technology such as telephone and virtual clinics to a much greater extent. This is the case across all of the Trusts and across a range of specialities. Within Belfast Trust, for example, Outpatients appointments have, where possible, moved to telephone appointments, consultations and essential communications. Before COVID-19 phone appointments accounted for 3% of new, and 2% of review, outpatient appointments. The comparable figures now stand at 36% and 46% respectively. Also within Belfast Trust the number of specialties using telephone clinics has increased from 25 to 55. In addition, a growing number of specialties are adopting virtual clinics using video conferencing. This approach to use of technology is replicated across the HSC Trusts.

4.27 Broadly the benefits of these technology models include reduced travel time and easier access to services for patients; less time spent in hospital for patients; and more flexible working and timetabling for staff. Technology should continue to play a significant role in the delivery of secondary care, where possible and appropriate. It will be important that clear criteria are adopted identifying which patients are suitable and the circumstances in which virtual or telephone clinics are appropriate.

4.28 Some of the early experiences of using technology suggests some issues such as withheld numbers or patients not answering. It will be important to collect data on these issues to ascertain if missed appointments are more prevalent using technology than face-to-face.

4.29 Trusts must now consider the continued use of technology in delivery of secondary care services, where appropriate.

Social Care

4.30 Many adult social care services have adopted new and innovative ways of working. For instance, care homes have made use of technology to connect residents with their families, through video-calls, and to enable 'virtual ward rounds' by GPs or other professionals with care homes residents. This has helped limit the physical footfall in and out of homes. The use of technology to monitor vital signs and residents' activities of daily living via a digital remote monitoring platform is being implemented by all Trusts. The identification of

residents requiring timely clinical assessment by a Registered Nurse or Doctor at an early stage is a key step in minimising the numbers of residents who clinically deteriorate in residential settings with presentations of COVID-19.

4.31 Many care homes have adopted innovative new ways of working, such as staff living in homes or creating separate changing areas as ways of trying to minimise the spread of infection. Homes have also been innovative in running activities for residents, while complying with social distancing rules.

Mental health

4.32 Mental health services have, like many other services areas, adapted to remote working, with extensive use of phone services and video communication. There are some indications that the use of remote working has improved efficiency of services, which may help reduce waiting lists post COVID-19. Further work is ongoing to evaluate this.

4.33 Other alternative methods have also been used. The HSC has partnered with ORCHA (The Organisation for the Review of Care and Health Apps) to create a library of health and wellbeing apps that have been reviewed and rated as helpful, safe and secure. As the library develops it will allow clinicians and wider professionals to "prescribe" and allocate apps to clients as appropriate.

4.34 Stress management support has also been provided using alternative channels, through Stress Control. This is a clinician-led service, available free of charge online through a collaboration across the UK nations and Ireland. It comprises of a six-session, cognitive-behavioural therapy class and is available free of charge. It runs over three weeks with two sessions a week. Work has also been escalated to develop and make psychological first aid available across Northern Ireland. The HSC has, in collaboration with the Red Cross and NHS Education Scotland, made available interim guidelines and a short E-Learning module on Psychological First Aid.

4.35 Subject to funding, Multidisciplinary Teams (MDTs) could enhance their focus on delivering mental health services to help meet the need emerging in the post lockdown period. MDTs provide direct, swift access to community services and could, if properly resourced, provide early access through general practice to mental health support and other related services. This could take the form of increased recruitment of mental health workers and social workers; better connections with community services; social prescribing; and developing shared services with secondary care; for example, Talking Therapies Hubs. Such an approach would both provide direct access to mental health services to meet the anticipated surge and would divert demand away from more specialist secondary services for those with more acute mental health issues.

4.36 As part of the COVID-19 Mental Health Response Plan published on 19 May 2020, review mechanisms will ensure that learning from alternative ways of working will be incorporated in service developments moving forward.

5. INCREMENTAL SERVICE CAPACITY PLANS

Overarching Approach

5.1 All HSC service providers will adopt a systematic and consistent approach to developing service specific incremental plans to increase capacity, under the auspices of this Strategic Framework. This will involve mandating the wide range of existing managerial clinical networks, project boards, task and finish groups or other service improvement vehicles to produce service specific incremental plans for their respective areas on an integrated and coordinated regional basis.

5.2 This will be achieved by reviewing the existing patient pathways, applying a range of COVID-19 factors (as summarised in the Checklist below) and producing revised patient pathways to implement rebuilding of services within the context of prevailing COVID-19 conditions.

5.3 The revised pathways will address the checklist considerations set out below and will produce revised activity levels for service providers to aim to deliver. The initial set of activity levels will cover the 3 months from July to September 2020. It is not considered feasible, at this stage, to produce plans beyond a three month planning period.

Checklist

5.4 A range of factors are likely to apply in the consideration of revising pathways and activity levels in the context of COVID-19. These are likely to include all, or some, of the issues set out below. Service providers must take account of all items that are applicable:

Communication with Patients

- Provide clear and consistent information to patients, clients and their carers, in an appropriate format, to reassure them that services are of the highest possible quality and they can re-engage with health and social care with confidence.

Staff Involvement

- Ensure you have a consistent approach to meaningful involvement of staff in developing solutions and in decisions which affect their working lives.

Working Environment Risk Assessment

- Ensure that you have an up-to-date risk assessment of the holistic working environment (reflecting the interdependencies between different services) in

which you will be seeing patients, clients and individuals who accompany them. You must ensure that the risk assessment addresses the risk of COVID-19 to reduce risk to the lowest practicable level by taking preventative measures, in order of priority, recognising that you cannot completely eliminate the risk of COVID-19.

- If feasible and appropriate, share the risk assessment with your workforce and the public by placing this on your website.

Infection Prevention and Control Measures

- Assess the need and provide appropriate Personal Protective Equipment (PPE) for HSC staff, by following PHA guidance, required for screening, diagnostics, treatment and social care in all HSC settings.

- Assess the need and provide appropriate Personal Protective Equipment (PPE) for specific patient groups or individuals on a risk-assessed basis within the context of regional and national guidance on PPE and taking into account the regional electronic PPE Modelling system.

Social Distancing

- Adhere to the extant social distancing requirements within all screening, diagnostic and treatment/care settings across primary, community secondary and social care sectors.

- Assess the impact of constraints on physical space for service delivery, for both patients and staff, arising from social distancing requirements.

- Assess the requirement for patients to be accompanied, taking account of the procedure or service being accessed and the individual needs of the patient and put in place protocols for safe practice.

Workforce

- In line with the Workforce Strategy, protect and support the HSC workforce by taking action to ensure the care and resilience of staff working in all HSC disciplines.

- Induction and training should be provided for staff members whose working environment has changed or who are redeployed to areas outside their normal practice.

Planning Service Delivery

- Where possible an appraisal of patient waiting lists should be undertaken to re-evaluate clinical urgency, with those with the highest clinical need appointed as a priority. This should be taken forward on a regional basis as appropriate. Patients should be updated on the rationale for any delays to their appointment in an appropriate format and signposted to support/information in the interim.

- In the planning of screening, diagnostic and treatment/care service delivery in all settings across primary, community secondary and social care sectors, assess the risk of reduction in activity throughput arising from requirements for social distancing and PPE.

- In the planning of appointments in all settings take account of the requirements for social distancing in HSC premises and public transport.

- Assess the available capacity and timescales for the reintroduction of aerosol generating procedures (such as with minimally invasive surgical techniques) and the impact on theatre schedules, length of stay and waiting times; and, align these factors with PPE requirements.

- Planning for rebuilding HSC services should take account of the potential for a further significant COVID-19 surge during autumn/winter which, if it materialises, would impact adversely on rebuilding HSC services.

Diagnostic Services

- Take account of the impact of the additional demand for COVID-19 testing in Labs and its potential impact on the capacity for diagnostic testing for non-COVID-19 service delivery when planning scheduled elective treatment, primary and community care service delivery.

- Recognise that COVID-19 testing capacity is managed as a regional resource.

Medicines and Critical Healthcare Supplies

- Take account of constraints on the supply of critical care medicines in the UK that have the potential to impact on plans for recovery in elective surgery and other treatment interventions.

- Take account of how the public will maintain access to prescription medicines, treatments for common conditions and the advice of pharmacists through community pharmacies.

- Consider how the public will maintain access to specialist pharmacy services, medicines and treatments e.g. palliative care.

Pre-admission to Hospital

- In planning elective treatment for patients who are being admitted to hospital, take account of advice to require patients to self-isolate beforehand and that they may need to be tested for COVID-19 prior to surgery.

- The timescales will be informed by national guidance (which is not a strict requirement but guidance for clinicians). Recognising that this is an evolving environment, service providers should take account of the latest guidance, advice and protocols on testing and isolation. Please note decisions should be taken on the prevailing balance of risk for the patient.

New Ways of Working

- Identify opportunities to embed, build upon and sustain innovations in service delivery achieved during the initial COVID-19 surge, including digital innovation and skills mix in order to increase resilience.

- Ensure the principles of co-production are embedded in the rebuilding of HSC services going forward, along with the monitoring of activity and outcomes for our service user and patients.

Expert Advice

- Take account of advice from subject cells or expert groups which provide ethical, modelling, testing, PPE and social distancing policies, assessments and guidance.

Ethical Advice and Support Framework

- Guidance will be available to assist clinicians and managers in their decision making.

Discharge to Nursing or Residential Setting

- Take account of COVID-19: Guidance for Nursing and Residential Care Homes in Northern Ireland (April 2020) with reference to discharge, testing and isolation.

Testing Strategy

5.5 On 27 May 2020 the Department published its contact Tracing Strategy[4]. This Strategy aims to minimize COVID-19 transmission in the community, thereby saving lives.

5.6 The Department is also developing a Testing Strategy, which aims to reduce harm to individuals from COVID-19 and to support measures needed to protect the general population. Delivery of the Strategy is underpinned by an Interim Protocol on Testing, this is an operational tool which sets out the priority groups for testing. The protocol is subject to regular review by the Department's Expert Advisory Group on Testing and each update is cascaded to HSCB, PHA and Trusts. Service providers should deliver services taking account of testing priorities established in the Interim Protocol. The Protocol will continue to be reviewed on an ongoing basis and will be adjusted over time as additional testing capacity becomes available and as priorities for testing change as the pandemic evolves.

Co-production

5.7 It will be important that the incremental service rebuilding plans are developed through the application of co-production principles as far as that is possible. The speed at which these plans will need to be developed and adapted will undoubtedly act as a constraint on applying full co-production principles. However, where at all possible, service providers should engage in a timely manner as widely as possible in the development of their incremental service plans.

[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/Test-Trace-Protect-Support-Strategy.pdf

6. IMMEDIATE PRIORITIES

6.1 It is recognised that developing the incremental service plans will take some months. However, there is a need for immediate action in terms of increasing normal HSC service delivery. HSC Trusts have already commenced, where possible and safe in the COVID-19 context, the scaling up of services. HSC Trusts have produced and published plans for scaling up services in the period to 30 June to ensure action is taken in parallel with development of the incremental service plans. In developing the short terms plans, Trusts had regard to the above Checklist.

6.2 Further service rebuilding plans will then be produced covering successive three month periods from July 2020 to March 2022. These three month planning cycles will be kept under review and may be extended if the prevalence of COVID-19 in the community improves.

HSC Trusts Rebuilding Plans

6.3 The initial phases of COVID-19 significantly changed the level of service that Health and Social Care Trusts ("Trusts") were able to provide, both in order to prepare for the predicted demands of the pandemic, and in order to adapt to the new ways of working necessary to sustain services. As a first stage in developing the new Strategic Framework for Rebuilding HSC Services, Trusts have produced plans setting out how they intend to increase the level of service provision for the period to 30th June while also maintaining key elements of the COVID-19 response.

6.4 In developing their plans, HSC Trusts have adopted the following three principles:

- Ensure equity of access for the treatment of patients across Northern Ireland.
- Minimise the transmission of COVID-19.
- Protect access to the most urgent services for our population.

6.5 While there is some unavoidable variation of approach depending on local circumstances, Trusts have worked together to ensure that they take a consistent approach to rebuilding services. For all Trusts, the overriding priority is to keep patients, service users, and staff safe at all times while incrementally increasing activity.

6.6 During the first surge period, Trusts took steps to prioritise urgent or time critical activity in terms of both surgery and other cancer treatments, and other urgent conditions. As we move into the rebuilding phase, Trusts will continue to see and treat patients according to clinical need and services will be prioritised on this basis.

6.7 Similarly, in relation to daycase and diagnostics, including endoscopy, Trusts have prioritised inpatient, urgent and red flag investigations across all sites. Patients falling into these categories will continue to be the priority, but all Trusts are also increasing scheduled routine activity for daycase and diagnostics, albeit with reduced capacity due to infection control constraints.

6.8 All Trusts have maintained full access to urgent and emergency care services throughout the pandemic. Some of the short term service models introduced to allow Trust to do so will need to remain in place to allow Trusts to deal effectively with COVID and non-COVID activity. Further details can be found in individual Trust plans.

6.9 Across Trusts, some of the services that have been hardest hit have been those dealing with mental health, learning disability, and long term condition management for children and adults. Each organisation is therefore taking steps to increase provision or introduce new ways of working to allow these services to recommence. Trusts are also prioritising services relating to Looked After Children and Child Protection visits. In all cases, it is likely that continuing to deal with COVID-19 will continue to impact negatively on overall capacity.

6.10 In all Trust areas, staff have adopted and embraced new ways of working that have allowed them to maintain more of their professional and service roles with their patients and service users. In many cases, these changes have been technology enabled and have reduced the need for face to face contact while delivering safe and effective outcomes. The learning and sharing of best practice from these initiatives will help the service to maintain and increase activity in the coming months and years.

6.11 Further detail on the Trusts priorities to resume services in the immediate term is set out in their respective plans, published concurrently with this Strategic Framework.

Planning for a further potential COVID-19 Surge

6.12 Early in the preparations for the initial surge period, it was necessary to make assumptions about the percentage of hospitalised patients in different age bands who would be admitted to critical care. At this stage the best available modelling showed a significant increase in demand for hospital capacity and, potentially, a catastrophic impact on critical care. Acute service planning therefore focused on the rapid expansion of critical care and hospital capacity to ensure that every patient requiring treatment would receive it.

6.13 During the course of the epidemic clinical practice in relation to COVID patients has evolved and additional data have accumulated. It has become apparent that a smaller percentage of hospital patients are admitted to critical care, particularly in older age groups, than was originally assumed. Based on the

experience of Wave 1 it will be possible to refine the modelling to account for this in the event of any further waves.

6.14 Outside the hospitals, while there was a focus on planning for the impact of COVID-19 in care homes from the early stages of the pandemic, protecting care homes has been a significant challenge for the system as a whole. While significant support has been provided to care homes, this is clearly an area that will continue to be a priority for further waves and where we will need to redouble our efforts.

6.15 It is expected that there will be a second wave of Covid-19 later in the year. At this stage, the timing and scale of a 2nd wave is unpredictable as it will depend on a range of factors, including the future approach to social distancing and population adherence to these measures.

6.16 However, given that a 2nd wave could potentially coincide with colder weather and winter pressures, it will be important that there are detailed surge plans in place for critical care, hospital beds and care homes. The Department is currently carrying out detailed work to model the possible capacity requirements in these areas in range of scenarios.

6.17 In planning for a second wave, there will also be significant focus on the system maintaining higher levels of non-COVID services while ensuring that there is sufficient capacity to treat every COVID patient appropriately.

Managing planned Non-Covid-19 services in hospital settings during COVID-19

6.18 The HSC has made enormous efforts to create additional surge capacity for the first wave of COVID-19 patients. As a result of these efforts, every patient requiring treatment for confirmed COVID-19 has been able to receive it.

6.19 However, the challenge that our health and care services now face, as we move into this phase of response to the pandemic, is how to maintain the capacity to provide care for patients with COVID-19, while simultaneously increasing other urgent clinical services, important routine diagnostics and planned surgery.

6.20 As we increase the amount of planned activity in hospitals over time, we will adopt the following principles:

- The HSC will immediately start to step up services on a prioritised basis while maintaining the necessary level of care for COVID-19 patients;
- Patients across Northern Ireland should have equitable access to specialist services according to their clinical need;

- In order to minimise the risk of infection, COVID-19 patients and staff providing care to them should be separated from non-COVID patients and staff where possible;
- The volume of planned activity to be delivered will align with other dependencies such as testing capacity, medicines supply, and PPE.
- The HSC will need to retain the capacity to quickly repurpose and 'surge' capacity if required.

6.21 As we increase the amount of planned activity, one of the key objectives must be to minimise the transmission of COVID-19 infection within hospitals, also referred to as hospital-onset infection or nosocomial transmission.

6.22 All Trusts have taken steps to put in place effective safe zoning plans in order to maintain safety of patients and staff on sites where elective care is delivered alongside urgent and emergency care. Where possible, we will also consider the possibility of physical separation of staff and patients delivering planned care from those dealing with unscheduled care.

6.23 Prior to the pandemic, the Department had been progressing the development of a regional network of elective care centres. The essence of these centres was to organise specialised procedures on a smaller number of hospital sites, completely separated from urgent and emergency care. The main benefits of this approach were considered to be: staffing resilience; productivity; standardisation of care; reliability and efficiency; and, better patient experience and equity of access.

6.24 Many of these factors are equally, or even more, important in the context of the ongoing pandemic. Furthermore, if there is a second wave of COVID-19 cases, the creation of dedicated elective care centres would facilitate the continuation of some planned activity even in the face of increasing demand for COVID-19 treatment. Through the first wave of COVID-19, the HSC has also used independent sector facilities to increase capacity to maintain the most urgent planned care. The Department is now considering how best to utilise the independent sector facilities in rebuilding health service capacity.

Prioritisation / Delivery of Health Services

6.25 It will continue to be important that hospital services are prioritised to ensure that treatments that have the highest impact on reducing mortality and morbidity are prioritised. The overriding principles that will continue to apply are that patient safety is paramount and that equity of service across Northern Ireland must be ensured as far as possible. The development of service plans on a regional basis will encourage equity of provision across Northern Ireland.

6.26 Clinical teams are skilled at making complex decisions about patient prioritisation on a daily basis, in the context that they find themselves in.

COVID-19 will continue to impose significant constraints and clinical decision making will therefore need to adapt to circumstances as they change. In taking decisions, clinical teams should have due regard to the NHS England / Royal College of Surgeons specialty guide[5]. In addition, the Royal College of Surgeons has recently published two COVID-19 toolkits: *'Safety considerations and risk assessment for patients and surgical teams'*[6] and *'Checklist for restarting elective surgical services'*[7]. Clinical teams should also consider these toolkits in their decision making.

6.27 Likewise the Royal College of Paediatrics and Child Health (RCPCH) has published guidance in respect of the reconfiguration and delivery of children's health services in the context of COVID-19: '*Reset, Restore, Recover - RCPCH principles for recovery*'[8]. Paediatric clinical teams should consider the principles set out in the RCPCH guidance.

6.28 Clinical teams should consider further guidance from professional bodies as it becomes available.

Cancer Services

6.29 COVID-19 has had a severe impact on a range of key cancer services. While emergency and urgent cancer services have continued throughout the surge, unfortunately, and out of necessity to reduce the risk of infection to both patients and staff, many procedures and diagnostic appointments have had to be postponed or delayed. These decisions are not taken lightly and will undoubtedly have an impact on waiting times for cancer treatment which are likely to persist for many months.

6.30 As part of the response to COVID-19 many patients' treatments plans have been modified to reduce the need for hospital visits and as a consequence the risk of infection; examples include measures such as the provision of hormone therapy or radiotherapy as an alternative to surgery, and the use of alternative drug regimens. When a decision is taken to delay diagnostics or modify treatment it is done so according to strictly observed and regionally agreed NICaN guidelines and on the basis of an individual assessment of risk / benefit. Trusts have put in place safety netting processes to ensure that any patients who has had a treatment paused or delayed resumes treatment on the appropriate pathway as soon as it is safe and possible to do so. Cancer waiting

[5] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf
[6] file:///C:/Users/1375921/Downloads/Recovery%20Toolkit%20Tool%201%20%20Checklist%20for%20restarting%20elective%20surgery.pdf
[7] https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/tool-2/
[8] https://www.rcpch.ac.uk/resources/reset-restore-recover-rcpch-principles-recovery

times guidance has been updated to reflect any changes to treatment pathways.

6.31 Work has now started to implement the reset of the full range of cancer services whilst taking into account the need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC. This work will be taken forward by the COVID-19 Regional Cancer Reset Cell. As part of our rebuilding programme, all patients across Northern Ireland will be prioritised in the same way and Trusts will be expected to work together in order to offer the earliest available appointment to a patient requiring diagnostics or surgery.

6.32 The Department recognises that the need to increase access to cancer services whilst minimising the transmission of COVID-19 infection within hospitals will require careful planning and organisation of services. Critical to this will be communication with the public and NICaN will continue to work with Trusts and third sector partners to ensure the provision of timely patient information.

General Dentistry / Ophthalmic / Other Allied Profession Services

6.33 The Department and the HSCB will work with the British Dental Association and Optometry NI to rebuild the services provided by General Dental Practitioners and General Ophthalmic Practices guided by the available medical and scientific guidance.

6.34 Likewise the Department and the HSCB will work with relevant professional bodies in respect of other Allied Health Professions such as physiotherapists, chiropodists etc. to rebuild services guided by the available medical and scientific guidance.

Adult social care

6.35 Across adult social care services there will be an important balance to be struck between protecting those who may be particularly vulnerable from COVID-19 and recognising the impacts this could have on their general health and wellbeing. The large majority of care homes have not had a COVID-19 outbreak and a key priority will be ensuring that this remains the case while considering how steps can be taken to facilitate engagement with families. Services such as respite and day care will need to operate differently than usual to manage infection control risks. Across adult social care there will need to be a separation of into groups of service users to try to minimise infection control risks, ongoing use of PPE and other mechanisms to minimise risks. This will include Trusts continuing to support unpaid carers, providing PPE when needed, and ensuring they have the support they need to continue providing

care. Sector specific guidance will be issued providing more details on the approaches to be adopted.

Children's Services

6.36 Regulations which provided flexibility in relation to the provision of services to looked after children during the pandemic came into operation on 7 May and, subject to flexibility continuing to be required, will expire on 7 November 2020. In addition, procedural changes have been implemented in children's services to take account of public health measures put in place to prevent the spread of infection. In some cases, this has promoted innovative service responses. A COVID-19 Childcare Support Scheme has been established to meet the childcare needs of key workers and to sustain large parts of the childcare sector forced to close as a result of reduced demand for childcare. Rebuilding planning is underway, which will align with the Executive's 5-stage plan and will be guided by up-to-date medical and scientific evidence.

Mental Health

6.37 Work is ongoing to consider both the safest and most effective ways to deliver services, building on emerging innovative approaches. In particular, consideration is being given to how to meet the challenge of the likely increase in demand for mental health services, linked to COVID-19 and recognising that very significant capacity challenges were faced by mental health services before the onset of COVID-19.

Workforce

6.38 The HSC workforce has been under significant strain during the pandemic and it will be necessary to consider the implications for staff with mental health issues, ensuring appropriate support.

6.39 It will also be important that proper induction and training is provided for staff members who are redeployed to areas outside their normal practice or working environment. Equally employers must ensure that proper risk assessments are carried out for all staff. This will include application of social distancing, to help avoid contact with COVID-19 wherever possible, and to manage that contact safely when there is no alternative. This should include particular risk factors for staff who are shielding; Black, Asian or Minority Ethnic; pregnant etc., and proper training for managers.

6.40 Early consideration must also be given to utilising learning from the COVID-19 response in relation to recruitment, resourcing and job banding. This will include a critical look at, and changes to be recommended in respect of, speeding up recruitment as well as proposals to develop a "reserve" of appropriately-qualified staff who can be called on in an emergency scenario.

Childcare and 7-day working patterns will also be considered. It will also be important to consider incorporating existing work on safe staffing, and agency and locum reduction within the rebuilding services agenda. It will also be important to provide clarity on means and timing of re-establishing pre-registration training and education.

6.41 Employers should engage with trade union representatives in a timely manner on all workforce issues.

Encompass Programme

6.42 The Encompass programme is the flagship digital investment that replaces ICT systems that are urgently end-of-life; supports regional reform initiatives; enables patient safety, quality and efficiency requirements; and supports the service in addressing rising demand within constrained resources.

6.43 Encompass working with Epic alongside frontline staff, operational management, and patients and carers, will implement a single Digital Care Record for every citizen, including a fully integrated patient portal. This will enable services to consolidate standardised digital workflows and revised patient pathways, naturally building on the integrated and coordinated regional basis for developing service incremental plans.

6.44 Encompass gives us the opportunity to develop the 'digital front door' to the HSC in terms of access, triage, support for self-care and even treatment; the urgency of which has been underlined by COVID-19. For example, using the Epic platform, NYU Langone Health[9] expanded video visits on March 2019 to all of its ambulatory care settings, reaching more than 7,000 visits within 10 days and representing more than 70 percent of total ambulatory care volume during this time.

Finance

6.45 The Department's budgetary position continues to be hugely challenging, with the Department facing a funding shortfall in respect of forecast inescapable pressures necessary to maintain existing services. Effectively, this means making difficult choices in the prioritisation of available limited resources to ensure we maintain safe services and achieve the best outcomes for citizens.

6.46 There are ever increasing demands on funding across a range of services. In addition, there are also delivery risks associated with the opportunity to lead on and make progress on significant savings targets across the HSC system in 2020/21. Inescapable cost pressures also exist across the Health Transformation programme. There have been significant additional funding requirements in our response to the unprecedented challenges of COVID-19;

[9] NYU Langone Medical centre is an academic medical centre located in New York, affiliated with New York University. The Medical Centre comprises the NYU School of Medicine and several hospitals.

the Department has secured additional funding from the Executive to respond to COVID-19 and continues to liaise with the Department of Finance to secure further required funding. Rebuilding health and social care services, whilst simultaneously dealing with the ongoing COVID-19 pandemic will likely require additional resource funding. The incremental service plans will identify further funding requirements.

Capital Investment

6.47 From a capital investment perspective, the COVID-19 outbreak has seen a delay to many of our projects that were under construction, whilst others have been fast-tracked and repurposed to assist with the response.

6.48 With construction workers increasingly returning to sites, it is clear that the timescales for ongoing projects will be extended, not just because of the inherent delay but because the need for social distancing will reduce the number of people who can safely work on sites at one time. The impact of this will only become clear once work recommences and timeframes can be reassessed in the light of experience of working with these adjustments.

6.49 Similarly, plans for new developments have been delayed whilst staff across the HSC have been focusing efforts on the immediate needs of the pandemic. This work will now need to be reinvigorated and clear priorities set to ensure that our efforts are collectively applied to move key projects forward. This will enable us to make the best use of the capital funding we have in 2020/21 and to bring forward plans for 2021/22 and beyond so that we are ready to maximise the use of future allocations. The incremental plans will identify any further capital investment requirements.

HSC Governance

6.50 Given the unprecedented challenges posed by COVID-19 and in order to achieve the mission set out in Section 3, a number of changes to the governance framework will also be implemented. The Department, through temporary amendments to the Framework Document, and the establishment of a new management board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) to reflect the Minister's priorities. These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision making in rebuilding HSC services.

6.51 The rebuilding of services will take some time and will require a response that is both agile and adaptable to ensure the system can respond to further surges of COVID-19, whilst optimising its ability to stabilise and move forward. The HSC system will continue to be significantly constrained in the delivery of services due to the ongoing prevalence of COVID-19. In this context the

analysis of performance levels against pre-COVID-19 indicators and targets would be not be an appropriate basis for performance monitoring and management in the current environment.

6.52 The performance targets will therefore need to be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

7. EXAMPLE PATHWAYS

Introduction

7.1 This section provides illustrative examples to show how the delivery of a number of key services may be impacted over the next three months. Each example describes the previous pathway, the new constraints and opportunities that need to be considered by service providers, the possible revised pathway and the anticipated activity in the three months period from July to September 2020.

Urology Red Flag Pathway

Previous Pathway

7.2 Red Flag referrals were previously triaged by a consultant and at time of triage the consultant would indicate what diagnostics would be required for the patient's visit. This clinical work up could involve a range of diagnostics including bloods, urinalysis, flexible cystoscopy, biopsy and ultrasound. The patient was then added to an outpatient waiting list where the wait for an appointment depended on the clinical priority of the patient.

7.3 At the start of the clinic, the clinical team would meet and discuss the treatment plan for each patient. The nursing staff would then see the patient and undertake the relevant diagnostic tests. The Consultant/Registrar would then see the patient, discuss the findings of the diagnostic test and discuss the treatment options and next steps. Often this would result in patients being added to waiting lists for treatment or sent for further diagnostic tests. Again this would result in a lengthy wait for the patient.

Key Constraints & Opportunities

7.4 The key constraints pertaining to the well-publicised risks associated with the COVID-19 pandemic and availability of capacity in all aspects of the pathway ultimately resulted in long waits and delayed diagnosis.

7.5 The availability of new technology, the willingness to embrace this technology and the challenges presented by the COVID-19 pandemic have provided the key opportunities to change the clinical pathway. The clinical team had already started adopting the virtual triage model and the embedding of this new pathway was reinforced further once traditional face-to-face clinics ceased due to COVID-19. The pandemic has also provided the opportunity for cross Trust working which is helping equalise waiting lists.

The Revised Pathway

7.6 The new pathways were implemented in line with guidelines agreed and provided by the British Association of Urological Surgeons (BAUS). All new red flag referrals are reviewed via electronic triage by one consultant, with back-up during times of leave. The non-red flags referrals are triaged by other consultants within the team.

7.7 The outcome from this triage can result in the patient being sent direct to test or managed virtually using a telephone clinic slot. Where it is deemed that a patient needs further diagnostic tests, new pathways have been established to allow safe and accessible treatment.

7.8 *Cross Trust Working*- Working across Trust boundaries has continued to expand with teams working collegially to help reduce patient waiting times. Southern Trust patients are now being sent to the South Eastern Trust (SET) for their Transperineal (TP) biopsy, under anaesthetic. This work has been able to proceed as the SET TP machine has been set up in a separate clean unit which has allow elective procedures to continue in a COVID-19 free environment.

7.9 *Cross site Working*- The new pathways have been developed in response to the challenges presented by staff being redeployed to support ICUs and the risk of COVID-19 infection on the Craigavon site. Flexible Cystoscopies are now being undertaken in Daisy Hill Hospital following the closure of the day surgery units in Craigavon and South Tyrone.

7.10 *Results reporting* - Where possible, the consultant will now telephone the patient with their cancer results and this will be followed by a clinic letter. This new pathway helps reduce the waiting times for cancer results, avoid unnecessary outpatient attendances and reduce the risk of infection.

Anticipated Activity: 3 months to 30 September 2020

7.11 It is anticipated that the 'new' pathway will continue for the next number of months due to the need for social-distancing and reduction of face to face. This will have an impact on the waiting times of those patients who are not deemed as an urgent patient. It is planned that as staff become available to reopen day surgery facilities then more flexible cystoscopies can be carried out for those patients deemed 'less' urgent, and it is hoped that the SET will continue to facilitate the TP biopsies.

Introduction of Faecal Immunochemical Testing (FIT) for Suspected Bowel Cancer Outpatient & Colonoscopy Referral Triage

Previous Pathway

7.12 Patients with suspect bowel cancer 'red flag' symptoms are referred into Secondary Care from Primary Care according to the Northern Ireland Referral Guidance for Suspected Cancer (https://nican.hscni.net/wp-content/uploads/2019/11/NICaN-GP-Referral-Guidance-2019.pdf). Following consultant triage, patients would either attend outpatients or, if appropriate, be referred direct to test. NICE guidance states that colonoscopy is considered to be the gold standard for diagnosing colorectal cancer. CT colonography (CTC) can be offered as an alternative for people with comorbidities that make colonoscopy unsuitable.

Constraints and Opportunities

7.13 In response to the COVID-19 pandemic the British Society of Gastroenterology (BSG) developed guidance on 'GI Endoscopy Activity and COVID-19: Next steps – Updated 3 April 2020'[10] which advised stopping all non-emergency, non-essential endoscopy immediately. In addition, the majority of patients referred as a suspected cancer referral during COVID-19 are assessed virtually/by telephone.

7.14 Within NI there were already patients waiting for an outpatient appointment or for an endoscopy procedure / CTC having been referred by their GP for suspected bowel cancer. Given the constraints on endoscopy related to the response to the COVID-19 pandemic, there are grave concerns of long waits and delayed diagnosis of cancer.

7.15 Most outpatient red flags/urgent referrals will not have cancer. The current NICE guidelines are based on a Positive Predictive Value threshold of 3% for symptoms being caused by cancer. Following the guidance on stopping non-emergency colonoscopy during the COVID-19 pandemic, the British Society of Gastrointestinal and Abdominal Radiology (BSGAR)[11] produced guidance for patients requiring investigation for possible colorectal cancer. They suggest that under a 2 week wait referral pathway, patients should be risk-stratified using symptoms and faecal immunochemical (FIT) testing.

7.16 FIT tests are designed to detect small amounts of blood in stool samples using antibodies specific to human haemoglobin. They have been developed as an

[10] https://www.bsg.org.uk/COVID-19-advice/gi-endoscopy-activity-and-COVID-19-next-steps/
[11] https://www.bsgar.org/society/COVID-19-and-bsgar-updates-1/

alternative to guaiac-based FOB tests, but as the faecal immunochemical tests are designed to specifically detect human haemoglobin, they may give more accurate test results than guaiac-based tests.

7.17 FIT testing was to be introduced for the Bowel Cancer Screening Programme in the first quarter of 2020. The availability of this test and the willingness of the NICaN Colorectal Clinical Reference Group provided the key opportunities to determine a regionally agreed process for the use of FIT to support the risk stratification of patients in Secondary Care during the response to COVID.

Revised Pathway

7.18 Patients waiting for colonoscopy / CTC or red flag / urgent referrals are identified by Secondary Care and sent a FIT testing kit for completion. The kit is returned via Primary Care and transferred to a central lab for processing. The Consultant will review the chart and the patients FIT results, which will allow risk stratification according to different regionally agreed categories. If the FIT <10, the referring Consultant will review the chart and if patient not anaemic consider discharge, with advice to return to their GP if persistent symptoms. If FIT>10, the patients remain on the waiting list but prioritised in order of highest FIT to lowest and imaged as per available resource.

Anticipated Activity: 3 Months to 30 September 2020

7.19 Funding is currently in place to support the use of FIT testing to allow risk stratification of urgent and suspect cancer patients until the end of June 2020. A proposal is being developed which subject to funding availability, will allow for that process to continue for the remainder of the financial year. NI is the first region in UK to use this technology in such an innovative way which offers the potential to make best use of reduced endoscopy capacity.

7.20 A phased restoration of cancer screening programmes will commence as quickly and safely as possible. It is obviously important that this is aligned to and is consistent with restoration of capacity and addressing any backlogs in the parts of the cancer screening pathways which sit in primary care (cervical screening ‘smear’ taking) and secondary care (breast assessment and breast cancer treatment services, bowel colonoscopy and bowel cancer treatment services and cervical colposcopy and cervical cancer treatment services).

Breast and Cervical Cancer Screening

Previous Pathways

7.21 Cancer screening programmes play a key role in the early detection of disease.

7.22 The NI breast screening programme calls women aged 50-70 who do not have symptoms for a mammography scan every three years. Where necessary (in around one in four cases) they are recalled for a screening assessment. Around 4% of those recalled for assessment will receive a cancer diagnosis and be placed on a treatment pathway. Breast screening mammography and assessment clinics are currently provided across four Trust sites: Altnagelvin, Antrim, Craigavon and Linenhall Street, Belfast. Women in a higher risk group from across the region are screened at the higher risk screening unit in Antrim Area Hospital.

7.23 Cervical Screening aims to prevent cervical cancer by detecting early pre-cancerous changes in the cells that line the cervix. It is recommended that all women aged between 25 and 64 years, who have ever been sexually active, have regular screening tests. Women aged 25-49 are invited every three years, while those aged 50-64 are invited every five years. Most women's test results show that everything is normal, but for around 1 in 10 women the test will show some abnormal changes in the cells of the cervix. Screening is carried out by a nurse or doctor at your GP practice or at a sexual and reproductive health (family planning) clinic.

Constraints and Opportunities

7.24 Screening programmes were paused from the second week of March 2020 in response to the COVID-19 pandemic. The purpose in pausing these programmes was to ensure that adequate healthcare and laboratory resources could be redirected to the pandemic response and to reduce the risk of COVID-19 infection in people eligible for screening programmes, many of whom are in population groups vulnerable to serious adverse health outcomes due to coronavirus infection.

7.25 Public Health England (PHE) has stated that disruption to screening programmes will most likely lead to an increasing disease burden and an increase in health inequalities, in addition to having a negative impact on the economy due to increased morbidity. In light of this, rebuilding NI screening services is a priority for the Department of Health.

7.26 Work is underway by the PHA in Northern Ireland to plan for the restoration of each of the paused programmes as quickly as possible, however the rate of rebuilding will be impacted by the need for social distancing and PPE, as well as the interdependency with other key diagnostic (imaging and laboratories) and treatment services across Trusts. In most instances it would not be

appropriate to offer a screening test if the remainder of the screening pathway (diagnostics and treatment) is not available for those who receive a positive screening test result.

7.27 Furthermore, the cohorts eligible for a number of the programmes include people who are at increased risk of severe COVID-19 if they become infected, because of underlying conditions (such as diabetes) and/or age.

7.28 Staff absence in provider services has increased due to the requirement to self-isolate because of staff or household symptoms. Some staff have been redeployed, some staff are in the vulnerable or shielding group and some staff have been or are currently ill.

7.29 Consideration will also need to be given to the availability and suitability of some screening venues in terms of hygiene and social distancing measures.

7.30 In light of these constraints, return to pre-COVID levels of activity and clearing the backlog of people who have missed out on the offer of screening during the pause is likely to take many months and will depend on the progress of the pandemic. Typically, based on average 2019 activity levels, around 5,200 breast mammograms and 15,000 cervical tests would be carried out per month across Northern Ireland. The estimated backlog at 31 May 2020, due to the pause in these programmes, is 12,800 mammograms and 45,000 cervical tests.

Revised Pathways

7.31 A risk-based and consistent approach will be adopted in order to make the best use of the available resources, whilst also taking account of the logistical issues and risks specific to each programme. The approach will be underpinned by a number of key principles:

(i) All screening services should prioritise activity to ensure a consistent approach, with emerging capacity used first for people at highest risk.

(ii) Screening should be offered to people where the benefits of screening are greater than the risk of contracting COVID-19 as a result of participating in the programme. This will differ between programmes and between groups of people eligible for each screening programme. The different risks and benefits associated with different programmes will require a phased approach, with some programmes being phased in before others.

(iii) There needs to adequate staffing and facilities for testing, diagnosis, high quality treatment and programme management. This needs to be supported by appropriate quality assurance arrangements to minimise risk and maximise benefits.

Anticipated Activity: 3 Months to 30 September 2020

7.32 Whilst it is relatively straightforward to pause population screening programmes, the task of restarting these programmes and restoring them to previous levels is much more complex and needs to take into account a wide range of variables which are compounded by the ongoing COVID-19 pandemic.

7.33 Breast assessment clinics for women who have previously been recalled for assessment following mammography continue to be held within our screening centres. In addition, women who have been identified as being at higher risk of breast cancer will continue to receive invitations to attend for surveillance screening at the regional higher risk screening unit at Antrim Area Hospital.

7.34 Colposcopy clinics offering further assessment following a cervical screening test are still being held where possible at the moment. Tests for people who have recently been screened will continue to be processed and results sent to GPs for onward communication to patients.

7.35 Those considered to be in the extremely vulnerable group, those who have, or had symptoms of COVID-19 and are self-isolating, and those who are currently self-isolating due to a household member having symptoms are advised not to attend these clinics. Alternative appointments may be made by contacting the clinic.

7.36 The restoration of cancer screening programmes will commence as quickly as possible. This will be aligned to and consistent with restoration of capacity and addressing any backlogs in the parts of the cancer screening pathways which sit in primary care and secondary care. The PHA, working with HSCB and Trusts, will lead a process to develop a phased plan for the restoration of each of the five paused screening programmes using a risk based approach. The plan will consider effective action that can be taken in the short, medium and long-term. This plan will be based on the principles outlined above and take into consideration the actions required in relation to the screening, diagnostic and treatment components of screening programmes, as part of the wider primary and secondary care recovery plans.

Cataracts – Belfast Health and Social Care Trust (BHSCT)

Previous Pathway

7.37 Prior to the COVID-19 Pandemic, the NI Cataract Pathway reform was well underway. The BHSCT surgical waiting lists stands at some 8000 patients, with some 9500 on the outpatient waiting list. The cataract surgical and outpatient waiting lists have been successfully amalgamated for BHSCT, Northern Health and Social Care Trust and South Eastern Health and Social Care Trust, therefore helping to establish equity of access.

Opportunities and Constraints

7.38 As the waiting lists in Northern Ireland are very long, a list of patients who were "certifiably blind" due to cataract was identified and these patients were prioritised for surgery (in limited numbers) in Kingsbridge Hospital and Ulster Independent Clinic during lockdown. This approach was constrained as some patients were unwilling to attend.

7.39 This allowed the service the opportunity to test the cataract surgery pathway in the COVID-19 climate. This has resulted in BHSCT maintaining approximately 15% of cataract surgical activity through Lockdown.

Revised Pathway

7.40 Cataract surgery has now had to adopt new processes and approaches as follows:

- Prioritisation of patients in terms of visual requirement and COVID-19 risk status.
- Contact patient to ascertain if prepared to attend (very time consuming)
- Attend 48 hours prior to scheduled surgery for COVID-19 testing, pre-assessment and biometry, if required.
- Self-isolation was not a requirement during lockdown but is now a requirement.
- Reduced surgical lists from 7 to 5 during lockdown but have strategies to improve flow once routine theatres open.
- Post-operative reviews carried out by telephone in most cases.

7.41 Improvements in flow have been made by staggering the arrival of patients on the list to avoid contact with others and the surgical day visit can be shortened by giving patients drops for self-dilation when they come for their COVID-19 testing.

Anticipated Activity: 3 Months to 30 September 2020

7.42 Pre-COVID capacity for BHSCT cataract surgery was 5418 patients per annum.

7.43 Currently the BHSCT is operating at 12% of cataract capacity. This can expand rapidly if the Day Case Elective Care Centre open for surgery. Going forward BHSCT has applied for the services of two medical students to help with prioritisation of cataract patients on the surgical waiting list, so that surgical capacity is used in the most effective manner.

Urgent & Emergency Care

7.44 Prior to COVID-19, there was clear evidence that our urgent and emergency care services were under increasing pressure with growing numbers of people experiencing long waits to be seen in overcrowded Emergency Departments (EDs). This was already an unsustainable position requiring radical transformation.

7.45 However, the impact of COVID-19 and the accompanying focus on infection prevention and social distancing, have driven home the urgency of ensuring that we do not allow EDs or hospitals to reach these levels of crowding in future. The way we provide care must change to prevent this.

Opportunities and Constraints

7.46 Attendances at EDs dropped during the first two months of the pandemic but numbers are starting to rise again and it is expected that they will eventually rise to pre-pandemic levels. Even with reduced numbers, our EDs are encountering difficulties with social distancing in waiting areas and, particularly, in ambulance turnaround times. Crowded EDs are unsafe for staff and patients.

Revised pathway

7.47 EDs are having to adopt new ways of working order to ensure that they do not become overcrowded. Some of the new approaches include:

- Segregation and streaming of patients to separate those more likely to have COVID-19 from those less likely;
- Closer working with primary care – including scheduled access to some urgent services;
- Maximum occupancy thresholds in all areas to allow for adequate social distancing;
- Walk-in patients triaged as low risk to wait in cars or nearby until called;
- Increasing the use of telemedicine and remote consultations;
- Expansion of anticipatory care models and acute care at home to prevent unnecessary or inappropriate attendance;
- Patients under active specialist care to be managed by their existing specialist team;
- Patients discharged as soon as they are medically fit.

7.48 Further areas to be explored include the establishment of a regional telephone triage system, alternative pathways for urgent patients including access to scheduled appointments.

7.49 As we move towards the busier winter period, it will be essential to consider more radical transformation of urgent and emergency care services. EDs must

be able to provide their core purpose of assessing and stabilising seriously ill and urgent patients.

SH:24 Pilot – Sexually Transmitted Infection (STI) Testing

Existing pathway

7.50 People in Northern Ireland that are either concerned about, or symptomatic with, a possible STI can either attend a Genitourinary Medicine (GUM) clinic or consult their GP for testing. Many do not do so either out of embarrassment, limited access to appointments, or other reasons like not knowing where to go and obstacles to travel. This contributes to ongoing transmission of STIs and rising STI levels in the population.

7.51 This imposes costs for treatments and in managing the long term consequences of STIs like birth defects, fertility problems, persistent pain, comorbidities and palliative care. For example, the life time costs of treating an HIV patient are estimated to be £380,000. Until recently approximately 100 people were newly diagnosed in Northern Ireland with HIV every year. The most effective way of reducing STI transmission is testing and treatment of those who are diagnosed with an STI. However, in Northern Ireland due to clinic and laboratory constraints the number of STI tests performed annually has not increased significantly over the last five years.

Revised Pathway

7.52 In response to this, PHA, HSCB and Health and Social Care Trusts commenced a six month pilot in October 2019 with SH:24, an online STI testing service provider. SH:24 is a not for profit community interest enterprise developed by clinicians and service designers. It offers testing for Chlamydia, Syphilis, Gonorrhoea, HIV and Hepatitis B and C.

7.53 The patient pathway is individualised, rapid and convenient. The costs are lower than for face-to-face consultations and the quality of the service is consistently high. Sophisticated algorithms analyse the information provided by the patient via their phone or other digital communication device and determine what kind of test kits are needed. These are discreetly posted to the patient with instructions on how to take swabs, urine and blood tests. The patient returns these by post to a designated highly accredited laboratory outside Northern Ireland and receives the results usually within 24 hours by text or telephone. Effective safeguarding mechanisms for children or sexually assaulted adults are also in place. Details of patients testing positive for STIs are shared with the relevant Trust GUM team, who takes over the management of complex patients. Simple STIs like Chlamydia can be treated via SH:24 through a postal of kiosk click and collect local pharmacy service without local GUM team involvement.

7.54 During the six months pilot October 2019- March 2020, nearly 7000 people accessed SH:24 online testing, which exceeded originally anticipated demand

by over 100%. Over 40% of NI SH:24 users had never been to a GUM clinic, and a further 15% had not been to one in over a year. This means that SH:24 reached a different group of people than traditional GUM services.

Constraints and Opportunities

7.55 Experience during COVID-19 in Belfast Health and Social Care Trust (BHSCT), to date shows that between April 1st and May 15th 2020, patient contacts reduced from an average of 1500 to 528 for the six week period. Of these, only 30 needed a face-to-face consultation. This means that 93% of the usual demand for GUM services in BHSCT could have been dealt with through SH:24.

7.56 BHSCT estimates that its service capacity will remain less than 50% of its pre-COVID-19 capacity due to staff redeployment, shielding and sickness absence, the requirements of social distancing and use of PPE during unavoidable face to face patient contact.

7.57 SH:24 provides an opportunity to ensure a safe, continued STI testing provision through the COVID-19 pandemic.

Anticipated activity to 30 September 2020.

7.58 Without advertising, it is estimated that SH:24 STI testing service will be accessed by 1500-2000 patients per month between April and June 2020 inclusive. Thereafter this is likely to stabilise at 2000 per month but could rise further. Monthly monitoring will help to determine this in coming weeks and months.

7.59 Service continuation beyond June 2020 is subject to funding being made available.

ANNEX A: ACTION LIST

Section 5 in the 'Rebuilding Health and Social Care Services Framework' document sets out the overarching approach to developing service stabilisation plans, with the aim to maximise activity in the context of the constraints and issues that COVID-19 presents. This will lead to incremental service activity plans and targets being developed for each programme of care / specialty to be updated in three monthly cycles for the period June 2020 to March 2022. If possible the planning cycles will be extended if the prevalence of Covid-19 in the community improves. The following actions will underpin the planning to be taken forward over the next two years.

Cancer Care

- Work has now started to implement the reset of the full range of cancer services whilst taking into account the need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC. This work will be taken forward by the Covid-19 Regional Cancer Reset Cell.

- The Belfast Trust has recommenced specialist surgery in Belfast City Hospital now that the Nightingale Hospital has been stood down.

- The Northern Ireland Cancer Network (NICaN) has produced regional guidelines for cancer care and changes to pathways have been implemented accordingly.

- NICaN and MCRN have collaborated to produce guidelines to support decisions around the prioritisation of patients in the event of a reduction in capacity due to the COVID-19 response.

- Regional guidance documents were compiled to support doctors in their decision-making and treatment planning across both haematology and oncology.

- Some patients' treatments plans have been modified in light of the current pandemic, in line with the regional NICaN guidelines.

- A testing protocol has also been developed for use within cancer services and incorporated into the regional testing protocol.

- NICaN has produced a patient information leaflet.

Adult Social Care

- The learning from the new and innovative ways of working adopted by adult social care services in response to the pandemic, such as the use of technology to connect care home residents with their families, will be utilised to further transform the delivery of this service.

- Across adult social care there will need to be a separation into groups of service users to try to minimise infection control risks, ongoing use of PPE and other mechanisms to minimise risks. This will include Trusts continuing to support unpaid carers, providing PPE when needed, and ensure they have the support they need to continue providing care. Sector specific guidance will be issued providing more details on the approaches to be adopted.

- Careful consideration will be given to the delivery of long term adult care services – both those delivered in institutional settings such as care homes, and in people's own homes, which serve many of those who are most vulnerable to the virus. There will need to be a careful balance struck between continuing to protect people and ensuring that other aspects of people's health and wellbeing – and their rights – are respected and looked after. There is also a continued reliance on unpaid carers, and the support of family and friends, alongside our formal health and social care services. Making sure this support can continue, or re-start, safely is as important as re-opening any hospital-based service.

Capital Investment

- Plans for new developments have been delayed whilst staff across the HSC have been focussing efforts on the immediate needs of the pandemic. This work will be reinvigorated and clear priorities set to ensure that our efforts are collectively applied to move key projects forward. This will enable us to make the best use of the capital funding we have in 2020/21 and to bring forward plans for 2021/22 and beyond so that we are ready to maximise the use of future allocations. The incremental plans will identify any further capital investment requirements.

Children's Social Care Services

- Planning for the rebuilding of children's social care services is underway, which will align with the Executive's 5-stage plan and will be guided by up-to-date medical and scientific evidence.

Co-production

- The incremental service rebuilding plans will be developed through the application of co-production principles as far as that is possible. The speed at

which these plans will need to be developed and adapted will undoubtedly act as a constraint on applying full co-production principles. However, where at all possible, service providers should engage in a timely manner as widely as possible in the development of their incremental service plans.

Encompass Programme

- The Encompass digital healthcare programme working with Epic, alongside frontline staff, operational management, and patients and carers, will implement a single Digital Care Record for every citizen, including a fully integrated patient portal. This will enable services to consolidate standardised digital workflows and revised patient pathways, naturally building on the integrated and coordinated regional basis for developing service incremental plans.

EU Exit

- Action will be taken to ensure that the HSC will be ready for EU Exit ahead of the end of the transition period on 31 December 2020. This includes understanding the implications for the health and social care sector of the implementation of the Northern Ireland Protocol and ensuring that the sector is prepared and risks are managed in areas such as workforce, health security and healthcare supplies.

Governance of the HSC

- Given the unprecedented challenges posed by COVID-19, a number of changes to the governance framework will be implemented. The Department, through temporary amendments to the Framework Document, and the establishment of a new management board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) to reflect the Minister's priorities. These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision making in rebuilding HSC services. This arrangement will be kept under review on a 6 monthly basis

- Service delivery performance targets will be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

Managing planned Non-Covid-19 services in hospital settings during COVID-19

- As we increase the amount of planned activity in hospitals over time, we will adopt the following principles:

    - The HSC will immediately start to step up services on a prioritised basis while maintaining the necessary level of care for COVID-19 patients;

- Patients across Northern Ireland should have equitable access to specialist services according to their clinical need;
- In order to minimise the risk of infection, COVID-19 patients and staff providing care to them should be separated from non-covid patients and staff where possible;
- The volume of planned activity to be delivered will align with other dependencies such as testing capacity, medicines supply, and PPE.
- The HSC will need to retain the capacity to quickly repurpose and 'surge' capacity if required.

- HSC Trusts will aim to minimise the transmission of COVID-19 infection within hospitals.

- All Trusts have taken steps to put in place effective safe zoning plans in order to maintain safety of patients and staff on sites where elective care is delivered alongside urgent and emergency care. Where possible, we will also consider the possibility of physical separation of staff and patients delivering planned care from those dealing with unscheduled care.

- The use of telephone triage and video consultations will be expanded within secondary care.

- The use of virtual clinics will be expanded within secondary care.

- Further work will be carried out to explore the feasibility of establishing dedicated elective care centres to potentially facilitate the continuation of some planned activity in the event of increasing demand for COVID-19 treatment arising from a second wave of the pandemic.

- The potential to continue the use of Independent Sector facilities to maintain the most urgent planned elective care will be explored.

Mental Health Services

- The remote ways of working introduced to support mental health services during the pandemic will be reviewed to explore the potential to further improve the efficiency of services.

- The library of health and wellbeing Apps to allow clinicians and wider professionals to "prescribe" and allocate apps to clients for mental health services will be further developed.

- The potential for Multidisciplinary Teams (MDTs) in primary care to enhance their focus on delivering mental health services, to help meet the need emerging in the post lockdown period, will be explored.

- As part of the COVID-19 Mental Health Response Plan published on 19 May 2020 review mechanisms will ensure that learning from alternative ways of working will be incorporated in service developments moving forward.

General Ophthalmic Services

- The learning from the innovations introduced in Ophthalmology patient pathways and communication with patients during the pandemic will be utilised to further strengthen patient access to this service.

- The Department and the HSCB will work with the Optometry NI to rebuild the services provide by Ophthalmic Practices guided by the available medical and scientific guidance.

General Dental Services

- The Department and the HSCB will work with the British Dental Association to rebuild the services provided by General Dental Practitioners guided by the available medical and scientific guidance. The restrictions on dental services are due to be eased on a phased basis with the first stage, starting from 8 June, being the extension of face to face urgent dental care to all practices where possible. In the second phase, non-urgent care is due to be provided with the exception of treatments involving Aerosol Generating Procedures (AGPs). The range of available treatments will be extended to include AGPs under the third phase.

Other Allied Health Professions

- The Department and the HSCB will work with relevant professional bodies in respect of other Allied health professions such as physiotherapists, chiropodists etc. to rebuild services guided by the available medical and scientific guidance.

Patient Pathways

- All HSC service providers will adopt a systematic and consistent approach to developing service specific incremental plans to increase capacity. This will involve mandating the wide range of existing managerial clinical networks, project boards, task and finish groups or other service improvement vehicles to produce service specific incremental plans for their respective areas on an integrated and coordinated regional basis.

- The existing patient and client pathways will be reviewed, applying a range of COVID-19 factors, summarised in the Checklist, producing revised patient

pathways to implement rebuilding of services within the context of prevailing COVID-19 conditions.

Pharmacy

- The learning from the new approaches in working practices and the use of technology, introduced in Community Pharmacy and HSC Trust Pharmacy to respond to the pandemic, will be utilised to identify opportunities to build upon these innovations to further transform pharmacy services.

- The learning from the new pharmacy support services provided to Care Homes during the pandemic will be utilised to identify opportunities to build upon these innovations to further transform the services provided to the care homes sector.

Planning for a Further Potential Covid-19 Surge

- Planning will continue to ensure that the HSC will be ready to respond to further potential surges of the Covid-19 pandemic.

- HSC Trusts will retain critical care capacity in line with the NI Critical Care Network's 'Low Surge' scenario, providing the recommended 112 critical care beds capacity.

Primary Care

- The Department will aim to continue to provide the primary care COVID-19 Centres in the short to medium term subject to some changes in configuration to respond to the emergent contours of the pandemic.

- The learning from the COVID-19 Centre approach will be utilised by identifying opportunities to build upon the benefits of this service delivery model to support the further transformation of HSC services by strengthening the effectiveness of the primary care partnership with secondary care through joint working and resource sharing.

- The Department and HSCB will discuss with the BMA and RCGPNI the future use of COVID-19 Centres.

- The use of telephone triage and video consultations will be expanded within primary care.

- The potential to use telecommunications in primary care to work more closely with secondary care, for example, with video consultations between patients, GPs and hospital specialists, will be explored.

- The primary care sector will be asked to produce proposals to expand the role of Multi-Disciplinary Teams (MDTs) in the future delivery of health services, in particular during the rebuilding phase to bring mental health support to the community level, accessible directly through GPs.

Prioritisation / Delivery of Health Services

- Hospital services will be planned to ensure that treatments that have the highest impact on reducing mortality and morbidity are prioritised. Ensuring patient safety is paramount and that equity of service across Northern Ireland must be ensured as far as possible.

- Where possible service plans will be developed on a regional basis to ensure equity of provision across Northern Ireland.

Testing Strategy

- Service providers should deliver services taking account of testing priorities established in the Interim Protocol. The Protocol will continue to be reviewed on an ongoing basis and will be adjusted over time as further capacity becomes available and as priorities for testing change as the pandemic evolves.

Workforce

- The HSC workforce has been under significant strain during the pandemic and it will be necessary to continue to consider the implications for staff with mental health issues, ensuring appropriate support.

- Induction and training will be provided for staff members who are re-deployed to areas outside their normal practice or working environment.

- Employers must ensure that proper risk assessments are carried out for all staff. This will include application of social distancing, to help avoid contact with COVID-19 wherever possible and to manage that contact safely when there is no alternative. This should include particular risk factors for staff who are shielding; Black, Asian or Minority Ethnic; pregnant etc. and proper training for managers.

- Employers should engage with trade union representatives in a timely manner on all workforce issues.

- Early consideration will be given to utilising learning from the COVID-19 response in relation to recruitment, resourcing and job banding. Potential improvements to childcare and 7-day working patterns will also be considered. The existing work on safe staffing, and agency and locum reduction will be incorporated within the rebuilding services agenda.

- Clarity will be provided on the means and timing of re-establishing pre-registration training and education for those disciplines that have had training disrupted by the pandemic.

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 30 June 2021

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Charlotte McArdle	DoH (Joint Chair)
M ire Redmond	DoH	Mark Lee	DoH
Siobhan Rogan	DoH	Ian McMaster	DoH
Aine Morrison	DoH	Brendan Whittle	HSCB
Sean Scullion	DoH	Emer Hopkins	RQIA (Observer)
Darren McCaw	DoH (Note)	Aidan McCarry	Family rep
Lorna Conn	HSCB	Martin Quinn	HSCB
Rodney Morton	PHA		
Deirdre McNamee	PHA		
Gillian Traub	Belfast Trust		
Brenda Creaney	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Margaret O'Kane	South Eastern Trust		
Petra Corr	Northern Trust		
John McEntee	Southern Trust		
Karen O'Brien	Western Trust		
Mandy Irvine	NI British Psychological Society		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
La'Verne Montgomery (for agenda item 4)	DoH		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received from Charlotte McArdle, Mark Lee, Ian McMaster, Brendan Whittle, Emer Hopkins, Aidan McCorry, and Martin Quinn.

Agenda Item 2 - Minutes of Previous Meeting

2. Sean Holland noted that the draft minutes of the previous meeting held on 28 April were circulated to members on 6 May. Following receipt of a number of comments from members, the draft minutes were amended and published on the Department's website as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. He advised that in relation to 28/04/AP1, a declaration of involvement form had been issued to Dr Maria O'Kane and would be shared with members once received. This action was now closed.

4. In respect of 28/04/AP2, it was noted that the ELFT presentation was on today's agenda at item 5 and as a result was now closed. Sean Holland advised that a copy of the presentation would be circulated to members by the MDAG secretariat.

AP1: ELFT presentation to be circulated to members. (Action: DoH)

5. Sean Holland noted that further to 28/04/AP3, an update from the Belfast Trust on additional safeguarding information and protection plans was included as Agenda item 8 for today's meeting.

6. Sean Holland advised that in relation to 28/04/AP4 Belfast Trust had provided an appendix 2 to the highlight report setting out the MAH psychological Therapies Support and the key aspects of each role; the action is now closed.

7. 28/04/AP5 was included on today's agenda at item 7, had been actioned and was now closed.

8. In relation to 28/04/AP6, Sean Holland asked Gillian Traub to provide an update on progress towards a future model of on-site provision. Gillian Traub advised that work was ongoing and the steering group, including the three Trusts involved and the HSCB, had now met twice to examine the feasibility of

a facility on site. Each Trust has assessed their patients' suitability for this, and although six potential patients had initially been identified, the most likely outcome was a facility providing for four patients supported by a nursing care model. Details of these assessments have been provided to the Estates Department in the Belfast Trust to gauge if this could be provided within the existing on-site infrastructure. Further detail will then be collated to help inform the timeframe, costs and workforce model required.

9. In respect of 28/4/AP7, Sean Holland asked Lorna Conn for an update on the development of a regional overview of progress on the resettlement programme. Lorna Conn provided an outline of work currently being taken forward by the HSCB in relation to resettlement, adding she would like some additional time to consider the recent proposal received from the Department commissioning work to examine and further develop current processes. Sean Holland advised members that work was underway within the Department to look at processes around resettlements. Sean also emphasised that the status quo was not sustainable and all options available to reduce the time taken to achieve successful resettlements, however radical, would be examined, with any proposals emerging from this work to be brought to MDAG for consideration. He also confirmed that the needs of individual patients would remain the paramount consideration.

10. Brigene McNeilly welcomed this work, and noted that efforts to resettle some individuals had been ongoing for 25 years. Lorna Conn confirmed she would welcome further discussion on potential improvements to the resettlement process.

11. Further to 28/04/AP8 Gillian Traub agreed to provide an update at the next meeting of MDAG as she had not yet engaged with PSNI.

12. Sean Holland confirmed that 24/02/AP1 was now closed following validation of the data presented in the resettlement dashboard.

13. Finally, in relation to 24/02/AP2 Sean Holland requested an update from Gillian Traub. Gillian advised that work was ongoing per the update given at the April MDAG.

Agenda Item 4 – Update on Public In uiry

14. Sean Holland welcomed La'Verne Montgomery to the meeting and invited her to update members on the work of the sponsor team taking forward the MAH Public Inquiry.

15. La'Verne advised the Group that today was a significant day for progress as the Minister had published the PCC report and announced the appointment of Tom Kark QC as Chair of the Inquiry. La'Verne confirmed that detail on the appointment of the Chair was shared in advance with those families the sponsor team and PCC hold contact details for before being formally announced by the Minister through a written statement in the Assembly at noon. La'Verne also confirmed that written detail on the appointment would be placed on the Departmental internet site.

16. La'Verne advised that the next steps would involve the Terms of Reference for the Inquiry being considered by the Chair ahead of formal approval by the Minister, and consideration by the Chair of the Panel support he will require. La'Verne confirmed that the Chair had also received a copy of the PCC report and this would be a key document in relation to his decision making. She advised it was planned to formally launch the Inquiry as soon as possible, with a proposed date of 1 September for this.

17. Dawn Jones welcomed the appointment and asked for an overview on the Chair and his qualifications and experience. La'Verne advised that the newly appointed Chair met a number of the key requirements identified by patients and families, including that he came from outside Northern Ireland, has suitable legal experience of issues likely to come up in the work of the Inquiry, is an experienced QC and part time Judge and has had extensive training in interviewing and questioning vulnerable witnesses. La'Verne provided a brief overview of Mr Kark's CV highlighting his work as Senior Counsel to the Mid-

Staff Inquiry and leading the review of the fit and proper persons test in the NHS, England. Dawn Jones expressed her satisfaction that both the medical and legal aspects were covered.

18. Brigene McNeilly asked La'Verne to convey thanks to the Minister, as he has lived up to the commitments he made to families, and the process to establish the Inquiry has been handled very well to date.

19. Sean Holland noted that the Minister has been very proactive in the establishment of the Inquiry and thanked La'Verne for her update.

Agenda Item 5 – East London Foundation Trust (ELFT) Presentation

20. Sean Holland advised members that, further to action point 28/04/AP3, it had been agreed that the Belfast Trust would provide detail to MDAG on the Trust's engagement with the East London Foundation Trust (ELFT) at today's meeting and invited Gillian Traub to provide the detail.

21. Gillian Traub delivered a presentation on the consultation between the Belfast Trust and the ELFT, setting out the background, detail of the engagement between the Trusts which covered learning disability services in both Muckamore and a number of community settings, a summary of the main findings including areas of good practice, those for development, and outcomes and recommendations.

22. Karen O'Brien advised that feedback received on the role of the Acute Liaison Nurse for Learning Disability used in the Western Trust had highlighted the positive difference this had made. Further to this, Rodney Morton advised that investment was being made in learning disability nursing in Northern Ireland with 20 new posts being created and there was potential to work with the Trusts to use one of these posts to develop a learning disability liaison nurse. Brenda Creaney confirmed the Belfast Trust would be keen to work with the other Trusts on this but highlighted the need to ensure this did not risk destabilising the Muckamore workforce.

23. Siobhan Rogan queried the figure for the population served by the ELFT quoted in the second slide. Brenda Creaney agreed to seek clarification and provide confirmation.

AP2: ELFT population served figure to be confirmed. (Action: Belfast Trust)

Agenda Item 6 – MAH HSC Action Plan – Exception Report

24. Sean Holland referred members to paper MDAG/10/2021, and invited Darren McCaw to update the Group on progress with delivery of the Action Plan. Darren McCaw summarised the key points from the report, including a summary of the current RAG status of the actions in the plan, and an update on the actions rated red including a request to approve a proposed revised completion date for A30 to September 2021.

25. Sean Holland noted the report and confirmed members' agreement to amend the completion date for A30 as outlined in the report.

AP3: Completion date for HSC Action Plan Action A30 to be updated to September 2021 (Action: DoH)

Agenda Item 7 – Progress Update – Actions Rated Red

26. Sean Holland advised that further to agreement at the April meeting there would be a focus at each meeting on a number of the actions rated red within the HSC Action Plan. This will be a rolling process to allow for consideration of all the red-rated actions. Sean confirmed that updates on four actions would be provided at today's meeting; the Belfast Trust providing updates on actions A29 and A21; and the HSCB providing updates on actions A39 and A40.

27. Sean invited Gillian Traub to provide the updates from the Belfast Trust. Brenda Creaney provided an update in relation to A29, advising that, the Trust had recently received additional investment from the HSCB for the creation of a number of new specialist nursing posts at Band 7, 8A and 8B to deliver the workforce plan for specialist nursing across learning disability services, which

would include Muckamore. She advised the Trust were seeking to extend the deadline for the delivery of this action to allow this work to develop. Rodney Morton confirmed that the Chief Nursing Officer has prioritised investment in Learning Disability nursing to develop specialist nursing roles. He advised that the posts at Band 8 level were specialist posts and regional job descriptions for these roles were being collated, however it would likely be September before the posts were filled. Brenda Creaney advised the Belfast Trust were seeking to agree the potential to bring staff in via training for these roles in order to develop their own staff and potentially attract nurses with the relevant skills back into learning disability nursing roles.

28. Sean Holland queried the proportion of Learning Disability nurses who choose to work in non-specialist roles, and indicated that the Learning Disability Service Model needs to recognise and address this disparity. Members outlined some of the factors which contribute to this, and Rodney Morton noted work to create a career framework with a view to addressing this issue.

29. In relation to A21, Gillian Traub advised that following feedback from the ELFT visit in 2019 the Trust seclusion policy has been significantly revised and is scheduled to go to the Trust Standards and Guidelines Committee meeting in August for sign off.

30. Sean Holland thanked Gillian for the updates and invited Lorna Conn to provide the HSCB updates.

31. Due to the linked nature of actions, A39 and A40, Lorna provided a combined update advising that the regional review of admissions criteria and the development of a regional bed management protocol for LD services under A39 was dependent on the appointment of the regional bed manager post outlined in A40. Due to the non-recurrent nature of the funding provided in 2019/20 and the inability to appoint to the post at that time, action A40 had not been completed.

32. Lorna further advised that given the work carried out at the time, and other related pieces of work since, it would be helpful to further consider how this

could be moved forward should funding be made available. Karen O'Brien raised the potential to combine the proposed learning disability bed management role with the already established mental health bed management network in order to achieve a better outcome. Sean Holland requested that a meeting be organised between Mark Lee, Brendan Whittle and Lorna Conn to examine potential options for funding in order to move to recruitment and requested an update be provided at the next meeting of MDAG.

AP4: Meeting to discuss funding options re A40 to be organised between the DoH and HSCB. (Action: DoH)

AP5: An update on progress in relation to A40 to be provided at the MDAG meeting in August. (Action: HSCB)

Agenda Item 8 – Highlight Report and Dashboard

33. Sean Holland referred members to paper MDAG/11/21 and invited M ire Redmond to provide an update.

34. M ire Redmond highlighted a number of new items included in the report including the recent ward re-profiling exercise that had been carried out at Muckamore Abbey Hospital in order to make use of the most modern of the wards on-site and the potential decommissioning of the Erne Ward. M ire also advised that the DoH are engaged in ongoing discussions with the Belfast Trust on the range of information provided to MDAG, through the Highlight Report, and scope to improve this. As a result of these discussions, additional information on adult safeguarding processes has now been included in the Highlight Report. M ire invited Gillian Traub to provide a presentation to members on the additional safeguarding information proposed for inclusion in the Highlight Report. She confirmed a copy of the presentation would be circulated following the meeting.

AP6: Copy of BHSCT adult safeguarding presentation to be circulated to MDAG members (Action: DoH)

Expanded information iro safeguarding

35. Gillian Traub provided a presentation to the Group setting out the additional adult safeguarding detail which is proposed for inclusion in the Highlight Report. This covered the period from 1st January 2020 to 31st May 2021 and was collated from the single Trust database used to record this information. Gillian advised work was being taken forward to ensure detail on the database was as comprehensive and accurate as possible and confirmed that for future meetings up to date data will be provided.

36. Gillian provided an overview of the ongoing work within the Trust to avoid any repetition of past safeguarding failings, and to demonstrate the priority given to patient safety. She provided information on two distinct adult safeguarding data sets; staff on patient referrals; and patient on patient referrals. Detail was provided on screening processes, investigations, outcomes and continuous learning from investigations in order to enhance these processes. Sean Holland acknowledged that the DoH was demanding in terms of the information being sought from the Trust in order to provide assurances on safeguarding processes, and Gillian advised the Trust would continue to develop the information provided with Departmental colleagues.

37. Brigene McNeilly expressed concerns that the information provided did not reflect her recent experience of adult safeguarding within Muckamore which was extremely poor. She considered that those involved in the safeguarding team appeared unsure of processes and this had increased the anxiety she and her family had around their relative's care. Dawn Jones indicated her agreement with Brigene's comments, adding that she felt safeguarding was one of the weakest parts of Muckamore and also highlighted her concerns in relation to the inexperience, competence and attitude of some staff involved in safeguarding arrangements.

38. Gillian Traub advised that, in order to remove any potential conflict with the provision of care at Muckamore, the Adult Safeguarding team were a separate team, but who remain under the management of the Belfast Trust who have a responsibility to ensure the service remains fit for purpose. Gillian said it was a

concern that the Trust was not meeting expectations in this area.

39. Aine Morrison advised members that the Department was working with the Belfast Trust and RQIA on a number of safeguarding issues which have been of concern to the Dept. These issues have included the number and nature of safeguarding referrals that have been made in the past 18 months, the adequacy of protection plans relating to staff members on site about whom there are some concerns arising from the CCTV viewing and the application of regional adult safeguarding policy. Aine informed the meeting that the Department has commissioned an external file review of Muckamore adult safeguarding referrals involving allegations about staff behaviour. The Department is concerned that there appears to be a high number of these referrals although acknowledges that benchmarking this is difficult. The Trust has explained to the Department their belief that the thresholds for referral and investigation are very low and that this accounts for the numbers. The external file review will examine thresholds for referrals and investigations as well as looking at levels of harm or potential harm being caused by the incidents that had been reported.

40. Vivian McConvey queried whether an additional forum was required to engage with families on the concerns being expressed about safeguarding arrangements at the hospital. Sean Holland advised the Department was already reviewing the adult safeguarding arrangements in Muckamore and he suggested that this work would benefit from considering feedback from those families and carers who have been engaged with the adult safeguarding team. Sean requested that the Belfast Trust consider systematically collecting data in relation to families' experience of adult safeguarding in order to fully understand the experience of adult safeguarding in addition to the data collected.

AP7: BHSCT to consider collecting feedback from all those affected by adult safeguarding investigations. (Action: Belfast Trust)

41. Sean Holland advised the family representatives that he was happy to follow up directly with them and the Belfast Trust and PCC on any issues they may have in relation to adult safeguarding.

42. The family representatives welcomed this offer, and considered that further work is needed to improve Adult Safeguarding arrangements.

43. Aine Morrison noted that ongoing protection arrangements were in place arising from the viewing of historic CCTV footage, and discussions were continuing about current activity on-site.

44. Gillian Traub noted her presentation was based on a summary of safeguarding referral data, and acknowledged that families were expressing a lack of confidence in the current arrangements, which the Trust would wish to address. Gillian noted that the Trust had previously highlighted to the Department significant challenges due to vacancies within the adult safeguarding service and difficulties with recruitment. Some recent recruitment had taken place which meant that there are very new team members who are less experienced. The complexity and demands of the work of this team also have an impact.

45. Sean Holland reiterated his offer to be involved in discussions with families as appropriate, and noted that in addition to the activity data, it was important to understand families' experience of safeguarding.

46. Sean Holland advised members that he is also Chairing a group working to place adult safeguarding arrangements onto a statutory footing in Northern Ireland, which was also reviewing policies and procedures in this area. This work will include the creation of new criminal offences that can be committed in relation to adult safeguarding for members of the public or staff. He noted that if members considered it would be helpful, a presentation on the draft legislation could be arranged for MDAG.

Agenda Item 9 – AOB

47. None raised.

Agenda Item 10 – Date of next meeting

48. The next meeting is scheduled for Wednesday 25 August at 2pm.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
30/06/AP1	ELFT presentation to be circulated to members.	DoH	Circulated 8 July 2021	Closed
30/06/AP2	ELFT population served figure to be confirmed.	Belfast Trust	Belfast Trust confirmed as 1.3m from ELFT website. This is broken down as follows: East London population served: 750,000 Bedfordshire and Luton population served: 630,000	Closed
30/06/AP3	Completion date for HSC Action Plan Action A30 to be updated to September 2021.	DoH	Date updated	Closed
30/06/AP4	Meeting to discuss funding options re A40 to be organised between DoH and HSCB	DoH	Meeting arranged for 2 August 2021	Closed
30/06/AP5	An update on progress in relation to A40 to be provided at the MDAG meeting in August.	HSCB		
30/06/AP6	Copy of Belfast Trust adult safeguarding presentation to be circulated to members.	DoH	Circulated to members 15 July 2021	Closed
30/06/AP7	BHSCT to consider collecting feedback from all those affected by	Belfast Trust		

Ref.	Action	Respon-sible	Update	Open/ closed
	adult safeguarding investigations.			

HSC Public Health Agency

Management Team Paper for	PHA AMT	**Item**	8

Date	6 July 2021
Title of paper	21/22 Delivering Care £20m Strategic Investment Plan
Reference	AMT/01/07/21
Prepared by	Siobhan Donald
Lead Director	Rodney Morton

Recommendation For **Approval** ☒ For **Noting** ☒

Summary

AMT is asked to approve the attached proposal for the PHA staff allocations (Table 2), totalling £433, 802 (5WTE Nursing posts) within the Regional Delivering Care Safe Staffing £20m Strategic Investment plan for 2021-22.

AMT is asked to note the proposed allocations for Trust Nursing resources within the £20M Regional Delivering Care Safe Staffing for 2021-22.

Funding Requirements

In-year	
Full Year	£438,802
Source of Funding	Delivering Care / Safe Staffing

Assessments

Equality Screening Assessment	Attached	☐	Not required	☒
Rural Needs Assessment	Attached	☐	Not required	☒
Data Protection Impact Assessment	Attached	☐	Not required	☒

Signed	
Title	Director of Nursing, Midwifery and AHPs
Date	2 July 2021

1. INTRODUCTION /BACKGROUND

Delivering Care (2011) is a DOH policy framework[1] aimed to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the Nursing and Midwifery workforce in a range of major specialities. There are currently 11 phases either completed or in progress and these are detailed in **Annex A**

Specific Implementation of the Delivering Care Framework is commissioned by the Chief Nursing Officer who delegates lead responsibility of delivery to PHA Director of Nursing in partnership with the HSCB Director of Commissioning.

Nursing & Midwifery Task group

In addition, the Nursing and Midwifery Task Group Report[2], launched by the Minister in March 2020, and in keeping with Health & Wellbeing 2026: Delivering Together 2026[3] Vision, set out an ambitious roadmap that would provide direction in achieving world class nursing and midwifery services, in a reconfigured Health and Social Care system over the next 10-15 years. This was accompanied with a 5 year costed action plan. The consideration for the allocation of Delivering Care is closely aligned to the strategic themes of the Nursing and Midwifery Task Group, which are aimed at maximising the contribution of Nursing and Midwifery to the health of the population**.**

This has also been underpinned by the commitment for a safe staffing investment from the Minister, of £60m over 5 years, which led to suspension of Industrial Action and Framework Agreement with Trade Unions in January 2020. The Minister also committed to ensuring the full implementation and comprehensive funding of the Delivering Care policy directive across all practice settings, with a view to developing further partnership with the nursing and midwifery trade unions to develop the case for safe nurse staffing legislation at the earliest legislative opportunity.

To this end, the Executive then agreed, on 14 January 2020, to initiate investment by providing funding of £5m in 2020/21 for Delivering Care.

Subsequently**,** in 2021 under the June 2021 monitoring round**, a £20m investment has been committed to Delivering Care,** to further enable this commitment and progress the implementation of the recommendations within the NMTG framework[4].

[1] https://www.health-ni.gov.uk/publications/delivering-care-nurse-staffing-levels-northern-ireland
[2] https://www.health-ni.gov.uk/sites/default/files/publications/health/NMTG-report-and-recommendations.pdf
[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/NMTG-implementation-framework.pdf

This Strategic Investment plan **(Annex B)** was agreed following discussions with DOH and HSC Trusts, professional colleagues and in partnership with HSCB commissioning and finance teams.

2. ACCOUNTABILITY

It is noted, PHA Director of Nursing, in partnership with the Director of Commissioning, is responsible for overseeing the allocation of Delivering Care resources.

In addition, in partnership with the HSCB Director of Finance and Director of Commissioning, the Director of Nursing is accountable to the HSCB CEO (as outlined in the 21/22 HSCB Corporate Objectives) and the CNO for the delivery of the investment plan outlined in this paper.

As with any investment, a robust performance management and monitoring arrangement is required, in order to strengthen the impact and provide assurance that the objectives are being realised. So, in light of this substantial investment in 21/22, a Regional Oversight Board, chaired by PHA Director of Nursing, with a specific terms of reference and membership has been established. The Oversight Board arrangements have also been mirrored by the formation of local Trust implementation teams, chaired by the Trust Directors of Nursing, who have responsibility to deliver the plan outlined in this paper.

Details of the Accountability Structure is detailed **Annex C.**

3. OVERVIEW OF INVESTMENT PLAN 21/22

20/21 Allocation:

The 20/21 allocation of £5m was invested in the following 3 key areas and agreed through agreement with DOH and Trust professional colleagues and in partnership with HSCB Finance and Commissioning. Agreement for funding was in two phases and Phase 2 is included in the 21/22 funding outlined in **Table 1**

- **Phase 2 – Emergency Departments** –In 2019 there was a gap of 99 wte. In 20/21 £590k was allocated for a further 10wte Band 6. The residual gap for ED after 21/22 investment of 20 wte will be 69 wte.
- **Phase 3- District Nursing**- In 2020 the gap was 858wte (based on agreed 10wte to 10,000 GP population). A 10 year implementation plan is being developed. In 20/21 £2.1m (fye) was allocated for an additional 30wte Band 7.The residual gap for District Nursing after 21/22 investment of 55 wte will be 773 wte.

- **Phase 5A –Mental Health Inpatients** – In 2019 the wte gap was 272. In 20/21£1.7m ((fye) was allocated resulted in an additional 30 wte Band 6. The residual gap after 21/22 investment of 40 wte will be 202wte.

In the context of the NMTG framework, and in addition to completing the investment commitment in the 20/21 priority areas outlined above, Table **1** shows the additional areas which have been included for investment in 21/22. Full details of the Strategic Investment plan are detailed in **Annex B**

Table 1

AREA	WTE	Financial Allocation (£)	% of total allocation	Residual Gap following 21/22 investment
Emergency Care	20	£1,339,240	6.7%	**69wte**
District Nursing	55	£ 3,843,025	19.2%	**773 wte**
Mental Health	40	£2,627,106	13.1%	**202wte**
CAMHS	10	£721,450	3.6%	Work ongoing
Learning Disability	20	£1,083,182	5.4%	Work ongoing
School Nursing	30	£1,680,601	8.4%	Work ongoing
Health Visiting	20	£1,377,340	6.9%	**52 wte**
Perioperative	32.7	£2,175,396	10.9%	Work ongoing
Critical Care	25	£1,674,048	8.4%	Work ongoing
Midwifery	15	£ 1,106,347	5.5%	Work ongoing
Cancer	5	£374,676	1.9%	Work ongoing
Public Health	5	£400,901	2.0%	New posts
Quality and Nursing & Midwifery Assurance	5	£ 400,901	2.0%	New posts
Digital Health Nursing & Midwifery Specialist	3.0	£282,295	1.4%	New posts

Safe Staffing Clinical Nurse & Midwifery Lead	5	£335,340	1.7%	New posts
	290.7	**£ 19,421,846**		

Rationale for 21/22 Investment in additional areas as outlined in above Table:

Phase 4: Health Visiting

Investment is required to continue with the incremental implementation of Phase 4 and following the direction of the Healthy Child Healthy Future Framework 2010[5] **.**

In 2017 there was a gap of 72wte. Please note this phase is now subject to review and in light of the requirement in Healthy Child, Healthy Futures, which is expected to significantly increase the gap. The residual gap after 21/22 investment of 20 wte will be 52 wte.

Phase 9: Learning Disability

Whilst Phase 9 is not yet completed, in recognition of the need to improve and reform learning disability nursing services, as outlined in the Muckamore Abbey review and the new services model for learning disability, the current regional review of learning disability nursing commissioned by CNO, identified the need to invest and strengthen senior clinician decision making roles, to both improve governance and improve care outcomes. This will focus on ensuring effective bio-psycho-social care by LD nurses by seeking to address the health inequalities and changing health demographics of the learning disability population.

Phase 1B: Theatres/ Recovery

As discussed at RMB, the 21/22 investment will be utilised to support the rebuild, redesign and recovery agenda, in line with the Elective Care Framework, and to increase nursing clinical capacity in response to waiting list demands.[6] It also supports the recommendations of the recently completed Review of Perioperative Nursing and the development of a career framework in this area.

[5] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/healthychildhealthyfuture.pdf
[6] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf

Phase 1B cont'd Critical Care Nursing

Following the experience of COVID and surge planning, a review of CCN was commissioned across Theatres / Recovery and the 21/22 investment will support:-

- The findings of the CCaNNI Preliminary Report - 2020
- The Establishment of a Regional Service Delivery Model for Day case Elective Care Procedures in Northern Ireland (DoH, 2020)
- Rebuilding, Transition and Transformation of Elective Orthopaedic care-EOC (DoH, 2020)
- The Recruitment & Retention of CCN's.

Phase 11: Maternity

Whilst this phase is not yet completed, investment is required this year for a number of reasons:-

- To fully implement the NMC Continuity of Care midwife programme across all Trusts and to enable the implementation of saving babies lives programmes.
- In line Maternity Strategy enable the delivery of midwifery lead services in all Trusts.
- To enhance the capacity of the risk midwife roles, as outlined in the Perinatal Mortality (still births) review.

Cancer

The Cancer Strategy and the cancer services rebuild plan, [7] identifies the need to support the development of the cancer nursing workforce and enhance their contribution to patient care across a number of areas.

To commence this process, it has been agreed that the three cancer centres, (BHSCT, NHSCT and SETHSCT), will appoint a Cancer Nurse consultant, and in the other two Trusts, appoint an Advanced Nurse Practitioner. In addition, the PHA will also appoint a Regional Nurse Consultant, who in partnership with NICAN and Trusts, will work together to deliver highly specialist cancer care. This investment will augment the additional investment proposed under the cancer rebuild plan.

[7] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-cancer-services-rebuild-plan.pdf

School Nursing

There has been no recent investment in school nursing, and due the expansion of early intervention and schools health and wellbeing programmes, school nursing lacks the capacity to deliver the full health and wellbeing requirements of children and young people. The investment in 21/22 will increase the capacity of school nursing, building off the Design a School nurse programme seeking to improve access to health and wellbeing through the provision of universal services for all children 5-19 years.

Clinical Leadership Posts

In addition, a number of posts relating, specific to the Nursing & Midwifery Task Group report, across all 3 strategic themes, are being funded specifically:-

Quality and Safety Assurance

The NMTG requires the development of nursing KPI's and development of nurse and midwifery sensitive outcome indicators. These roles will support the Director of Nursing and Midwifery to ensure the highest standard of nursing care and to demonstrate the impact of nursing in relation to health and social care reform.

- **Population / Public Health Consultants**

There has been no investment in lifespan Public Health Nursing Roles; in line with the NMTG, a new Public Health and Population Health Nursing Network will be established. These roles will work with Public Health Consultants and other Public Health and Social Care Roles to ensure that prevention, early intervention and recovery are at the heart of all nursing and midwifery practices. It is also anticipated these roles will support the nursing and midwifery contribution to the development and implementation of the new NI Population Health Planning model, and will be expected to support the development of population health planning across ICS's.

- **Digital Health Nursing Lead**

These roles will support the full implementation of encompass and enable the development and digitalisation of nursing and midwifery care over the next 10 years, as outlined in the Nursing and Midwifery Task Group Action Plan.

Regional Infrastructure

In order to support the implementation of this ambitious allocation and support the rollout of the Nursing & Midwifery Task Group Action Plan, a number of regional

clinical lead roles have been included. These roles will provide regional clinical leadership across Public Health, Mental Health, Midwifery, Cancer, Quality and Safety and in specialist and advanced practice developments. These represent **2.8 %** of the overall allocation and are detailed in **Table 2.**

Table 2:

21/22	NMTG Regional Professional Lead Roles		
PHA	**1 Band 8 D (Public Health)**	**1 WTE**	**£433,802**
	1 Band 8B Midwifery	**1 WTE**	
	Assurance Regional Clinical Lead	**1 WTE**	
	1 Band 8B Lead Cancer Nurse Consultant.	**1 WTE**	
	1 Band 8B Children & Young Adults Programme	**1 WTE**	
	0.5wte System Dynamic Modelling £60k	**0.5WTE (non –recurrent)**	**£60K**
NIPEC Career Pathways	**NMTG Nursing Career Pathways Leads (8A)**	**2 WTE**	**£134,136**
DoH	**Regional workforce support**	**(non-recurrent)**	**£283,000**
		Total Regional Costs (Table 2)	**£850,938**
		Total Plan Costs (Table 1)	**£19,421,846**
		Total Project Costs (including £283K non recurrent)	**£20,272,784**

4. RISKS

It is estimated there will be at least 6 months slippage, on some aspects of the investment plan, due to recruitment timelines and the availability of the required Specialist Workforce, although this is a direction of travel and each Trust should outline specific slippage at point of submission of IPT.

Whilst acknowledging recruitment will be challenging, a number of mitigations have been put in place:-

1. The 21/22 investment has been spread across a number of areas to maximise expenditure through in-year recruitment.
2. Trusts were asked to create waiting lists for ED, Mental Health and District Nursing in 20/21, in preparation for the continuation of investment made in 20/21.
3. Preliminary meetings have also been held with all Directors of Nursing to assess recruitment confidence. Across most areas, there was a high degree of confidence with the exception of Learning Disability services.
4. To support recruitment to senior roles e.g. Nurse Consultants, it is proposed to create training posts to enable the requirements of these posts to be filled.
5. A regional approach has been agreed to the development of Job Descriptions.
6. There will be monthly performance management reviews via the new accountability structure.
7. It is anticipated that this significant investment will go towards attracting zero hours Bank and Agency contract workers to more permanent positions, as they see potential career progression pathways and therefore, having an impact on current recruitment and retention challenges

In addition, a detailed slippage plan is being progressed and will be available by the end of June for consideration.

5. RECOMMENDATION

SMT are asked to consider and approve the attached proposal for the £20M allocation to Delivering Care Safe Staffing for 2021-22.

Name of Directors: Mr Rodney Morton / Mr Paul Cavanagh

ISSUE:	**Delivering Care Accountability Structure** **Annex C**
TIMING:	
PRESENTATIONAL ISSUES	**None**
FOI IMPLICATIONS	**None**
FINANCIAL IMPLICATIONS	**£20M**
LEGISLATION / POLICY IMPLICATIONS	**None**
EQUALITY / HUMAN RIGHTS / RURAL NEEDS IMPLICATIONS	**None**
RECOMMENDATION	**SMT are asked to note the attached Annex, for the Accountability Structures, for the monitoring of the £20M allocation to Delivering Care Safe Staffing for 2021-22**

Annex B

Delivering Care Accountability Structure

Accountability Structure:

Delivering Care Strategic Oversight Board:

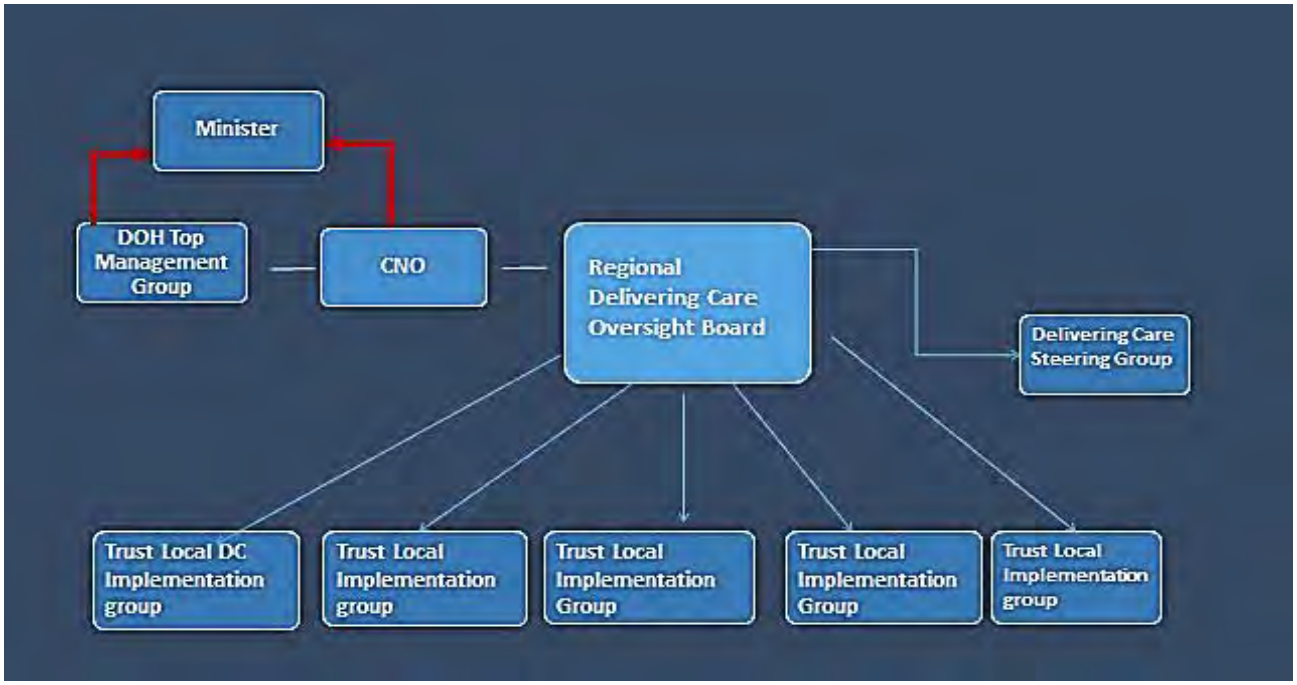
Membership:

- PHA Director of Nursing (Chair)
- PHA Assistant Director of Nursing – Workforce
- Deputy Chief Nursing Officer –Workforce
- Trust Directors of Nursing
- HSCB Finance
- HSCB Commissioning
- Staff Side
- RCN
- Regional HR

Trust Delivering Care implementation groups.

Membership:

- Trust Directors of Nursing (Chairs)
- Nursing Workforce Leads
- DCNO Workforce
- AD Nursing Workforce (PHA)
- Finance Representative
- HR Representative
- Staff Side
- Appropriate clinical leads (Interim membership)



FROM: Rodney Morton/ Siobhan Donald

DATE: 29 June 2021

TO: SMT

ISSUE:	Delivering Care £20m Strategic Investment Plan Annex B
TIMING:	
PRESENTATIONAL ISSUES	None
FOI IMPLICATIONS	None
FINANCIAL IMPLICATIONS	£20M
LEGISLATION/POLICY IMPLICATIONS	None
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	None
RECOMMENDATION	SMT are asked to approve the attached Annex for the £20M allocation to Delivering Care Safe Staffing for 2021-22

Nursing and Midwifery Task Strategic Investment Plan 21/22

21/22	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total	Funding Cost (£)
Emergency Care	4 Band 6 24/7	4 Band 6 24/7	4 Band 6 24/7	4 Band 6 24/7	4 Band 6 24/7	20	£1,339,240
District Nursing	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	55	£3,843,025
Mental Health	1 Band 8B CN 1 Band 8A 1 Band 7 5 Band 6	1 Band 8B CN 1 Band 8A 1 Band 7 5 Band 6	1 Band 8B CN 1 Band 8A 1 Band 7 5 Band 6	1 Band 8B CN 1 Band 8A 1 Band 7 5 Band 6	1 Band 8B CN 1 Band 8A 1 Band 7 5 Band 6	40	£2,627,106
CAMHS	1 Band 8B CN 1 Band 7	1 Band 8B CN 1 Band 7	1 Band 8B CN 1 Band 7	1 Band 8B CN 1 Band 7	1 Band 8B CN 1 Band 7	10	£721,450
School Nursing	1 Band 7 2 Band 6 1 Band 5	1 Band 7 2 Band 6 1 Band 5	1 Band 7 2 Band 6 1 Band 5	1 Band 7 2 Band 6 1 Band 5	1 Band 7 2 Band 6 1 Band 5	20	£1,083,182
Health Visiting	1 Band 7 FNP 5 Band 6	1 Band 7 FNP 5 Band 6	1 Band 7 FNP 5 Band 6	1 Band 7 FNP 5 Band 6	1 Band 7 FNP 5 Band 6	30	£1,680,601
Learning Disability	1 Band 8B CN 1 Band 8A 2 Band 7	1 Band 8B CN 1 Band 8A 2 Band 7	1 Band 8B CN 1 Band 8A 2 Band 7	1 Band 8B CN 1 Band 8A 2 Band 7	1 Band 8B CN 1 Band 8A 2 Band 7	20	£1,377,340
Theatres / Recovery	1 Band 7 CEF 7.7 Band 6	1 Band 7 CEF 5 Band 6	1 Band 7 CEF 5 Band 6	1 Band 7 CEF 5 Band 6	1 Band 7 CEF 5 Band 6	32.7	£2,175,396
Critical Care	5 Band 6	5 Band 6	5 Band 6	5 Band 6	5 Band 6	25	£1,674,048
Midwifery	1 CM 8B 1 Band 8A CoC 1 Band 7	1 CM 8B 1 Band 8A CoC 1 Band 7	1 CM 8B 1 Band 8A CoC 1 Band 7	1 CM 8B 1 Band 8A CoC 1 Band 7	1 CM 8B 1 Band 8A CoC 1 Band 7	15	£1,106,347
Cancer	1 Band 8B CN +	1Band 8A ANP	1CN 8B	1Band 8A ANP	1 Band 8B	5	£374,676
Public Health	1 Band 8B CN/M	1 Band 8B CN/M	1 Band 8B CN/M	1 Band 8B CN/M	1 Band 8B CN/M	5	£400,901
Quality and Nursing & Midwifery Assurance	1 Band 8B	1 Band 8B	1 Band 8B	1 Band 8B	1 Band 8B	5	£400,901
Digital Health Nursing & Midwifery Specialist	0.6 WTE Band 8C	0.6 WTE Band 8C	0.6 WTE Band 8C	0.6 WTE Band 8C	0.6 WTE Band 8C	3.0	£282,295
Safe Staffing Clinical Nurse & Midwifery Lead	1 Band 8A	1 Band 8A	1 Band 8A	1 Band 8A	1 Band 8A	5	£335,340
Total HSCT Trust posts	60.3 wte	57.6 wte	57.6 wte	57.6 wte	57.6 wte	290.7wte	£19,421,846

Regional Infrastructure:

21/22	**NMTG Regional Professional Lead Roles**		
PHA	**1 Band 8 D (Public Health)** **1 Band 8B Nursing and Midwifery Assurance Regional Clinical Lead** **1 Band 8B Lead Cancer Nurse Consultant.** **1 Band 8B Children & Young Adults Programme** **1 Band 8B Midwifery** **0.5wte System Dynamic Modelling £60k (for 2 years)**	**1 WTE** **1 WTE** **1 WTE** **1 WTE** **1 WTE** **0.5 WTE**	**£433,802** ***£60k**
NIPEC Career Pathways	**NMTG Nursing Career Pathways Leads (8A)**	**2 WTE**	**£134,136**
DOH	**Delivering Care Bill Team (2 Year allocation)**		***£223,000**
Total Recurrent **Total Non-Recurrent**	 **System Dynamic Modeller + Safe Staffing Bill Team**	**297.7 WTE**	**£19,989,784** **£283,000**
OVERALL Planned Investment: 21/22	***Please note £283K funded in-year**	**297.7 WTE**	**£20,272,784**

Public Health Nurse Consultant Mental Health and Learning Disability

Working together Excellence Openness & Honesty Compassion

BE PROUD.
BE PART OF IT.

JOB DESCRIPTION

JOB TITLE	Public Health Nurse Consultant (Mental Health and Learning Disability)
BAND	8B £51,164
DIRECTORATE	Nursing, Midwifery and Allied Health Professionals
INITIAL LOCATION	Public Health Agency
REPORTS TO	Assistant Director, Nursing and AHPs
ACCOUNTABLE TO	Director of Nursing and AHPs, Public Health Agency
FLEXIBLE WORKING PROVISIONS AVAILABLE	Full-time; Part-time and flexible working.

JOB SUMMARY

The post holder will work within the Nursing & AHP Directorate within the PHA.

They will be responsible for contributing to supporting the development of the nursing workforce in Northern Ireland to ensure safe and effective services in a range of areas and have expert knowledge in mental health and learning disability practice and will lead on specific regional and local projects. This will include detailed analysis of issues and challenges to safe staffing, to patient pathways, including the prevention of treatment and harm.

The post holder will work to secure and promote high quality, evidence based, person centred services which deliver positive outcomes and promote social and emotional wellbeing, in line with regional priorities, local needs, relevant legislation and professional standards.

In all duties the post holder will be expected to act with integrity, consistency and purpose in improving and enhancing health and social care services and reducing health inequalities.

KEY DUTIES / RESPONSIBILITIES

Strategic Direction and Planning

- Support population health planning and commissioning processes required to ensure the safe and effective delivery of all mental health and learning disability services throughout the region.
- Develop and lead where required service reform and modernisation initiatives (both uni and multidisciplinary).

- Contribute to the analysis of highly complex issues, including the development of solutions related to the modernisation of clinical and care practice in both planned and unscheduled pathways.

- Develop and support the implementation of agreed service improvement standards for the management of elective and unscheduled care services.

- Support the effective delivery of services and the achievement of performance targets.

- Contribute to the delivery of excellence in professional standards of nursing practice.

- Promote best practice and innovation in the provision of services and ensure the best possible patient journey and experience.

Collaborative Working

- Ensure effective active partnerships are developed with services users, their families, communities and across wider HSC services.

- Support individuals and communities have more control over decisions that affect them and promote health equity, equality and justice.

- Work as part of the multidisciplinary team maximising active partnerships with the public and service users using coproduction/codesign techniques, personal and public involvement standards and feedback from 10,000 Voices and other patient experience systems.

- Develop effective working relationships in partnership HSC Trust staff, PHA, and DoH staff to ensure a positive environment for the resolution of challenges and the achievement of standards and targets.

- Work with all Trusts and Independent sector providers to review patient pathways, identifying areas where a regional approach will improve services and enhanced efficiency and productivity.

- Contribute to corporate planning, policy and decision-making processes including contribution to the development of the joint Commissioning Plan.

- Contribute to and work with PHA and SPPG colleagues and Trusts in the development of new models of care across HSC to promote better quality/outcomes, improved access and help organisations ensure better value for money.

- Pursue all opportunities to develop integrated service models involving the relevant organisations and providers in the design implementation.

- Participate in local network groups to assist in building their capacity in the understanding and effectiveness in dealing with the needs of their population.

- Collaborate to create new solutions to complex problems by promote innovation and sharing of ideas, practice, resources, leadership and learning.

Communication and information Management

- Facilitate dialogue with groups and communities to improve care pathways improve health literacy and reduce inequalities using a range of tools and techniques.

- Measure, monitor and report on population-based information in relation to the use of services, targeting activities to address the wider determinates of health and health inequalities.

- Use information and data along with facilitation skills, to gain agreement on clinical, care and organisational issues, with a wide range of groups with competing priorities and perspectives.

- Contribute to and lead as required business case development, as part of the commissioning or external procurement process, for a wide range of projects.

- Identify and agree the information requirements necessary to support effective regional service improvement and performance management of targets and standards.

Service Development

- Ensure the development of a robust evidence base for pathway redesign, supported by impact analysis, quality assurance process and handovers in pathways maximising the potential for regional approaches where possible.

- Promote the adoption of innovative strategies and techniques in the development of departmental policies and strategies in care services.

- Facilitate change (behavioural and/or cultural) in organisations, communities and/or individuals including professional staff.

- Drive and challenge, teams and working relationships to innovate and implement reform to achieve and objectives of task groups.

- Work with Uni and multi professional teams to guide, develop and implement service reform and modernisation programmes

Research and Development

- Work to and for the evidence base, conduct appropriate research and provided informed advice and support to care teams to ensure impact on patient services.

- Apply research techniques and principles to the evaluation of local and regional services and interventions to establish evidence of effectiveness.

- Research and identify examples of national and international best practice in linking these into the work of the Improvement Teams to improve service to patients.

- Commission and coordinate research and audits when required ensuring learning and improvements are made a result.

- Audit and evaluate service redesign as an integral part of a service transformation strategy.

- Using current expert and professional networks to inform and develop strategies to improve health and social care services in Northern Ireland.

People Management

- Lead by example in practicing the highest standards of conduct, commitment and drive.

- Maintain good relationships and morale amongst staff

- Continuously review the performance of staff reporting to him/her taking action as appropriate, and provide guidance and direction on the personal development requirements of staff

Finance and Resource Management

- Prioritise, align and deploy resources towards clear strategic goals and objectives.

- Manage programme/project schedules resources and budgets including the tracking and evaluation of programmes against schedules and regularly review quality assurance, risks and opportunities to realise benefits and outcomes.

- Provide professional advice and support in relation to Trust Delivery Plans and any associated savings.

- Contribute to monitoring the performance of any consultancy contracts within sphere of responsibility to ensure compliance with expected outcomes and targets, including financial parameters.

- Identify and monitor any resources required to implement PHA priorities.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Organisation supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Organisational policy and procedure in all staffing matters, participating as appropriate in a way which underpins The Organisation's values.

RAISING CONCERNS - RESPONSIBILITIES

6. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

7. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Organisation's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.

GENERAL REQUIREMENTS

The post holder will be required to:

8. Assist the organisation in fulfilling its statutory duties under Section 75 of the Northern Ireland Act 1998 to promote equality of opportunity and good relations and under the Disability Discrimination (Northern Ireland) Order 2006. Staff are also required to support the organisation in complying with its obligations under Human Rights Legislation.

9. Ensure the Organisation's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

10. Co-operate fully with the implementation of The Organisation's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

11. Adhere at all times to all PHA policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

12. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

13. Co-operate fully with regard to PHA policies and procedures relating to infection prevention and control.

14. Take responsibility to minimise the PHA's environmental impact wherever possible. This will include recycling, switching off lights, computers, monitors and equipment when not in use. Helping to reduce paper waste by minimising printing/copying and reducing water usage, reporting faults and heating/cooling concerns promptly and minimising travel.

15. All employees of the Organisation are legally responsible for all records held, created or used as part of their business within the PHA including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

16. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

17. Represent the Organisation’s commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all PHA staff may be required to serve at any location within The Organisation's area, as needs of the service demand.

September 2023

PERSONNEL SPECIFICATION

JOB TITLE AND BAND	**Public Health Nurse Consultant. Band 8B**
DEPARTMENT / DIRECTORATE	**Nursing, Midwifery and Allied Health Professionals**
SALARY	**£51,164**
HOURS	**37.5**

ESSENTIAL CRITERIA			
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.			
Factor	**Essential Criteria Number**	**Criteria**	**Method of Assessment**
Qualifications/ Registration	*E1*	1a. Live on the Nursing and Midwifery Council Register as a Registered Nurse – Learning Disabilities and hold a university degree and have worked for at least 3 years at band 7 or above within mental health and/or learning disability services. **OR** 1b. Live on the Nursing and Midwifery Council Registered as a Registered Nurse – Learning Disabilities and have at least 5 years' experience working at a band 7 or above within mental health and/or learning disability services.	Shortlisting by Application Form
Experience	*E2*	Demonstrate experience of delivering improvements in mental health and/or learning disability care in line with evidence based best practice.	Shortlisting by Application Form
Other	*E3*	Hold a current full driving licence valid for use in the UK and have access to a car on appointment. These criteria will be waived in the case of applicants whose disability prohibits driving but have access to a form of transport approved by The Organisation which will permit them to carry out the duties of the post.	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:			
Skills / Abilities	*E5*	Demonstrate track record of leading, supporting and delivering significant positive change in services, including for example hospital, community and primary care.	Interview / Test
	E6	Demonstrate an ability to work independently with a proven track record of achieving challenging targets and standards.	Interview / Test

	E7	Demonstrate evidence of multidisciplinary team working which benefited patient/client care.	Interview / Test
	E8	Demonstrate excellent communication skills, to meet the needs of the post in full.	Interview / Test

DESIRABLE CRITERIA			
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job-related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted			
Factor	**Desirable Criteria Number**	**Criteria**	**Method of Assessment**
Experience	D 1	Experience of working in mental health and/or learning disability services at a regional level	Shortlisting by Application Form
Qualifications	D 2	Have undertaken post-graduate study/training in an area relevant to mental health and/or learning disability practice.	Shortlisting by Application Form

Ref No: <to be inserted by HR> **<Month & Year>**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note The Organisation reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model; http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model.

Particular attention will be given to the following dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results.

As part of the Recruitment & Selection process it may be necessary for The Organisation to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

THE ORGANISATION IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants:

- *may be required to attend for a Health Assessment*
- *can expect to be placed at the minimum point of the pay scale, although a higher starting salary, within the range of the pay band may be available if the person appointed has experience relevant & equivalent to the post. If the successful candidate is an existing HSC employee moving to a higher band, AfC Pay on Promotion will apply.*
- *are able to request Flexible Working from the 1st day of their employment. A number of flexible working provisions are offered by all HSC Organisations including Full-time working, Fixed working patterns, Part-time working, Flexi-time, Compressed/elongated hours, Average hours working patterns, Term-time working, Job-share or Homeworking for some or all of the working pattern, depending on the role being undertaken. Successful applicants are encouraged to discuss with their manager what Flexible Working provisions may be available in the role they are taking up, prior to commencing employment, to help them achieve a positive Work/Life Balance.*

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

All staff are expected to display the HSC Values at all times


WORKING TOGETHER
EXCELLENCE
COMPASSION
OPENNESS & HONESTY

HSC Public Health Agency

Delivering Care Safe Staffing Allocation Meeting

15.00-16.30

22/04/2021

Join Zoom Meeting
https://hscni-net.zoom.us/j/82070424317?pwd=anM4Vkx3V2xRdmM1VzljbzV6TGJMUT09

AGENDA

1. Opening Comments and Expectation:-
2. Overview of Financial Requirements -
3. Current Delivering Care Position inclusive of NMTG £5 Million
4. 21/22 Delivering Care Priorities
5. High-level Delivering Care Commissioning Plan for 20/21 and 22/21 Priorities
6. NMTG Delivering Care Implementation Structure – PHA/DOH Co-lead and Trust Establish Local Implementation Team

From the Chief Nursing Officer
Professor Charlotte McArdle

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

VIA EMAIL: Rodney Morton
(Rodney.Morton2@hscni.net)

Department of Health
C5.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: 028 9052 0562
Email:
Charlotte.McArdle@health-ni.gov.uk

Date: 10th June 2021

Dear Rodney,

Re: NMTG and Delivering Care 21/22 Investment Plan

Thank you for the updated indicative investment plan for the £20 million safe staffing allocation for 2021/22 and the Terms of Reference for the Regional Oversight Board to oversee the delivery of the plan.

I am content to approve the investment plan on the proviso that discussion and agreement takes place with operational directorates in each Trust regarding the additional posts. It is critically important that everyone is clear on the roles and governance arrangements of the new posts, including agreement on where they will sit within directorates.

It is imperative that recruitment progresses at pace. Given recruitment timeframes I note you aim to estimate in-year slippage and have already identified workforce needs where this could be effectively targeted. Once the estimates are determined I would ask you to forward a slippage plan to me for approval.

I am content with the proposed regional oversight arrangements for delivering the plan and the Terms of Reference for the Regional Oversight Board. I would ask that I be provided with a monthly progress report on the regional implementation of the investment plan.

Yours sincerely

PROFESSOR CHARLOTTE McARDLE
Chief Nursing Officer

Cc:

Heather Finlay, DCNO

Siobhan Donald, Assistant Director of Nursing, PHA

Office of the Director of Nursing,
Midwifery and Allied Health
Professionals
Public Health Agency
4th Floor South
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: 028 9536 3505
Website: www.publichealth.hscni.net
Email: Rodney.morton2@hscni.net

Professor Charlotte McArdle
Chief Nursing Officer
Department of Health
Stormont
Belfast

BY EMAIL

21 May 2021

Dear Charlotte

NMTG and Delivering Care 21/22 Investment Plan

Thank you for securing a £20m commitment, under the June monitoring round, to further enable the implementation of the NMTG recommendations. On behalf of Nursing and Midwifery, this is most welcome. Further to our workshop with Trust Directors of Nursing on 22 April 2021 and a follow up discussion at the CNO business meeting on 29 April 2021, I have attached, for your approval, the indicative investment plan. The net effect of this investment will result in approximately 294.5 wte nursing posts in 21/ 22, building on the 72 wte invested in 20/21.

As agreed, we are establishing a regional oversight board to oversee the delivery of the attached plan. (See attached TOR)

Once you have approved, I will be writing out to Directors of Nursing to lead implementation within their respective Trusts and will be issuing IPT's, which will set out key deliverables. I expect, subject to approval, to receive Trust responses to our proposed plan by the end of May.

Please note, the above figures are based on FYE allocation and whilst we are endeavouring to ensure Trusts' recruitment of the required posts will progress at pace, we would advise, that considering recruitment timeframes and workforce availability, there may be a possibility of in - year slippage, which we aim to estimate by early June.

We are also currently reviewing how any identified slippage may be used and already have a number of options for your consideration:-

- Supplementing of ECG in view of backfill salary costs.
- Providing some non-recurrent posts to School Nursing and Health Visiting to facilitate the backlog of assessments and referrals, which have developed through COVID-19.
- Supplementing the gap of the Band 5-6 costings for the Transformation project for enhanced levels of senior nurses on designated wards

Yours sincerely

Mr Rodney Morton
Executive Director of Nursing, Midwifery and Allied Health Professionals

Enc. NMSI Plan Oversight Board TOR
Draft 3 Nursing and Midwifery Task Strategic Investment Plan 21/22

Cc. Siobhan Donald, PHA

Nursing and Midwifery Task Strategic Investment Plan 21/22

Draft 3

Summary Table 21/22 Delivering Care Indicative Allocation:

Investment Area	NMTG Reference	WTE (Regional)	COSTINGS
Emergency Care	Strategic Theme 2 – Action 6	20	£1,339,240
District Nursing	Strategic Theme 2 – Action 6	55	£ 3,843,025
Mental Health	Strategic Theme 2– Action 6	40	£2,627,115
CAMHS	Strategic Theme 2 – Action 6	10	£655,889
School Nursing	Strategic Theme 1 – Action 3	20	£1,083,182
Health Visiting	Strategic Theme 1 – Action 3	30	£1,680,601
Learning Disability	Strategic Theme 2 – Action 6	20	£1,377,340
Theatres /Recovery & Critical Care	Strategic Theme 2 – Action 6	55	£3,668,650
Midwifery	Strategic Theme 2 – Action 6	15	£ 1,106,345
Cancer	Strategic Theme 2 – Action 6	5	£400,901
Public Health	Strategic Theme 1 – Action 2	5	£400,901
Quality and Nursing Assurance	Strategic Theme 3 – Action 3	5	£ 400,901
Digital Health Nursing Specialist	Strategic Theme 3 – Action 4	2.5	£235,246
Trust Safe Staffing Delivering Care- Implementation Senior Nurse co-ordinator	Strategic Theme 3 – Action 6	5	£335,340
Total HSCT WTE/Funding	Strategic Theme 2 – Action 6	287.5 WTE	£19,154,675
NMTG Regional Professional Lead Roles	Strategic Theme 2 – Action 6	5.5 WTE	£433,802
NMTG Career Pathway Leads	Strategic Theme 2 – Action 4	2 WTE	£134,136
Bill Team and System Dynamic Modelling	Strategic Theme 2 – Action 6		£360,000 NR
TOTAL Costs		294 WTE	£20,082,614

MAHI - STM - 308 - 1060
Proposal for DC ALLOCATION 21/22 –FINAL DRAFT 19/05/21

21/22	NMTG Reference	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total	Funding Cost (£)
Emergency Care	Strategic Theme 2 – Action 6	4 Band 6 24/7	5 Band 6 24/7	5 Band 6 24/7	5 Band 6 24/7	5 Band 6 24/7	20	£1,339,240
District Nursing	Strategic Theme 2 – Action 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4Band 6	1 Band 8B CN 1 Band 8A (ANP) 5 Band 7 4 Band 6	55	£3,843,025
Mental Health	Strategic Theme 2– Action 6	1 Band 8B CN 1Band 8A 1BND 7 5 Band 6	1 Band 8B CN 1Band 8A 1BND 7 5 Band 6	1 Band 8B CN 1Band 8A 1BND 7 5 Band 6	1 Band 8B CN 1Band 8A 1BND 7 5 Band 6	1 Band 8B CN 1Band 8A 1BND 7 5 Band 6	40	£2,627,115
CAMHS	Strategic Theme 2 – Action 6	1 Band 8A 1 Band 7	1 Band 8A 1 Band 7	1 Band 8A 1 Band 7	1 Band 8A 1 Band 7	1 Band 8A 1 Band 7	10	£655,889
School Nursing	Strategic Theme 1 – Action 3	1 Band 7'S 2 Band 6's 1 Band5's	1 Band 7'S 2 Band 6's 1 Band5's	1 Band 7'S 2 Band 6's 1 Band5's	1 Band 7'S 2 Band 6's 1 Band5's	1 Band 7'S 2 Band 6's 1 Band5's	20	£1,083,182
Health Visiting	Strategic Theme 1 – Action 3	1 Band 7 FNP 5 Band6's	1 Band 7 FNP 5 Band6's	1 Band 7 FNP 5 Band6's	1 Band 7 FNP 5 Band6's	1 Band 7 FNP 5 Band6's	30	£1,680,601
Learning Disability	Strategic Theme 2 – Action 6	1 Band 8B CN 1 Band 8A's 2 Band 7's	1 Band 8B CN 1 Band 8A's 2 Band 7's	1 Band 8B CN 1 Band 8A's 2 Band 7's	1 Band 8B CN 1 Band 8A's 2 Band 7's	1 Band 8B CN 1 Band 8A's 2 Band 7's	20	£1,377,340
Theatres /Recovery & Critical Care	Strategic Theme 2 – Action 6	1Band 7 CEF 10 Band 6	1Band 7 10 Band 6	1Band 7 10 Band 6	1Band 7 10 Band 6	1Band 7 10 Band 6	55	£3,668,650
Midwifery	Strategic Theme 2 – Action 6	1 MC 8B 1 Band 8A 1 Band 7	1 MC 8B 1 Band 8A 1 Band 7	1 MC 8B 1 Band 8A 1 Band 7	1 MC 8B 1 Band 8A 1 Band 7	1 MC 8B 1 Band 8A 1 Band 7	15	£1,106,345
Cancer	Strategic Theme 2 – Action 6	1 Band 8B CN	1 Band 8B CN	1 Band 8B CN	1 Band 8B CN	1 Band 8B CN	5	£400,901
Public Health	Strategic Theme 1 – Action 2	1 Band 8B CN	1 Band 8B CN	1 Band 8B CN	1 Band 8B CN	1 Band 8B CN	5	£400,901
Quality and Nursing Assurance	Strategic Theme 3 – Action 3	1 Band 8B	1 Band 8B	1 Band 8B	1 Band 8B	1 Band 8B	5	£400,901
Digital Health Nursing Specialist	Strategic Theme 3 – Action 4	0.5 WTE Band 8C	0.5 WTE Band 8C	0.5 WTE Band 8C	0.5 WTE Band 8C	0.5 WTE Band 8C	2.5	£235,246
Safe Staffing Clinical Nurse Lead	Strategic Theme 3 – Action 6	1 Band 8A	1 Band 8A	1 Band 8A	1 Band 8A	1 Band 8A	5	£335,340
Total HSCT Trust posts		57.5 wte	57.5 wte	57.5 wte	57.5 wte	57.5 wte	287.5wte	£19,154,675

21/22	NMTG Reference	NMTG Regional Professional Lead Roles		
PHA	Strategic Theme 1 – Action 2	1 Band 8 D (Public Health) 1 Band 8B Nursing and Midwifery Assurance Regional Clinical Lead 1 Band 8B Lead Cancer Nurse Consultant. 1 Band 8B Children & Young Adults Programme 1 Band 8B Midwifery 0.5wte System Dynamic Modelling £60k (for 2 years)	1 WTE 1 WTE 1 WTE 1 WTE 1 WTE 0.5 WTE	£433,802 *(£60k)
NIPEC Career Pathways	Strategic Theme 2 – Action 4	NMTG Nursing Career Pathways Leads (8A)	2 WTE	£134,136
DOH	Strategic Theme 2 – Action 6	Delivering Care Bill Team (2 Year allocation)		*£300,000
TOTAL Regional			7.0 WTE	£567,938
Total Recurrent			294.5 WTE	£19,722,614
Total Non-Recurrent		System Dynamic Modeller + Safe Staffing Bill Team		£360,000
OVERALL Planned Investment: 21/22		Please note £360K funded in-year	294.5 WTE	£20,082,614

Nursing and Midwifery Strategic Investment Plan Oversight Board

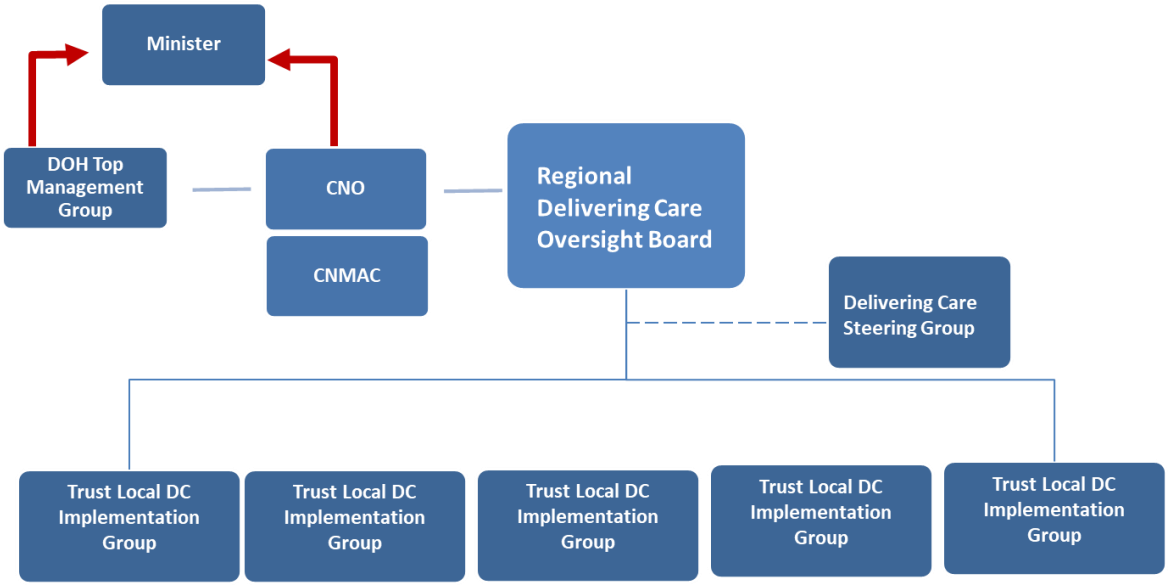
1.0 Background and rationale.

A £20m investment has been committed to the Delivering Care Policy Framework, under the June monitoring round, to further enable the implementation of the NMTG recommendations.

This is an opportunity to further realise the ambition within the NMTG recommendations to maximise the contribution of the nursing and midwifery workforce and create the conditions for the professions to develop and co-design services.

As with any investment, a robust performance management and monitoring arrangement is required in order to strengthen the impact and provide assurance that the objectives are being realised.

The Accountability structure is detailed below:



2.0 Regional Oversight Board Objectives and Responsibilities;

- To set direction, implement and delivering the agreed 21/22 delivering care programme.
- To monitor progress and implementation across all Trusts.
- To trouble shoot and resolve emerging implementation problems.
- To progress regional standardisation of job specification and roles across HSC system.
- To provide prepare and submit SIT report /performance updates to CNO business meeting on monthly basis.
- To provide a summary report to the Delivering Care Steering Group, it should be noted under the NMTG implementation infrastructure the

Regional Delivering Care Steering Group will be aligned with NMTG strategic theme 2- subgroup.

The Oversight Board will meet on a monthly basis in first instance until August 2021, and following a review will move to a quarterly thereafter

3.0 Regional Oversight Board Membership

- PHA Director of Nursing (Chair)
- DOH Deputy Chief Nursing Officer (Workforce) Co-Chair
- PHA Assistant Director of Nursing –Workforce
- Trust Directors of Nursing
- HSCB Finance
- Human Resource (HRD) Representative
- Staff Side Representative
- HSCB Commissioning

4.0 Local Implementation Team Objectives and Responsibilities.

- To develop a local implementation against the agreed 21/22 Regional agreed Delivering Care Programme.
- To ensure progress is made across all field of practice.
- Under the leadership of the Director of Nursing, partner with relevant programme heads, human resource and finance to ensure the effective co-ordination and implementation of the agreed 21/22 priorities.
- To put in place SIT/performance management arrangements to ensure delivery and report on monthly basis to oversight board.
- To engage with local operational teams to maximise progress.

5.0 Local Implementation Team Membership

- Trust Directors of Nursing (Chairs)
- Nursing Workforce Leads
- Finance Representative
- HR Representative
- Staff side Representative
- Appropriate clinical leads (Interim membership)

6.0 Performance Management:

- The oversight group will meet monthly for 6 months initially
- The Local Implementation Teams will meet weekly/fortnightly for 6 months to progress their local implementation plan.
- Develop a implementation risk register
- Baseline data will be collated from Delivering Care end of year returns (March 2021)
- Trusts will be asked to provide Baseline data for those areas for investment that are not included in the Delivering Care returns e.g. School Nursing etc.
- The local implementation groups will provide monthly SIT/Performance reports on progress, to include constraints and action to mitigate risks.
- Updated data collection against baseline will be collated monthly from month 6 (September 2021).
- Local Implementation Groups will provide a comprehensive data report in March 2022

From the Chief Nursing Officer
Professor Charlotte McArdle

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

VIA EMAIL: Rodney Morton
(Rodney.Morton2@hscni.net)

Department of Health
C5.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: 028 9052 0562
Email:
Charlotte.McArdle@health-ni.gov.uk

Date: 10th June 2021

Dear Rodney,

Re: NMTG and Delivering Care 21/22 Investment Plan

Thank you for the updated indicative investment plan for the £20 million safe staffing allocation for 2021/22 and the Terms of Reference for the Regional Oversight Board to oversee the delivery of the plan.

I am content to approve the investment plan on the proviso that discussion and agreement takes place with operational directorates in each Trust regarding the additional posts. It is critically important that everyone is clear on the roles and governance arrangements of the new posts, including agreement on where they will sit within directorates.

It is imperative that recruitment progresses at pace. Given recruitment timeframes I note you aim to estimate in-year slippage and have already identified workforce needs where this could be effectively targeted. Once the estimates are determined I would ask you to forward a slippage plan to me for approval.

I am content with the proposed regional oversight arrangements for delivering the plan and the Terms of Reference for the Regional Oversight Board. I would ask that I be provided with a monthly progress report on the regional implementation of the investment plan.

Yours sincerely

PROFESSOR CHARLOTTE McARDLE
Chief Nursing Officer

Cc:

Heather Finlay, DCNO

Siobhan Donald, Assistant Director of Nursing, PHA

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

ADVANCED NURSING PRACTICE FRAMEWORK

Supporting Advanced Nursing Practice in Health and Social Care Trusts

HSC

NIPEC

Contents

Acknowledgements

The Chief Nursing Officer, Department of Health, Social Services and Public Safety (DHSSPS) and the Director of Nursing and Allied Health Professions, Public Health Agency (PHA) would like to thank all of those who were involved in the development of the Advanced Nursing Practice Framework.

Particular thanks to the Executive Director of Nursing and User Experience, Belfast Health and Social Care (HSC) Trust, who chaired the Steering Group and the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), who managed the project. Thanks also for the commitment and contribution of the Steering Group members, who were representative of senior nurses in HSC Trusts, PHA, Regulation and Improvement Authority (RQIA), education providers, DHSSPS, Royal College of Nursing (RCN). Also represented on the Group were the Directors of Human Resource (HR) Forum, NIPEC Council and Northern Ireland Medical and Dental Training Agency (NIMDTA) (See Appendix 1).

In addition, it is important to acknowledge the role played by the HSC Trust Executive Directors of Nursing, who helped shape the Framework, and medical colleagues, who provided guidance in relation to the clinical aspects of this important nursing role. Finally, thanks to all those who contributed during and following the two workshops in April and June 2014, which helped further refine the Framework.

1.0 Purpose of the Advanced Nursing Practice Framework

Northern Ireland's Advanced Nursing Practice Framework was developed to provide clarity about the Advanced Nurse Practitioner role. The Framework

- provides a definition of Advanced Nursing Practice
- highlights the associated professional support and supervision required by Advanced Nurse Practitioners
- identifies the core competencies and learning outcomes essential for the Advanced Nursing Practice role
- acts as a guide for Commissioners, workforce planners, Executive Directors of Nursing, education providers, employers and managers of nurses, including nurses themselves.

The Advanced Nurse Practitioner role is a clinically focussed one. As it is continually evolving, the elements contained within this Framework will require periodic review.

2.0 What is Advanced Nursing Practice?

An Advanced Nurse Practitioner practises autonomously within his/her expanded scope of clinical practice, guided by The Code. Professional standards of practice and behaviour for nurses and midwives (Nursing and Midwifery Council (NMC) 2015). The Advanced Nurse Practitioner demonstrates highly developed assessment, diagnostic, analytical and clinical judgement skills and the components of this level of practice are outlined in Table 1. See Appendix 2 for the characteristics which distinguish between Advanced and Specialist Nursing practice.

Table 1. Components of Advanced Nursing Practice	
Clinical Practice & Scope of Role	• work autonomously, using a person-centred approach within the expanded scope of practice • undertake comprehensive health assessment with differential diagnosis and will diagnose • prescribe care and treatment, or appropriately refer and/or discharge patients/clients • provide complex care, using expert decision-making skills • act as an educator, leader, innovator and contributor to research.
Supervision Requirement	• supervision relevant to the area of practice [1] • professional nursing supervision.
Service Improvement	• work with DHSSPS and other relevant organisations to influence policy development and services • lead on service improvement initiatives.
Education Requirement	• have completed a Master's programme in the relevant area of practice • NMC recordable Non-Medical Prescribing V300.

3.0 Core Competencies for Advanced Nursing Practice

In Northern Ireland, the Advanced Nursing Practice role is supported by a set of four core competencies and related learning outcomes, which have been developed from the work already completed nationally and internationally in Republic of Ireland (2005), Scotland (2007), Hamric et al (2009), Wales (2010), England (2010), Australia (2011) and RCN (2012, revised).

Direct Clinical Practice is the first core competency of Advanced Nursing Practice and is supported by three additional competencies (see Figure 1):

- **Leadership and Collaborative Practice**
- **Education and Learning**
- **Research and Evidence-Based Practice**

[1] The Advanced Nurse Practitioner should receive supervision from an expert within the relevant area of practice. In some instances, this may be a practitioner from a discipline other than nursing for example, a GMC registered Consultant/Specialty Doctor grade or equivalent.

Figure 1. Entry criteria and Core Competencies of Advanced Nursing Practice.

Based upon the work of Hamric et al (2009)

4.0 The Advanced Nurse Practitioner Role

The Advanced Nurse Practitioner will undertake comprehensive health assessments, and will manage a range of illnesses and conditions that frequently present in the care settings within which the individual works. S/he will:

- practise autonomously within an expanded scope of practice
- demonstrate a person-centred approach to care delivery
- develop and sustain partnerships and networks to influence and improve healthcare outcomes and healthcare delivery
- educate, supervise or mentor nursing colleagues and others in the healthcare team
- contribute to and undertake activities, including research, that monitor and improve the quality of healthcare and the effectiveness of practice.

It must be noted that only those who meet the requirements of the role and who are employed as Advanced Nurse Practitioners, will be able to use the title.

5.0 Academic Preparation for Advanced Nurse Practitioners

The Advanced Nurse Practitioner role requires the nurse to have acquired a Master's educational and training programme in the relevant area of practice. The entry requirements for such academic programmes are highlighted in Figure 1 and include the following:

- be on the live register of the Nursing and Midwifery Council
- have a graduate level qualification
- be employed in the relevant area of clinical practice.

6.0 Application of Core Competencies

The four core competencies relevant to the Advanced Nurse Practitioner's role have specific core learning outcomes and are presented on pages 8 – 9. The learning outcomes have been developed to guide:

- curriculum development of the MSc Educational and Training programmes (commissioned by the DHSSPS)
- development of job descriptions for Advanced Nurse Practitioners
- ongoing learning and development of the individual employed in the role.

The core competencies and core learning outcomes will complement other generic competency frameworks which are relevant to the Advanced Nurse Practitioner's role, such as Knowledge and Skills Framework (DH, 2004); Healthcare Leadership Model (NHS Leadership Academy 2013); Attributes Framework (DHSSPS 2014).

7.0 MSc Advanced Nursing Practice Programmes

The MSc Advanced Nursing Practice Programmes are designed to prepare nurses to assess, diagnose and manage the plethora of conditions that present in their specific area of clinical practice. The modules within each MSc Programme focus on developing nurses' advanced skills in evidence-based practice, case management of patients with complex health needs and issues in advanced practice; they will also include the development and implementation of new roles.

The MSc Advanced Nursing Practice programmes have a significant emphasis on clinical acumen in the area of practice, and require over 500 hours of supervised practice in a variety of relevant settings. In addition, the programmes integrate research and evidence-based practice in each module, with the Extended Independent and Supplementary Prescriber (NMC V300 award) being an essential component of each programme.

It is important to note that the specific content of the direct clinical practice competency differs significantly by speciality and this will be reflected in each MSc Advanced Nursing Practice programme.

8.0 Core Competencies and Core Learning Outcomes

Core Competency 1. Direct Clinical Practice

The Advanced Nurse Practitioner will:

1.	Practise autonomously, using a person-centred approach, within the expanded scope of practice.
2.	Demonstrate comprehensive skills for assessment, diagnosis, treatment, management and prescribing within the field of practice.
3.	Use clinical judgement in managing complex and unpredictable care events, drawing upon an appropriate range of inter-agency and professional resources in his/her practice.
4.	Demonstrate ability to manage and negotiate person-centred health related/care needs for patients and their families.
5.	Monitor and report quality issue affecting the provision of advanced nursing care delivery.

Core Competency 2. Leadership and Collaborative Practice

The Advanced Nurse Practitioner will:

1.	Develop and sustain partnerships and networks to influence and improve healthcare outcomes and healthcare delivery.
2.	Engage stakeholders and use high-level negotiating and influencing skills to develop and improve practice, processes and systems.
3.	Provide professional and clinical advice to colleagues regarding therapeutic interventions, practice and service improvement.
4.	Demonstrate resilience as a clinical and professional leader.
5.	Develop robust governance systems by interpreting and synthesising information from a variety of sources in order to contribute to the development and implementation of evidence-based protocols, documentation processes, standards, policies and clinical guidelines and promote their use in practice.

Core Competency 3. Education and Learning

The Advanced Nurse Practitioner will:

1.	Continue to keep knowledge and skills up to date by engaging in a range of relevant learning and development activities.
2.	Educate, supervise or mentor nursing colleagues and others in the healthcare team.
3.	Advocate and contribute to the development of an organisational culture that supports continuous learning and development, evidence-based practice and succession planning.
4.	Lead person-centred care using a practice development approach.
5.	Lead and contribute to a range of audit and evaluation strategies which inform education and learning.

Core Competency 4. Research and Evidence-Based Practice

The Advanced Nurse Practitioner will:

1.	Contribute to and undertake activities, including research, that monitor and improve the quality of healthcare and the effectiveness of practice.
2.	Critically appraise the outcomes of relevant research and evaluations and apply the information to improve practice.
3.	Advocate and contribute to the development of a research culture that supports evidence-based practice.
4.	Lead and contribute to publications and dissemination of work.
5.	Demonstrate an understanding and application of a range of research methodologies.

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Royal College of Nursing (RCN) (2012) ***Advanced Nurse Practitioners. An RCN Guide to Advanced Nursing Practice, Advanced Nurse Practitioners and Programme Accreditation. Revised.*** London: RCN.

Appendix 1.

Membership of Steering Group

Brenda Creaney (Chair)	Director of Nursing, Belfast HSC Trust
Moira Mannion *	Co-Director of Nursing, Belfast HSC Trust
Elizabeth Graham *	Assistant Director of Nursing, Northern HSC Trust
Sharon McRoberts *	Assistant Director of Nursing, South Eastern HSC Trust
Lynn Fee *	Assistant Director of Nursing, Southern HSC Trust
Annetta Quigley *	Lead Nurse, Workforce Planning and Development, Western HSC Trust
Siobhan McIntyre	Regional Lead Nurse Consultant, Commissioning, Public Health Agency (also representing Health and Social Care Board)
Maryna Wylie	Assistant Director Human Resources, Northern HSC Trust (representing Directors of Human Resources Forum)
Roisin Devlin	Emergency Nurse Practitioner, Royal College of Nursing, NI Board
Linzi McIlroy	Senior Professional Development Officer, Royal College of Nursing
Catriona Campbell	Nurse Education Consultant, Clinical Education Centre
Caroline Lee	Nursing Officer, DHSSPS
Prof. Linda Johnston (until May 2014)	Head of School of Nursing and Midwifery, Queen's University, Belfast
Dr Kevin Gormley * (from June 2014)	Assistant Director of Education, School of Nursing and Midwifery, Queen's University, Belfast
Donna McConnell *	Lecturer, School of Nursing, University of Ulster
Christine Goan (until December 2013)	Corporate Improvement and Public Engagement Manager, RQIA
Kathy Fodey (from January 2014)	Director of Regulation and Nursing, RQIA
Dr John Collins	Associate Post-Graduate Dean (Careers), NIMDTA
Dr Vinod Tohani	Lay Council Member, NIPEC
Cathy McCusker * (Project Lead)	Senior Professional Officer, NIPEC

* Members of the sub-group which developed the content of the Advanced Nursing Practice Framework.

Appendix 2.

Distinguishing characteristics between Advanced and Specialist Nursing practice.

Components of Practice	Advanced Nursing	Specialist Nursing
Clinical Practice & Scope of Role	• work autonomously using a person-centred approach within the expanded scope of practice • undertake comprehensive health assessment with differential diagnosis and will diagnose • prescribe care and treatment or appropriately refer and/or discharge patients/clients • provide complex care using expert decision-making skills • act as an educator, leader, innovator and contributor to research.	• work as member of a team, • usually consultant-led, within a defined area of nursing practice • undertake comprehensive health assessment with differential diagnoses and may diagnose • prescribe care and treatment or appropriately refer and may discharge • contribute to education, innovation and research.
Supervision Requirement	• supervision relevant to the area of practice • professional nursing supervision.	• professional nursing supervision.
Service Improvement	• responsible for policy development, implementation and service development • lead on service improvement initiatives.	• contribute to policy and service development • contribute to service improvement initiatives
Education Requirement	• have completed a Master's programme in the relevant area of practice • have NMC recorded Non-Medical Prescribing V300.	• Have completed a BSc (Hons) • NMC recorded Specialist Practice qualification • may have NMC recorded Non-Medical Prescribing V300.

[2] The Advanced Nurse Practitioner should receive supervision from an expert within the relevant area of practice. In some instances this may be a practitioner from a discipline other than nursing for example, a GMC registered Consultant/Specialty Doctor grade or equivalent.

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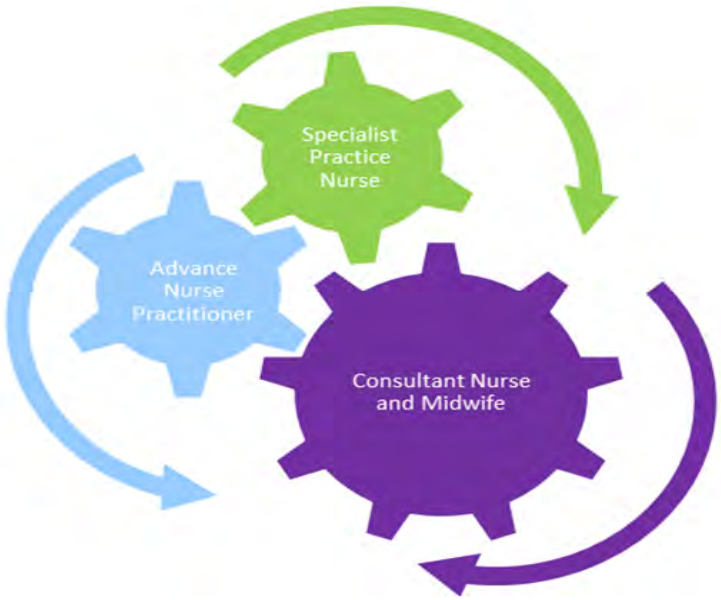
February 2016

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

PROFESSIONAL GUIDANCE FOR CONSULTANT ROLES

Supporting Consultant Nurses & Consultant Midwives in Health and Social Care



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FOREWORD

Northern Ireland's Department of Health (DoH) introduced Consultant Nurse and Midwife roles in 2000, to act as the pinnacle of a clinical career pathway for the most experienced and expert practitioners, working at an advanced level of practice[1]. These roles enable nurses and midwives to combine their role as clinician with the ability to have strategic influence and provide strong professional clinical leadership across the Health and Social Care System. *Health and Wellbeing 2026: Delivering Together*[2] sets out ambitious plans to transform health and social care. Delivering on this agenda requires all of us to work differently and at the highest standard of our practice.

I want the *Professional Guidance* to help reinvigorate this vital clinical, expert leadership role to drive the transformational changes required to deliver the world class service described in *Delivering Together.* Consultant Nurses and Midwives will also work within their multidisciplinary teams to ensure that services meet the needs of their populations through effective co-production with service users, collaborative engagement and impact measurement of outcomes.

This *Professional Guidance* is designed to support:

- practitioners in the Consultant role and those aspiring to the role;
- the introduction of new Consultant roles to facilitate service developments;
- education providers to enhance the professional development of these practitioners.

It will be reviewed three-yearly to ensure it stays aligned with other relevant professional resources and government policy.

PROFESSOR CHARLOTTE McARDLE
CHIEF NURSING OFFICER

[1] Department of Health Social Services and Public Safety (2004) *Circular HSS (TC5) 1/2000 (GB Advance Letter (NM) 2/2000).* Belfast*:* DHSSPS.
[2] Department of Health (2016) *Health and Wellbeing 2026: Delivering Together*. Belfast: DoH

1.0 Introduction

The policy for the establishment of Nurse, Midwife and Health Visitor Consultants[3] was first introduced in Northern Ireland in 2000. The posts were created to help provide better outcomes for patients/clients, strengthening clinical leadership and providing new career opportunities with the hope of retaining expert practitioners in clinical practice.

The policy guidance requires that all Consultant Nurse and Midwife posts:
"must be firmly based in nursing, midwifery or health visiting practice and involve working directly[4] with patients, clients or communities for at least fifty percent of the time available ("communities" may be relevant in the case of a nurse working in public health)."

(*Annex A, Section B, para 6*)

The policy guidance also identified four principal functions[5] for Consultant roles "irrespective of the field of practice, setting or service in which it (the role) is based":

- Expert Practice
- Education, Training and Development
- Professional Leadership and Consultancy
- Practice and Service Development, Research and Evaluation

The professional guidance in this document is designed to provide clarity, regarding the government policy, for practitioners, employers, managers, education providers and workforce planners.

The title Consultant Nurse or Consultant Midwife is only to be used by those employed in the role which fulfils the four principal functions in the DHSSPS policy guidance (2004)[1].

[3] Although the policy refers to nurse, midwife and health visitor consultants the title to be used from 2016 is Consultant Nurse or Consultant Midwife.
[4] In this document "working directly with" also includes practice which directly impacts upon the care of patients/clients or communities.
[5] The four principal functions hereafter are refered to as the four core competencies

2.0 Consultant Nurse and Consultant Midwife Roles

The Consultant Nurse and Consultant Midwife practises autonomously at an advanced level in the delivery of high quality, safe and effective care. The Consultant role blends a significant proportion of direct, higher level clinical care with education, research, service development and evaluation activities. These practitioners work within multidisciplinary teams across organisational, and professional boundaries,. They lead and influence service and policy development at strategic level while continuing to provide a strong clinical commitment and expert advice to clinical colleagues.

The core components of Consultant Nurse and Consultant Midwife roles are outlined in Table 1. The distinguishing characteristics between Consultant Nurse and Midwife Roles, Advanced Nurse Pracitioner and Specialist Nurse Practitioner roles is provided in Table 2 adapted from NI Advanced Nursing Practice Framework[6] (Annexe One, p. 11).

Table 1. Core Components of Consultant Nurse and Consultant Midwife Roles	
Expert Practice & Scope of Role	• exercise advanced levels of clinical judgment, knowledge and skill and possess a high degree of personal/professional autonomy to enable complex decision-making; • use an innovative, person-centred approach to contribute to better outcomes and experience for patients/clients, families, carers or communities; • provide strategic professional leadership to support improvements in professional practice, standards of care and effective identification and management of risk within the organisation's clinical governance framework; • act as an educator for colleagues wishing to develop advanced knowledge and skills and establish university links to provide academic and research support; • develop and influence professional practice locally and nationally through the promotion and evaluation of evidence-based practice, research and service development; • present and contribute to local/national professional conferences, special interest groups/working parties, research and relevant publication; and • lead and facilitate interprofessional working.
Supervision Requirement	• supervision relevant to the area of practice through local/national professional networks; and • professional nursing/midwifery supervision.
Service Improvement	• work with DoH and other relevant organisations to influence policy development and service/quality improvement; • lead on service/quality improvement initiatives at local, regional and national level; and • lead innovations across multidisciplinary teams.
Professional & Education Requirements	• live NMC registration; • have completed a Master's Degree as a minimum; • have completed a post-graduate qualification within the relevant area of practice; and • pursuing continuous professional and scholarly activity.

[6] Department of Health, Social Services and Public Safety (2016) *Advanced Nursing Practice Framework: Supporting Advanced Nursing Practice in Health and Social Care Trusts.* Belfast: NIPEC

3.0 Core Competencies for Consultant Nurse and Consultant Midwife Roles

The Consultant roles are the pinnacle of advanced practice and comprise four core competencies (see Figure 1):

- Expert Practice
- Professional Leadership and Consultancy
- Education, Learning and Development
- Practice and Service Development, Research and Evaluation

Figure 1. Entry criteria and core competencies for Consultant Nurse and Consultant Midwife Roles

4.0 Application of Core Competencies

The four core competencies relevant to the Consultant Nurse and Consultant Midwife roles have specific core learning outcomes and are presented on pages 8 – 11. The learning outcomes in this *Guidance* should be followed for:

- future curriculum development of the MSc Educational and Training programmes (commissioned by DoH)
- development of job descriptions for the roles
- ongoing learning and development of the individual employed in the role.

The core competencies and core learning outcomes will complement other generic competency frameworks which are relevant to the Consultant Nurse and Consultant Midwife roles, such as Knowledge and Skills Framework (DH, 2004)[7]; Healthcare Leadership Model (NHS Leadership Academy 2013)[8]; Attributes Framework (DoH, 2016)[9].

5.0 Continuing Professional Development (CPD) for Consultant Nurses and Consultant Midwives

The nature of Consultant Nurse and Midwife posts demand a portfolio of career long learning, experience and formal education, up to or beyond master's degree level; research experience and a record of scholarship and publication. Consultants should:

- seek opportunities to develop their knowledge and skills within all four core competency areas. It is important that the individual continues their portfolio of practice development, scholarship and research and is recognised as an expert and innovator in their field of practice
- develop their role in leading and influencing strategic planning, interprofessional and interagency working service developments and through co-production and co-design, facilitate improvement in services and patient/service user experience.
- have well established professional networks and collaborations associated with the area of practice, including Medical and Allied Health Professions colleagues, which will assist them with supervision and support them to develop their professional knowledge and leadership skills. These networks are an important element of the individual's CPD and can be local, regional, national and international.

[7] Department of Health (2004) *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process.* London: DH.

[8] National Health Service Leadership Academy (2013) *Healthcare Leadership Model.* Available at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model

[9] Department of Health Social Services and Public Safety (DHSSPS) (2014) *Supporting Leadership for Quality Improvement and Safety: An Attributes Framework for Health and Social Care.* Belfast: Health and Social Care Board and Public Health Agency.

6.0 Core Competencies and Learning Outcomes

Core Competence: Expert Practice

NMC Code theme: Prioritise People, Practise Effectively & Preserve Safety **KSF Core Dimension: Quality, Health, Safety & Security** **The Consultant Nurse/Midwife will**	
1.	Exercise a high degree of personal and professional autonomy in making complex clinical decisions drawing on advanced knowledge, skills and behaviours.
2.	Make decisions where precedents do not exist, challenge as necessary and provide advice and support to colleagues where standard protocols do not apply within multidisciplinary teams across organisational, professional and agency boundaries.
3.	Lead and influence service and policy development at strategic level while continuing to provide a strong clinical commitment and expert advice to clinical colleagues.
4.	Demonstrate advanced skills for assessment, diagnosis, treatment, management and prescribing within the field of practice and make and receive referrals, where appropriate.
5.	Identify and adopt innovative clinical practice models, eg. implementation and evaluation of new treatments, technologies, and therapeutic techniques.
6.	Lead/collaborate in the design and conduct of quality improvement initiatives.
7.	Actively participate in formalised ongoing supervision with Consultant peers eg. peer review of clinical practice at Consultant level.
8.	As an expert, conduct and contribute to systematic reviews of clinical practice.
9.	Provide a professional opinion on and where relevant lead clinical investigations/reviews
10.	Lead and support authentic stakeholder engagement, through co-production and co-design, to facilitate improvement in services and patient/service user experience.

Core Competence: Professional Leadership and Consultancy

NMC Code theme: Prioritise People, Practise Effectively & Promote Professionalism and Trust **KSF Core Dimension: Communication** **The Consultant Nurse/Midwife will**	
1.	Demonstrate professional leadership to support and inspire colleagues to improve standards, quality and professional practice.
2.	Have a significant role in Quality Improvement, providing expert input and influencing/challenging other professions, the wider organisation and across organisational boundaries to help deliver better services.
3.	Provide expert advice to others within and outside of the professions of Nursing/Midwifery, acting as a resources for others and also facilitating support within and outside of the organisation.
4.	Provide leadership to national/ international, as well as local, developments in their recognised area of expertise.
5.	Have the ability to challenge, motivate and inspire others, including other staff groups and organisations, to deliver the highest quality of care within their area of practice and beyond.
6.	Challenge organisational and professional barriers that limit or inhibit effective service delivery.
7.	Process complex, sensitive or contentious information in contributing to the development of strategic planning at local and national levels.
8.	Contribute to strategic planning to drive service change within and across health care organisations and across organisational boundaries and systems, where appropriate.
9.	Assume leadership roles, which promote broader advancement of clinical practice, eg. membership of editorial boards, leadership of position papers and development of advanced nursing practice standards.

Core Competence: Education, Learning and Development

NMC Code theme: Practise Effectively & Preserve Safety **KSF Core Dimension: Development of self & others** **The Consultant Nurse/Midwife will**	
1.	Contribute to the education, training and development of colleagues and others especially supporting experienced colleagues to develop advanced competencies.
2.	Support others in achieving their potential by acting as coaches, mentors and role models.
3.	Advocate and contribute to the development of an organisational culture that supports continuous learning and development, evidence-based and person centred practice and succession planning.
4.	Lead and contribute to a range of Quality Improvement, audit and evaluation strategies which inform education and learning.
5.	Work with key stakeholders, including Higher Education Institutes and other education providers, to develop and promote a range of learning opportunities.
6.	Self-development towards academic activity, leadership skills, service improvement methodology, leading/participating in multidisciplinary teams and peer supervision, publication and learning opportunities

Core Competence: Practice and Service Development, Research and Evaluation

NMC Code theme: Preserve Safety & Promote Professionalism & Trust **KSF Core Dimension: Service Improvement, Equality & Diversity** **The Consultant Nurse/Midwife will**	
1.	Provide direction for professional practice and service improvement within NI, nationally and/or internationally. Mentor colleagues and advise on personal development.
2.	Promote evidence-based, person-centred practice, setting of standards monitoring, management of risk and evaluation of care and services.
3.	Develop and advance professional practice to benefit patients/clients/carers and communities by creating, monitoring and evaluating practice protocols.
4.	Lead or collaborate in the application of research in practice, and develop research proposals with academic colleagues, business cases and funding applications, in addition to setting research objectives in line with the strategic direction of the organisation.
5.	Develop a research culture within the area of practice, act as a role model, establishing appropriate policies, support clinical research activity and contribute to publications and dissemination of work. Liaise and collaborate as appropriate with the Lead Research Nurse/Midwife in the HSC Trust.
6.	Maintain a publication record in relevant professional, peer reviewed journals and present at local, national and international conferences.
7.	Contribute to evaluations of service developments, which may lead to service redesign and the introduction of new models of care that are evidence-based and person-centred.

Annexe One

Table 2. Distinguishing characteristics between Specialist Practice Nurse, Advanced Nurse Practitioner and Consultant Nurse and Midwife Roles

Components of Practice	Specialist Practice Nurse	Advanced Nurse Practitioner	Consultant Nurse & Consultant Midwife
Clinical Practice & Scope of Role	• work as member of a team, within a defined area of nursing practice; • undertake comprehensive assessments with differential diagnoses and may diagnose; • prescribe care and treatment or appropriately refers and may discharge; and • contribute to education, innovation and research.	• work autonomously using a person-centred approach within the expanded scope of practice • undertake comprehensive health assessment with differential diagnosis and will diagnose • prescribe care and treatment or appropriately refers and/or discharges patients/clients • provide complex care using expert decision-making skills • act as an educator, leader, innovator and contributor to research.	• exercise advanced levels of clinical judgment, knowledge and skill and possess a high degree of personal/professional autonomy to enable complex decision-making • use an innovative, person-centred approach to contribute to better outcomes and experience for patients/clients, families, carers or communities • provide strategic professional leadership to support improvements in professional practice, standards of care and effective identification and management of risk within the organisation's clinical governance framework • act as an educator for colleagues wishing to develop advanced knowledge and skills and establish university links to provide academic and research support • develop and influence professional practice locally and nationally through the promotion and evaluation of evidence-based practice, research and service development • present and contribute to local/national professional conferences, special interest groups/working parties, research and relevant publication • lead and facilitate interprofessional working
Supervision Requirement	• professional nursing supervision	• supervision relevant to the area of practice* • professional nursing supervision.	• supervision relevant to the area of practice through local/national professional networks • professional nursing/midwifery supervision.
Service Improvement	• contribute to policy and service development • contribute to service improvement initiatives	• responsible for policy development, implementation and service development • lead on service improvement initiatives	• work with DoH and other relevant organisations to influence policy development and service/quality improvement • lead on service/quality improvement initiatives at local, regional and national level • lead innovations across multidisciplinary teams.
Education Requirement	• live NMC registration • BSc (Hons) in Nursing or other Health Related Subject; • NMC recorded Specialist Practice qualification; and • may require a NMC recorded Non-Medical Prescribing qualification.	• live NMC registration • has completed a Master's programme in the relevant area of practice • NMC recorded Non-Medical Prescribing V300.	• live NMC registration • have completed a Master's Degree as a minimum • have completed a post-graduate qualification within the relevant area of practice • may require a NMC recorded Non-Medical Prescribing qualification. • pursuing continuous professional and scholarly activity.

***** The Advanced Nurse Practitioner should receive supervision from an expert within the relevant area of practice. In some instances this may be a practitioner from a discipline other than nursing for example a GMC registered Consultant/Specialty Doctor grade or equivalent

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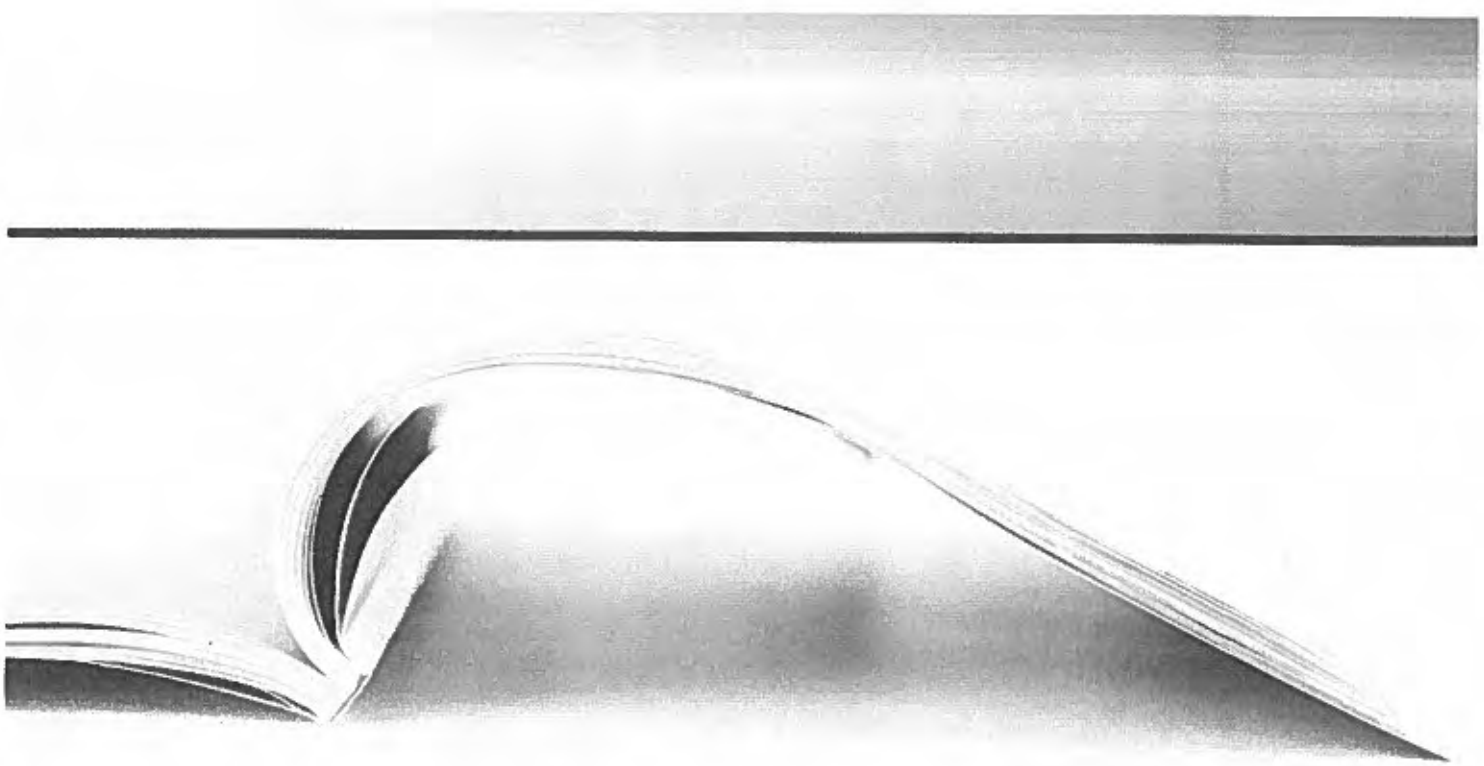
June 2017



A Review of Leadership & Governance at Muckamore Abbey Hospital

The Muckamore Abbey Hospital Review Team

31 July 2020

Executive Summary

1. The confidence of families and carers in the health and social care system's ability to provide safe and compassionate care was significantly undermined by the abuse of patients at Muckamore Abbey Hospital (MAH) which came to light in 2017. An Independent Review Team was commissioned by the Health and Social Care (HSC) Board and Public Health Agency at the request of the Department of Health to review leadership and governance arrangements within the Belfast HSC Trust between 2012 and 2017 to ascertain to what degree, if any, said leadership and governance arrangements contributed to the abuse of vulnerable patients going undetected. An Independent Team was appointed in January 2018 to conduct a level three Serious Adverse Incident (SAI) investigation of patient safeguarding at MAH. The outcome of that review, the *A Way to Go* report, was published in November 2018. The Department of Health (DoH) considered that that report had not explored leadership and governance arrangements at MAH or the Belfast HSC Trust sufficiently. The current review commenced in January 2020.

2. MAH opened in 1949 as a regional hospital for children and adults with learning disabilities. Initially, the hospital principally provided long-term inpatient care. In 1984 the Hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients. During the 1980s the policy direction was to provide care for people with learning disabilities within the community. From that time the intention was to reduce the number of patients and to develop resettlement options. The 1992/97 Regional Strategy established three targets: 'develop a comprehensive range of support services by 2002; have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and reduce the number of adults admitted to specialist hospitals.' Progress was slow but following the Bamford Reviews and the 2011 publication of Transforming Your Care, targets were established to close long-stay institutions and complete resettlement by

2015. The rate of ward closures and the numbers resettled progressed significantly with targets monitored for compliance. The current review took place within the context of retraction and resettlement which had significant implications for staffing, patients, and their relatives and carers. By July 2020 there were fewer than 60 patients at MAH.

3. The Review Team conducted the review by examining a range of Trust documents and by interviewing key staff at Muckamore Abbey Hospital, Belfast Health and Social Care Trust, the Health and Social Care Board and Public Health Agency, and the Department of Health. It also visited MAH during February 2020 and met staff and patients during visits to the wards. The Review Team met with a number of parents, advocates, a Member of Parliament, the PSNI, the Regulation and Quality Improvement Authority (RQIA), the Patient and Client Council (PCC), the Permanent Secretary of the Department of Health, and the Health Minister. Representatives of the Review Team also had the opportunity to attend a meeting of the Muckamore Abbey Departmental Advisory Group. The Review Team acknowledges the cooperation afforded to them by all those they met. It regrets that due to the Covid-19 lockdown it was not able to meet with more patients, relatives, and carers. Only three retired members of staff did not meet with the Review Team for a number of reasons.

4. The Belfast HSC Trust is one of the largest integrated health and social care organisations in the UK. It has appropriate governance structures in place with the potential to alert the Executive Team and the Trust Board to risks pertaining to safe and effective care. The Trust Board and Executive Team rarely had MAH on their agendas. Issues which were discussed at that level generally focused on the resettlement targets. The annual Discharge of Statutory Functions Reports did not provide assurance on the degree to which statutory duties under the Mental Health Order 1986 were discharged. The Review Team saw no evidence of challenge at Trust, HSC Board, or Department of Health level regarding the adequacy of these reports. The Review Team was informed that matters came to the Trust Board on an issue or exceptionality basis and that the acute hospital agenda dominated. In

addition, the Review Team was advised that the emphasis was on services rather than facilities, such as MAH. The comprehensive governance arrangements were not a substitute for staff at both MAH level and Director level in the Trust exercising judgment and discernment about matters requiring escalation. The Review Team was informed that there was a high degree of autonomy afforded to Directors and senior managers given the scale of the Trust's operation. The Review Team concluded that there was a culture within MAH of trying to resolve matters on-site. The location of MAH at some distance from the Trust and the lack of curiosity about it at Trust level caused the Review Team to view it as a place apart. Clearly, it operated outside the sightlines and under the radar of the Trust.

5. The leadership team at MAH was dysfunctional with obvious tensions between its senior members. There was also tension around the intended future of the hospital with some managers viewing its future as a specialist assessment and treatment facility while others perceived it as a home for patients; many of whom had lived in the hospital for decades. There was a lack of continuity and stability at Directorate level and a lack of interest and curiosity at Trust Board level. Visits of Trust Board members and other Directors to MAH were infrequent. Leadership was not visible. The Review Team was told that staff at MAH were not always clear which Trust Director had responsibility for services on-site. As the *A Way to Go* report noted, staff felt a loyalty to one another rather than to the Trust. Leadership was also found wanting at Director level as issues relating to the staffing crisis at MAH and its impact on safe and compassionate care were not escalated to the Executive Team or Trust Board as a means of finding solutions. One Director told the Review Team of his efforts to undertake regular walkabouts at MAH as a means of understanding the issues confronting staff and patients. Other Directors referred to occasional visits to the site but not on a structured or regular basis. The value base of the Belfast Trust is well articulated in its strategies and leadership frameworks. Unfortunately, there were no effective mechanisms in place to ensure that these values were cascaded to staff at MAH. The value base of some staff was antithetical to that espoused by the Trust as an organisation.

6. The Review Team considered three events at MAH to structure its review of leadership and governance. The first was the Ennis investigation which commenced in November 2012 following complaints from a private provider's staff about physical and verbal abuse of patients in the Ennis Ward. The investigation was carried out jointly with the police under the Trust's adult safeguarding and the Joint Protocol processes. It resulted in two staff members being charged with assault. One staff member was not convicted while the other's charge was overturned on appeal. The investigation took eleven months to produce a final report. The Review Team considered the Ennis investigation to be a missed opportunity as it was not escalated to Executive Team or Trust Board levels for wider learning and training purposes. It was not addressed in the Discharge of Statutory Functions Reports nor was there evidence in the documentation examined that its findings were disseminated to staff and relatives/carers. The Review Team considered that the Ennis Investigation merited being addressed as an SAI, as a complaint, and as an adult safeguarding matter. Each of these additional processes would have provided a mechanism to bring matters at Ennis to the Trust Board. The HSC Board for some considerable time pressed the Trust to submit an SAI in respect of Ennis. When the Trust accepted that it was in breach of requirements by not conducting an SAI, the Board let the matter rest. The Review Team considered the situation at Ennis to be an example of institutional abuse. Learning from Ennis therefore had the potential to identify any other institutional malpractice at an earlier stage.

7. The second issue considered by the Review Team was the installation of CCTV initially at Cranfield in the male and female wards and in the Psychiatric Intensive Care Unit (PICU), as well as in the Sixmile wards. The concept of installing CCTV for the protection of patients and staff was first raised around August 2012. A business case was developed and approved in 2014. In 2015 CCTV cameras were installed in Cranfield and Sixmile wards. From an extensive examination of all documentation, the Review Team concluded that the CCTV system was operational and recording from July 2015. There was no policy nor procedure to inform the use of CCTV. The

Review Team identified extensive delay in finalising a CCTV policy; some 25 months after the cameras were installed. During July/August 2017 notices were displayed in Cranfield and Sixmile wards advising that the CCTV cameras would become operational from the 11th September 2017.

8. The Trust paid for regular maintenance of the cameras following their installation. The system on which the CCTV cameras operate is one where the cameras are triggered by motion. Recordings are due to overwrite after 120 days. Due to the motion activation of the cameras it is likely that recordings were of longer duration than the 120 days. The Review Team concluded that the footage now available had overwritten previous footage.

9. CCTV footage in late August/early September 2017 revealed abuse and poor practice in several of the wards. The CCTV cameras had been recording for a considerable amount of time, apparently without the knowledge of staff or management. The discovery of historical CCTV recordings prompted by the intervention of a concerned parent, revealed behaviours which were described as very troubling, professionally and ethically, which were morally unacceptable and indefensible. It is apparent from extensive discussion with staff at all levels that there was no awareness that the cameras were operational. The MAH staff member (retired) most likely to be in a position to clarify matters regrettably did not respond to the request to meet with the Review Team.

10. The existence of CCTV recordings was reported to senior staff at the Trust's HQ on 20th September 2017. This was at least two to three weeks after the situation was identified at MAH. Immediate steps were taken at Trust Executive Team level to inform the police about the existence of CCTV footage in relation to an alleged assault which occurred on 12th August 2017 as well as other incidents. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions; at least 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. Despite

the scale of the abuse it is important to note that carers and families have frequently attested to the care and professionalism of many staff working at MAH.

11. The third incident considered was a complaint about an assault on a patient at PICU which occurred on 12th August 2017. This assault was not reported to the patient's father until 21st August 2017. The father was understandably concerned about the delay in notifying him especially as he was used to being regularly contacted by the staff about his son. A thorough review of all of the evidence led the Review Team to conclude that the delay in notifying the father was due to a breach of the Trust's adult safeguarding policy rather than an attempt to hide misdoings. The incident of the 12th August 2017 was immediately reported by a staff nurse who witnessed it. The Nurse in Charge failed to initiate the adult safeguarding arrangements at that time. Instead he emailed the Deputy Charge Nurse (DCN) seeking to meet in order to discuss a concern. At the meeting on the 17th August the DCN considered the information to be vague and emailed the staff nurse for details as he was on leave. As soon as matters were brought to the attention of the Charge Nurse on 21st August all appropriate action was taken in a timely manner, including notification to the patient's father.

12. Following a meeting with MAH staff on 25th August the father complained to the Trust. Due to an incorrect email address, this was not received by the Complaints Department until the 29th August. In a letter to the father dated the 30th August 2017 he was advised that at the completion of the safeguarding investigations any outstanding matters could be addressed through the complaints procedure. The safeguarding investigation concluded in November 2018. The complaint remains open and incomplete. The Review Team considered this unacceptable.

13. The Review Team intended to visit centres of excellence to provide comment on best practice. Due to lockdown this was not possible. The Review Team has however, provided comment which it considered appropriate to the development of a person-centred rights based model of care for patients in learning disability hospitals.

14. The Review Team concluded that the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels within the organisation. This failure resulted in harm to patients. The Review Team concluded that while senior managers at MAH may not have been aware of the culture of abuse, that their responsibility for providing safe and compassionate care remained. The Review Team made twelve recommendations to the Department, HSC Board, and the Trust in order to improve future practice. These recommendations took account of the improvements already implemented by the Trust.

15. The Review Team acknowledges the recent efforts made by the Belfast HSC Trust to promote and monitor a safe person-centred environment at MAH.

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Appendices

1. Introduction

1.1 At the request of the Department of Health (DoH), the Health and Social Care Board (HSCB) and Public Health Agency (PHA) commissioned a review to examine critically the effectiveness of the Belfast Health and Social Care Trust's (Belfast Trust) leadership and governance arrangements in relation to Muckamore Abbey Hospital (MAH).[1] The review's remit spans the period from 2012 to 2017.[2] This five year period preceded serious adult safeguarding allegations that came to light in August 2017. Under its Serious Adverse Incident policy the Belfast Trust commissioned a review into these allegations by appointing a team of independent experts in January 2018.

1.2 The expert team in November 2018 published its report, *A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital.* The HSCB/PHA and the DoH concluded that leadership and governance issues in MAH and within the Belfast Trust merited further examination. It was therefore decided that a further review focusing on leadership and governance be conducted in order to 'establish if good leadership and governance arrangements were in place and failed, and, if so, how/why; or were effective systems not in place.'[3]

1.3 A complaint and allegations made in 2017 that vulnerable patients were physically and mentally abused by staff at Muckamore Abbey Hospital resulted in the police and the Belfast Trust initiating investigations under the Trust's Safeguarding of Vulnerable Adults policy, Complaints policy, and its Serious Adverse Incident policy. A considerable volume of video evidence exists in relation to the alleged abuse; the PSNI has a lead role in these investigations given their criminal nature.

[1] Terms of Reference, Appendix A(i)
[2] During that period there were three key events around which the Review Team focused its attention: November 2012 allegations made regarding the care and treatment of patients in the Ennis Ward; August 2017 complaints by a parent regarding his son's care; and August 2017 the identification of video recording regarding the care and management of patients.
[3] Purpose of Review, Terms of Reference, January 2020

A number of MAH staff and ex-staff have subsequently been arrested, some of whom have been referred to the Public Prosecution Service (PPS), while others have been suspended from their jobs. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions, 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. The PSNI has confirmed that the scale of the evidence has required the establishment of a dedicated investigation team.

1.4 During 2018/19 the Belfast Trust and DoH set up a series of measures to address the serious allegations and evidence that was emerging regarding the safety of patients at MAH. This included the establishment of: the *Way to Go* Review Team by the Belfast Trust; as well as the Muckamore Abbey Hospital Departmental Assurance Group (MDAG) jointly chaired by the DoH's Chief Social Services Officer and the Chief Nursing Officer.

1.5 From the outset the leadership and governance Review Team decided to accept the safeguarding concerns raised in the following reports, rather than re-examine these events:

- November 2012 in the Ennis Ward;
- the incidents evident in CCTV footage available from March to August 2017; and
- the complaint made by a patient's father in August 2017 regarding his son's alleged abuse by staff.

The Review Team has accepted these events as key events in its review of governance and leadership and will consider them within that context in Section 8 of the report.

2. Terms of Reference

2.1 The Terms of Reference (ToR) were agreed between the HSCB/PHA and the Department in consultation with the MDAG. The full Terms of Reference are available at Appendix 1. The ToR can be summarised as follows:

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to the quality, safety and user experience. Drawing upon families, carers and staff's experience; conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

- *Strategic leadership across the Belfast Trust.*
- *Operational management*
- *Professional / Clinical leadership*
- *Governance*
- *Accountability*
- *Hospital culture and informal leadership*
- *Support to families and carers*

2.2 The ToR also requires that the Review Team:

- interview key individuals and scrutinise relevant documentation;
- establish lines of communications with all the organisations impacted by the review; and
- act fairly and transparently and with courtesy in the conduct of its work.

3. The Review Team

3.1 The HSCB and PHA established a three-person review team with organisational, clinical, and professional expertise from their previous work experiences within health and social services in Northern Ireland. Review Team members comprised:

David Bingham

Maura Devlin

Marion Reynolds

Katrina McMahon – Project Manager

Appendix 2 sets out brief curriculum vitae in respect of each of the Review Team members.

4. Methodology

4.1 The methodology provided by the HSCB/PHA was based on the establishment of a team of independent members with extensive experience of leadership and management within the health and social care sector (See Para 3.2).

4.2 The Review Team's first task was to establish lines of communication with all those likely to be impacted by the review. The Belfast Trust was the main focus of the review. Others contacted included: the DoH; HSCB; PHA; RQIA; families and carers as well as their representatives; advocacy services; the Patient and Client Council (PCC); other HSC Trusts with patients in MAH; and the PSNI.

4.3 The Review Team met with senior staff from each of these organisations and a number of family members. On 21st February 2020 the Review Team visited MAH to meet with patients and staff. The Review Team determined the type and range of documentation required to establish the policies and operational protocols extant during the period under review. The Belfast Trust was asked to provide extensive documentation to enable the Review Team to assess its governance and leadership arrangements. This included Trust policies on controls assurance, management of risk, complaints, and serious adverse incidents. Details of organisation charts, minutes of management, Directorate, and Board meetings were also sought. The Review Team experienced some difficulty in acquiring documentation due to Lockdown. Other organisations were also asked to provide relevant documentation. The list of documentation examined by the team is set out in Appendix 3

4.4 Having examined documentation furnished by the Belfast Trust the Review Team met with key individuals in the Trust and other organisations. It also identified further documentation it required. The purpose of these interviews was to establish how leadership and governance were exercised between 2012 and 2017 and to

ascertain the degree of adherence with extant policies and protocols. A list of those interviewed is provided in Appendix 4. Three retired senior managers of the Belfast Trust did not engage with the review process:

- a retired Service Improvement and Governance manager and Co-Director of Learning Disability Services at MAH[4] replied to a request to meet with the Review Team stating she was not willing to participate;

- a retired co-Director for Learning Disability Services who retired from the service in September 2016 would not meet with the Review Team as his request to the Trust for an extensive range of documents to examine prior to interview was not met. He requested that the Review be extended in order to facilitate his review of documents. This request could not be met by the Review Team due to the time frame set for completion of this Review and the view that his request for an extension was unreasonable;

- a retired Business and Service Improvement Manager at MAH made no response to repeated requests, made through the Trust, for an interview with the Review Team.

In each of these cases the Review Team informed the individual that it would reach its conclusions on the basis of the documentary evidence available to it and comments made by other interviewees. A former Chief Executive of the Trust was also not available for interview within the time scale set for the Review. The Review Team regrets that its conclusions were not informed by input from these individuals.

[4] Service Improvement and Governance until October 2016 when then promoted to Co-Director for Learning Disability Services

4.5 A timeline for the Review was established by the HSCB and PHA. The Review Team commenced its work in January 2020 with an agreed target date of 30th April for an interim report with the full report being produced by 30th June 2020. It was recognised that there was a particular urgency to this work given the need to reassure family members, carers, staff, and the public that the serious safeguarding issues that had arisen in MAH had been identified and addressed, and that lessons had been learned and acted upon.

4.6 The lockdown and social distancing measures that followed the start of the Coronavirus pandemic in March 2020 meant that the Review Team had to suspend its work for a period of six weeks. The Review Team resumed its examination of documents and interviews in mid-April 2020 using online conferencing technology, namely Zoom. The HSCB/PHA set a new date for a final report of 31st July 2020. It was also agreed that the interim report stage would be omitted to minimise the delay in delivering the Review Team's report. Plans to visit centres of excellence to inform Best Practice had to be shelved and replaced by a literature review.

4.7 During lockdown the Review Team was unable to meet with as many patients, relatives, and friends as it would have wished. It deeply regrets that it was unable to meet with more service users. It did, however, benefit from interviews with:

- three parents/relatives;
- The Chair of Friends of Muckamore Abbey;
- representatives of Bryson House and Mencap which provide advocacy services to patients at MAH; and
- a representative of the Patient and Client Council which the Department had engaged to provide independent support for Families and Carers who became involved with the review process.

Representatives of the Review Team attended one meeting of the Muckamore Abbey Departmental Advisory Group in March 2020. The Review Team also issued a general invitation through a representative of the Action for Muckamore group, to meet with any relatives/carers who wished to meet either in person or via Zoom. No further requests for interview were received.

4.8 The Review Team would appreciate an opportunity to meet with patients, relatives and carers at the conclusion of the Review to provide feedback to them about its conclusions and recommendations.

5. Background to Muckamore Abbey Hospital

5.1 This section provides a brief historical overview of Muckamore Abbey Hospital and the plan to resettle patients in community settings.

A. Muckamore Abbey Hospital – A Brief Historical Overview

5.2 Muckamore Abbey Hospital opened in 1949 as a regional service for children and adults with learning disabilities. It is located in a rural setting outside of Antrim town. The opening of the hospital enabled children and adults to be admitted over time from six mental health hospitals; some 743 patients of whom 120 were children.

5.3 Initially, the hospital principally provided long-term permanent inpatient care for its patients. Services provided have undergone significant changes over the years, reflecting evolving policy imperatives for people with a learning disability. The function of the hospital has therefore expanded over time to include: supervised activity for a minority of patients; return to the community; and a centre for medical research. 'Latterly, the mission of the hospital is confirmed as an Assessment and Treatment centre with no patient living there long term.'[5]

5.4 The *A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go* report sets out a timeline for the hospital, from 1946 to 2016 which notes that nurse training began at the hospital in 1955; followed by the opening of a special needs teacher training college in 1963.[6]

[5] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 46
[6] Op. Cit., Pages 46 - 51

5.5 In 1966 Muckamore Abbey Hospital had 880 patients. By the late 1960s and early 1970s there was a growing realisation that treatment and training should take place outside of a hospital setting. There was also a problem with overcrowding at the hospital.[7] By 1980 the hospital had more than 20 units on its site. During 1984 the hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients.

5.6 From the 1980s attempts were made to provide care in the community for patients. The delivery of this objective was described as 'a very slow process'. 'We had targets and dates before [2015/16], and there was a lot of criticism that those were not met. We are talking about a long period; certainly, in my experience of work, from the 1980s to today.'[8] In 1986 a Rehabilitation Unit was established at the Hospital to promote a return of patients to community settings.

5.7 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy, Health and Wellbeing into the New Millennium, required that Boards and Trusts:

- develop a comprehensive range of support services by 2002, and
- have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and
- reduce the number of adults admitted to specialist hospitals.

The target established by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.[9]

[7] Ibid, Page 48
[8] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Mr. Aidan Murray, Page 6
[9] By that time, half of patients had been resettled and none of the three hospitals had been closed to long-stay patients. Between 1992 and 2002 the number of long-stay patients in such facilities dropped from 878 to 453.

5.8 In 1993 the number of patients in the Hospital had reduced to 596. Despite the Regional Strategy the hospital argued for the retention of a specialist Assessment and Treatment service on the site. In 1994 a Forensic Unit was also established. The *A Way to Go* Report noted that, 'by the mid-1990s the presence of adolescents on adult wards had become a significant problem.'[10] The removal of children from the Hospital was achieved with the establishment of the Iveagh Centre an inpatient service for children.

5.9 In 1998 Pauline Morris' study of long stay hospitals for patients with a learning disability was published.[11] The study criticised the medical model of care and recommended a socio-therapeutic model in which training was deemed as important as nursing and medical functions. There was however, a lack of community resources in Northern Ireland to support the discharge of long-stay patients from the hospital. It was therefore acknowledged that patients who had been resident for 30 to 40 years would remain in hospital.

5.10 Due to inappropriate living conditions seven of the hospital's wards were closed in 2001. Around this time a survey of admissions to the hospital found, 'that most admissions … were of people with behaviour which challenged – most of whom have been brought up in family homes and had attended special schools.'[12] In 2003 a business case for a new core hospital was submitted to the Department. This resulted in the building of a 35 bed Admission and Treatment Unit and a 23 place Forensic Unit. Both facilities were completed in 2006/07 at a cost of £8.4m. The hospital at that time had three distinct patient treatment groups:

- Admissions and Treatment;
- Resettlement; and

[10] Ibid, Page 49
[11] Morris, Pauline Put Away: A Sociological Study of Institutions for the Mentally Retarded Taylor & Francis, 2003 First Published in 1998
[12] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 49

- Delayed discharges.

5.11 In 2002 the Department of Health, Social Services and Public Safety (DHSSPS) established the Bamford Review to inquire into the law, policy, and services affecting people with a mental illness or a learning disability. A key message emerging from the Bamford Review was an emphasis on a shift from hospital to community-based services. The second report from the Bamford Review, *'Equal Lives'*, published in 2005, set out the Review's vision for services for people with a learning disability which envisaged that hospital should not be considered as a home for learning disabled people. *Equal Lives* included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. For the purposes of monitoring progress towards this commitment to resettlement, individuals who had been living in a long stay learning disability hospital for more than a year as of 1st April 2007 were defined as Priority Target List patients. There have been two Action Plans (2009-2011 and 2012-2015) created to take forward the Bamford Review's recommendations.

5.12 In 2005 the Hospital had 318 patients and a target was set that this would reduce to 87 by 2011. By December 2011 however, 225 patients remained.[13]

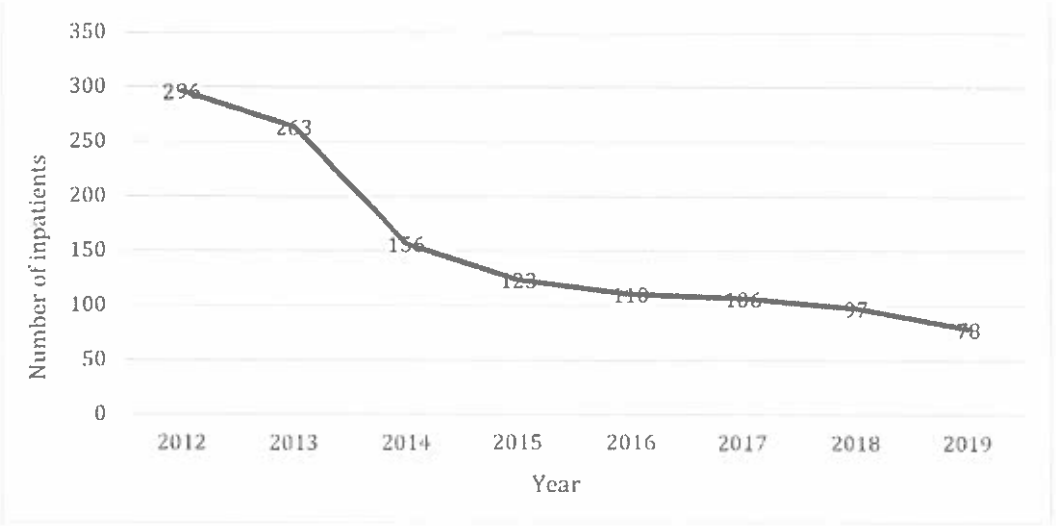
5.13 In 2011 The Minister for Health published *Transforming Your Care: A Review of Health and Social Care (TYC)*[14]. TYC sets out 99 proposals for the future of health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. It restated the Bamford Review commitment to closing long-stay institutions and completing the resettlement programme by 2015.

[13] Ibid, Page 50

[14] http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

5.14 As part of the TYC agenda a central feature of the Department's plans for the reform of the health and social care system in Northern Ireland was the move from hospital-based care towards an integrated model of care delivered in local communities, closer to people's homes. In addition to the TYC document, a draft Strategic Implementation Plan (SIP) was developed.[15] In terms of learning disabilities, the SIP focused efforts on resettlement, delayed discharge from hospital, access to respite for carers, individualised budgets, day opportunities, Directly Enhanced Services (DES), and advocacy services.[16]

5.15 As of April 2020 the Hospital has under 60 patients and operates from six wards[17] providing inpatient assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs, or challenging behaviour. From a regional hospital with more than 20 units and at one time over 1,400 patients, the hospital is now greatly reduced in both the number of wards and the number of patients. The following table[18] demonstrates the reduction in number of patients between 2012 and 2019:



[15] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40
[16] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40.
[17] Ardmore for female patients, Cranfield 1 and 2 for male patients, Sixmile Assessment and Sixmile Treatment wards which deal mainly with forensic patients, and Erne wards for male and female patients with complex needs.
[18] The figures in the Table include Iveagh Unit which is a 6 bed unit caring for children aged under 12 years of age.

5.16 Although originally a regional service, the hospital now largely serves the Belfast HSC Trust which manages it, and the Northern HSC Trust in whose area it is located, as well as the South-Eastern Trust. Remaining Trusts have arrangements in place to meet the needs of their learning disabled residents without recourse to the hospital.

B. Resettlement

5.17 Various plans and targets aimed at resettling patients from the hospital to community settings have been in place since the 1980s (see Paras 5.6 – 5.13). Since 1992 however, the Department's overarching policy direction has been the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey Hospital to community living facilities. In 1995 a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to community accommodation.

5.18 Efforts to secure this strategic objective in relation to the hospital are evident in the 1992/97 Regional Strategy, the Bamford Review (2002 and 2005), and TYC (2011) as well as associated action plans. The reasons for delay are complex and include:

- the difficulty in moving patients from a facility which they have regarded as their home. As noted in Para. 5.9 there was an acknowledgement that patients who had been resident for 30 to 40 years could remain in hospital;

- the lack of community resources to support the discharge of long-stay patients from the hospital;

- the fact that many people living with a learning disability have associated co-morbidities, such as physical and mental health conditions, including epilepsy and autism. Mental health conditions and certain specific syndromes may also be associated with other physical conditions and challenging behaviour. Patients currently remaining in the hospital have, therefore, very complex needs which makes their resettlement particularly challenging.

5.19 A senior Medical Adviser in her evidence to an Assembly Committee in 2013 set out the broad policy thrust of the Department of Health in relation to mental health and learning disability services. She stated that, 'in the January 2013 Bamford action plan that scopes 2012-15 - the emphasis across mental health and learning disability was on early intervention and health promotion; a shift to community care; promotion of a recovery ethos, largely in respect of mental health; personalisation of care; resettlement; service user and carer involvement; advocacy; provision of clearer information; and short break and respite care.'[19]

5.20 The evaluation of the second Bamford Action Plan 2013 - 2016 was completed in 2017. It found that the resettlement programme was nearing completion. Of the 347 long-stay patients in learning disability hospitals in 2007, only 25 remained in long-stay institutions in 2016. Since then further progress has been made. By early 2020 there were ten inpatients from the original Priority Target List remaining in the hospital, with a further individual undergoing a trial resettlement in the community.

5.21 The increased focus on the resettlement of patients driven forward by the Bamford Review and TYC resulted in the closure of wards and the bringing together of staff and patients into new living arrangements. The Review Team

[19] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Page 2

concluded that the focus on resettlement had a negative impact on the culture of the hospital with insufficient attention being afforded to the functioning of the inpatient wards.

5.22 The criticism that the 1980s resettlement objective was progressed slowly, was due in the Review Team's opinion, to the arrangements which were established to monitor delayed discharges and patient discharges post the Bamford Review. The scale of the resettlement achieved was significant with a decrease from 347 long-stay patients in learning disability hospitals in 2007, to 25 by 2016 and 10 by 2020. From the information available to the Review Team they concluded that the Belfast HSC Trust's focus was on its resettlement objectives rather than on the hospital in its totality.

5.23 The resettlement plan caused anxiety among the staff team. During its orientation visit to the hospital in February 2020 and afterwards in written comments made in 2012 by hospital staff, the Review Team found that in addition to anxiety around job security and staff recruitment, there were a number of concerns including:

- the adequacy of staffing levels and skill mix on wards;
- the staffing rota which was heavily supplemented by bank staff which led to tiredness and increased sickness levels;
- insufficient staffing to run the resettlement programme. An email sent in October 2012, to an Operations Manager (part-time) by a Sister in one of the Wards, stated that resettlement could not continue due to staffing levels;
- the resettlement process which increased workload in respect of assessments;
- patient activities which were curtailed due to staff shortages;
- the mix of patients' needs in wards which were at time incompatible and competing;

- the impact of some patients' behaviour on the dynamics of a ward and reservations expressed regarding the decision to place specific patients within a given ward;

There was also a view that the 'resettlement wards are not up to 21st Century standards'.

5.24 The drift associated with earlier resettlement plans from the 1980s was possibly also associated with the resistance of some staff and families to the plan to close the hospital. In the opinion of the Review Team this may explain why the post Bamford resettlement plans were advanced without the benefits of feedback systems capable of monitoring how the roll-out impacted upon matters such as: the operation of wards; staff sickness and absences; untoward incidents; and patient safety. Such a process would have ensured that core hospital functions could have been maintained safely while the resettlement model was progressed.

5.25 At the hospital there were two competing service models: a medical model which informed the core hospital services and a social care model focused on resettling patients into the community. The *A Way to Go* report noted the 'hospital requires focus regarding its role and place in the future of learning disability services in NI'.[20] The Welsh government's review of learning disability services stated that 'hospital is not a home'. It found: 'Patients were remaining in hospital units for a long time and were transferred between hospitals when alternatives in the community could have been considered. The average length of time was found to be five years, with one patient staying for 49 years. People should only stay in hospitals if there are no other ways to treat them safely.'[21]

[20] *Way to Go, November 2018, Page 5, par. 5*
[21] Warmer, K. Hospitals should never be anyone's home, Published February 2020, Welsh Government https://www.ldw.org.uk/hospital-should-never-be-anyones-home/

5.26 Resettlement needs a cultural shift in thinking about the resourcing of learning disability services. It also requires an approach which provides adequate financial resources and community infrastructure to support resettlement objectives and to successfully maintain discharged patients in the community. Section 9 on Best Practice considers this cultural shift in greater depth.

5.27 In conclusion, in undertaking its review the Review Team wants to place the key events listed in Para. 1.5 and in Appendix 5 in the context of a comprehensive understanding of the hospital, its culture, and the resettlement programme which it actively pursued after the two Bamford Reviews.

6. Review of Governance

6.1 The following section considers:

i. what governance is

ii. corporate and clinical/professional governance

iii. the Effectiveness of Corporate and Clinical/Professional Governance

i. What governance is

6.2 In undertaking its review of governance the Review Team considered a range of definitions and guidance which was available at all levels within the Health and Social Care system in Northern Ireland in order to decide on which definition to use to inform its examination of the Trust's governance structures and arrangements.

6.3 The Social Care Institute for Excellence (SCIE) notes that the quality of services provided are the responsibility of individual staff members and their employers: 'Every staff member has, responsibility for providing good quality social care. Social care governance is the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[22]

6.4 More organisationally focused definitions conceive of governance as 'a framework within which health and personal social services organisations are accountable for continuously improving the quality of their services and taking

[22] Social care governance: A practice workbook (NI) 2nd edition, SCIE, 2013, Page 1
http://www.belfasttrust.hscni.net/pdf/Social-Care-Institute-for-Excellence-Social-care-governance.pdf

corporate responsibility for performance and providing the highest possible standard of clinical and social care' (Best Practice, Best Care, DHSSPS, 2002[23]).

6.5 The Department of Health (DoH) cites in its Introduction to Governance[24] Her Majesty's Treasury (HMT): 'the system by which an organisation directs and controls its functions and relates to its stakeholders.' DoH noted that this influenced the way in which organisations:

- manage their business;
- determine strategy and objectives; and
- go about achieving these objectives.'[25]

6.6 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland.[26] To facilitate the achievement of service improvements the Quality Standards for Health and Social Care were published in 2006. These standards require governance arrangements which 'must ensure that there are visible and rigorous structures, processes, roles, and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.'[27]

6.7 The Quality Standards also require the RQIA to commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five quality themes

[23] https://www.scie-socialcareonline.org.uk/best-practice-best-care-the-quality-standards-for-health-and-social-care/r/a11G000000182tdIAA
[24] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[25] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[26] Article 34.—(1) Each Health and Social Services Board and each [F1HSC trust] shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—
(a)the health and [F2social care] which it provides to individuals; and
(b) the environment in which it provides them. http://www.legislation.gov.uk/nisi/2003/431/article/34
[27] The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, Page 1, par. 1.3, March 2006 https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

contained within them.[28] This enhanced the RQIA's general duty of encouraging improvements in the quality of services commissioned and provided by the HSC by promoting a culture of continuous improvement and best practice through the inspection and review of clinical and social care governance arrangements.[29]

6.8 The Quality Standards comprise three key themes, one of which is clinical and social care governance. The Quality Standards note that to promote service improvements 'clinical and social care governance ... must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments.'[30]

6.9 Standard 1 of the Quality Standards, Corporate Leadership and Accountability of Organisation, has as its Standard Statement: 'The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.'[31]

6.10 The criteria by which compliance can be assessed are:

a) 'has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

[28] Ibid, Page 5 par. 1.7 and 1.9 Quality themes: 1. Corporate Leadership and Accountability of Organisations; 2. Safe and Effective Care; 3. Accessible, Flexible and Responsive Services; 4. Promoting, Protecting and Improving Health and Social Well-being; and 5. Effective Communication and Information.
[29] Ibid, Page 4, par. 1.8
[30] Ibid, Page 6, par. 2.1
[31] Ibid, Page 10, par. 4.2

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation

k) undertakes robust pre-employment checks including: qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body:

- police and Protection of Children and Vulnerable Adults checks, as necessary;
- health assessment, as necessary; and references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.'[32]

6.11 The Review Team considered the Quality Standards approach appropriate to its task, particularly as these were the basis upon which the RQIA served four Improvement Notices in respect of failures to comply on the Belfast HSC Trust in

[32] Ibid, Pages 10 -11, par. 4.3

November 2019. The Quality Standards require governance arrangements which: 'must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care' (see Para 6.6). By doing so the Review Team will be facilitated by having access to a number of the criteria established (see Para 6.10) to determine the robustness of the Trust's governance arrangements objectively.

ii. Corporate and Clinical/Professional Governance

6.12 The Review Team considered corporate and clinical/professional governance arrangements within the Trust as it related to MAH.

Corporate Governance

6.13 The Trust was formed under the Belfast Health and Social Services Trust Establishment Order (Northern Ireland) 2006. It came into existence on 1st April 2007 with the merging of six Trusts, namely:

- the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust
- the Mater Hospital Health and Social Services Trust
- North and West Belfast Health and Social Services Trust
- South and East Belfast Health and Social Services Trust
- Green Park Health and Social Services Trust
- Belfast City Hospital Health and Social Services Trust.

6.14 The Belfast HSC Trust is a complex organisation with an annual budget of over £1.3bn and a workforce of over 20,000 full time and part time staff. It is one of

the largest integrated health and social care Trusts in the United Kingdom delivering integrated health and social care to approximately 340,000 citizens in Belfast. In order to ensure the best possible delivery of these services they have been grouped into ten Directorates. The Trust also provides the majority of regional specialist services in Northern Ireland and comprises the major teaching and training hospitals in Northern Ireland. The following section considers governance under two headings:

A. Organisational Structures; and
B. Information Systems.

(A) Organisational Structure

6.15 The Belfast Trust provides a range of disability services in the community, at home, and in hospitals. The Review Team examined the systems and information systems established by the Belfast HSC Trust to enable it to assure 'the quality of services that it commissions and provides to both the public and its staff' in respect of the services provided at MAH (see Para 6.9). The Trust's organisational structure in 2012/13 encompassed the following:

- a Trust Board of five Executive Officers and seven non-Executive Directors, including the Chairman. Accountable directly to the Board were four committees (Remuneration, Charitable Trust Funds, Audit, and Assurance) which met on a bi-monthly basis. The Executive consists of the Chief Executive and the Executive Directors of Finance, Medicine, Social Work, and Nursing. The Board is responsible for the strategic direction and management of the Trust's activities. It is accountable, through its Chairman, to the Permanent Secretary at the Department of Health and ultimately to the Minister for Health;

- the Executive Team which is accountable to the Trust Board in regards to the day to day operational management and development of the Trust. It meets on a weekly basis. It receives reports from Executive and Operational Directors based on information received from Co-Directors who have operational responsibility for service areas such as: Learning and Disability Services; Mental Health; and Health Estates. Information was also provided from the Assurance Group;

- an Assurance Group. The Trust's Assurance Framework sets out the committee structures for Clinical and Social Care Governance and risk management. The Framework describes the mechanisms to address weaknesses and ensure continuous improvement, including the delivery of the delegated statutory functions and corporate parenting responsibilities. Five groups report to The Assurance Group:

  - the Governance Steering Group, which covers 15 areas including: risk management; policies; control assurance; and information governance. The steering group was served by two sub-committees;

  - a Safety and Quality Steering Group which was served by five sub-committees;

  - a Serious Adverse Incident (SAI) Board which reviewed each SAI;

  - a Social Care Steering Group which was served by three sub-committees; and

  - an Equality, Engagement and Experience Steering Group which was served by three sub-committees.

6.16 The organisational governance structure remained largely consistent throughout the 2012 to 2017 period covered by the Review Team's Terms of Reference. The only change to the structure, which occurred in 2013/14, was that the SAI Group was merged with the Governance Steering Group; no longer was it a stand-alone entity. In the 2015/16 business year the Social Care Committee structure was altered so that it had a direct relationship with the Trust Board.

6.17 Structurally therefore the Belfast HSC Trust had arrangements in place capable of assuring the quality of the services which it provided. The structure is complex with a significant number of Committees, Steering Groups, and Sub-Committees. This structure placed significant demands and challenges on senior and middle management staff. The range of services provided by the Trust and their complexity inevitably requires systems which are complex.

6.18 The change to the status of the Serious Adverse Incident (SAI) Group in 2013/14 outlined in par. 6.15 may have contributed to the failure to address the Ennis complaint as an SAI. The allegations made in respect of staff's management of patients in Ennis ward made in November 2012 were dealt with under the Trust's Safeguarding Vulnerable Adults Policy. This meant that the ensuing investigation focused exclusively on the allegations as a means of acquiring the evidence in order to either substantiate the allegations or to discount them. Wider issues relating to the organisation of services, pressures within the Ennis ward in terms of caring for patients with complex and at times conflicting needs, the adequacy of staffing, and the skill mix available to care for patients were not subject to fuller investigation.

6.19 From email correspondence between the HSC Board's Deputy Director and the Trust dated between the 6th February 2013 and the 3rd September 2015 it is apparent that repeated requests from the Board for the Ennis allegations to be dealt with as an SAI were not met. In September 2015 the HSC Board wrote

asking that the Trust accept that this was a breach of requirements. On 7th September 2015 the Trust responded accepting that it was in breach of the SAI procedures [both the 2010 and 2013 procedures] but 'as the allegations were not substantiated by the safeguarding investigation it was content to live with the procedural breaches.'

6.20 At MAH level governance arrangements were also in place during the period under review. On site was a Service Improvement and Governance member of staff. On a weekly basis the Trust's Co-Director for Learning Disability Services convened a multidisciplinary meeting at MAH comprising the Service Improvement and Governance manager and hospital and community staff.

6.21 The minutes of these meetings show that they were well attended by all staff and comprehensive minutes were taken of the proceedings. A community-based social worker regularly attended these meetings as one of her duties was to complete the Statutory Functions Report for the learning disability programme of care.[33] None of the minutes examined provided information on the following:

- the information which would be provided to the HSC Board in respect of the Discharge of Statutory Functions; or
- issues arising from the Ennis investigation and follow-up actions.

6.22 Information was available on the receipt of RQIA inspection reports; there was, however, no indication from the MAH records examined that findings from these inspections were viewed as negative or requiring remedial action. This finding is confirmed by an examination of governance meetings chaired by the Service

[33] The requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions (DSFs) from Health and Social Care Trusts (Trusts) to the Health and Social Care Board (HSCB) and ultimately to the Department of Health, Social Services and Public Safety (Department) has been in place since 1994. The Chief Social Work Officer (CSWO) in the Department, the Director of Social Care and Children in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the Trusts are individually and collectively responsible for the effective operation of an unbroken line of professional oversight of DSFs. CIRCULAR (OSS) 4/2015: STATUTORY FUNCTIONS/PROFESSIONAL OVERSIGHT https://www.health-ni.gov.uk/sites/default/files/publications/health/CIRCULAR%28OSS%29-4-2015.pdf

Improvement and Governance manager. The minutes regularly reference an RQIA announced or unannounced inspection at wards within the hospital. From these minutes information was not available to indicate any serious concerns being raised by the Regulator. As noted in Para. 6.11 it was not until November 2019 that RQIA served four Improvement Notices in respect of failures to comply on the HSC Trust, in respect of the MAH site. Improvement Notices had previously been served on Iveagh which was the children's disability service. The Review Team was advised by RQIA that there was significant learning emerging from its inspection of Iveagh which, had it been applied, could have improved practice at MAH. The Review Team found that issues arising from complaints and incidents or RQIA reports were not discussed. Therefore they did not inform the education plans for staff in MAH.

(B) Information Systems

6.23 The only way in which any organisation can know how it is performing is to have access to all the relevant data describing its performance in meeting the relevant legislation and regulatory and professional standards. As the inquiry into the practice of breast surgeon Dr Ian Patterson noted: 'it is important to recognise that the collection of data and information is insufficient alone to prevent what has been described here. It is how information is analysed and used, and then made available to the public, which determines its value. Managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb.'[34]

6.24 The Review Team therefore considered the range of data collated by the Trust, how it was analysed, and how it was used by the Trust to monitor and review performance with particular reference to MAH.

[34] The report of the Independent Inquiry into the issues raised by Paterson, Page 2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf

6.25 The Trust had a number of systems in place to record and monitor adverse incidents, serious adverse incidents, and complaints as part of its risk management strategy. Risk management involves the establishment of systems to understand, monitor, and minimise risks to patients and staff. It involves learning from mistakes/incidents in order to improve the quality of patient care and to inform staffing numbers and qualifications to ensure that patients' needs are met. It is apparent that Governance and Core Group meetings at MAH regularly had access to a wide range of data (see Para 6.83).

6.26 MAH was also monitored by its regulator, the RQIA, which over the course of its inspections, collated significant information on practice within wards and also acquired verbal feedback from patients and staff. The scale of the significant concerns revealed by the CCTV footage (2017) or the Ennis investigation (2012/13) was not identified through inspections. Regulators, such as senior managers, rely on the information provided to them as well as what they can reasonably be expected to identify in the course of inspection activities.

6.27 A relevant backdrop to how information was divulged is provided by the *A Way to Go* report. It noted that it, 'was advised of the presence of staff who are related at the Hospital, including families who have worked there for generations. Also, since some staff are very comfortable in each other's presence...the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore... the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients. There was no reference to conflict of interest declarations in any file.'[35]

6.28 Learning from mistakes or near-misses requires staff to be open to a review of their practice and to be willing to challenge when they observe concerning

[35] Op. Cit Para. 32, Page 13

professional practices. From the Ennis Report (2013) and the CCTV footage it is apparent that the challenge function was generally not evident among the staff team. In respect of the Ennis complaints, the verbal and physical abuse of patients was not raised by ward staff but rather staff from a private provider who were working on the ward to prepare a number of patients for discharge to their facility. Similarly, the very significant number of alleged assaults on patients captured on CCTV footage which, to date, has resulted in seven members of staff being reported to the PPS by the PSNI, 59 have been placed on temporary suspension, with a further 47 staff working under supervision. The nature and scale of events were not brought to the Trust's attention by MAH staff.

6.29 The Trust had corporate and clinical/professional arrangements in place. The Review Team concluded however, that the nature of the hospital as somewhat of a place apart from the mainstream of the Trust's hospital services, together with ongoing issues around its future, meant that staff loyalties were with their colleagues rather than the patients or their employer. There is also no indication from the records examined that staff from different professional groups were voicing concerns about the level or the nature of adverse incidents, serious adverse incidents, complaints, or the issues likely to be associated with staffing deficits and limited behavioural supports for patients.

6.30 In conclusion, governance structures were in place at Board and Trust level to enable the Trust to assure itself of the quality of the services it provided at MAH. The next section considers governance specific issues.

Clinical and Professional Governance

6.31 Clinical governance is 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which

excellence in clinical care will flourish.'[36] It covers activities which help sustain and improve high standards of patient care. Clinical governance is a means of reassuring the public that the care they receive within the health and social care system is of the highest standard.

6.32 Clinical governance is often thought of in terms of the following seven constructs:

6.33 The British Medical Journal definition of clinical governance: 'In short, it's doing the right thing, at the right time, by the right person - the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team. But that's not all - that individual or team must work within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risks, and learns from good practice, and indeed mistakes.'[37]

[36] Scally G and Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. British Medical Journal 317(7150) 4 July pp.61-65
[37] BMJ 2005;330:s254 https://www.bmj.com/content/330/7506/s254.3

6.34 As noted in Para. 6.6 the Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland. Clinical governance is a means by which the duty of quality can be achieved for service users of health and social care services in Northern Ireland. Clinical governance 'aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided (in terms of outcomes, access and appropriateness.'[38]

6.35 In 2012, The King's Fund set out three lines of defence 'in the battle against serious quality failures in healthcare:'[39]

- frontline professionals, both clinical and managerial, who deal directly with patients, carers, and the public and are responsible for their own professional conduct and continued competence and for the quality of the care that they provide;
- the Boards and senior leaders of healthcare providers responsible for ensuring the quality of care being delivered by their organisations who are ultimately accountable when things go wrong; and

- the structure and systems that are external, usually at a national level, for assuring the public about the quality of care.

6.36 The legislative framework within which the health and social care structures operates is the Health and Social Care (Reform) Act (Northern Ireland) 2009. The roles and functions of the various health and social care bodies and the systems that govern their relationship with each other and the Department, alongside the

[38] Clinical Governance in the UK NHS. DFID Health System Resource Centre https://assets.publishing.service.gov.uk/media/57a08d59ed915d622c001935/Clinical-governance-in-the-UK-NHS.pdf
[39] The King's Fund (2012), Preparing for the Francis report: How to assure quality in the NHS, [online], accessed September 2019. https://1vju531mjrgz2givvt3vgvrr-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/MPAF_WEB.pdf

roles and responsibilities devolved from the Department, which are taken forward on behalf of the Department by the PHA/HSCB are set out in the Health and Social Care Assurance Framework (2011).

6.37 Service Frameworks set out the standards of care that individuals, their carers, and wider family can expect to receive from the HSC system. The standards set out in a service framework reflect the agreed way of providing care by providing a common understanding of what HSC providers and users can expect to provide and receive.

6.38 The Belfast Trust's Assurance Framework sets out the roles and responsibilities of the Executive Team in ensuring that effective governance arrangements are in place within their areas of responsibility. Key elements of professional, clinical, and social care governance are identified within the roles of the:

- **Executive Director of Nursing and User Experience** who is responsible for advising the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy as well as statutory and regulatory requirements. The post holder is also responsible for providing professional leadership and ensuring high standards of nursing, midwifery, and patient client experience in all aspects of the service. In addition to other responsibilities the post holder also holds professional responsibility for all Allied Health Professions;

- **Director of Social Work** who is responsible for ensuring the effective discharge of statutory functions across all social care services; reporting directly to the Trust Board on the discharge of these functions. The post holder is also responsible for providing leadership and ensuring high standards of practice to meet regulatory requirements for the social work and social workforce;

- **Medical Director** who is responsible for advising the Trust Board and Chief Executive on all issues relating to professional policy, statutory requirements, professional practice, and medical workforce requirements. The post holder is also responsible for ensuring that the Trust discharges its delegated statutory medical functions, alongside providing professional leadership and direction.

6.39 There is also a service framework pertinent to the services provided at MAH which applies to all those working with patients namely, the Service Framework for Learning Disability published in 2013 and revised in 2015. '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.'[40]

6.40 Professional Governance Frameworks are underpinned by legislation and a range of standards and policies set by the Department of Health alongside standards set by professional regulators. A robust assurance framework provides clarity about professional responsibility and evidence that structures and processes are in place to provide the right level of scrutiny and assurance across the professions.

6.41 Since its formation in 2007 the Belfast Trust has had in place a structure to support the Executive Directors of Nursing, Social Work, and Medicine to provide assurance to the Chief Executive, Executive Management Team, and the Trust Board. Muckamore Abbey Hospital is medically led by a Clinical Director. The largest workforce on site is drawn from the nursing profession and healthcare assistants. There was a small social work team and a number of Allied Health

[40] Ministerial Foreword, Service Framework for Learning Disability, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/service-framework-for-learning-disability-full-document.pdf

Professionals based at the hospital. Although MAH is a hospital and is led as such by medical personnel, the day-to-day operation of MAH was in practice left to nurse managers and their staff. The following section therefore focuses strongly on the governance arrangements within nursing, which also encompasses healthcare assistants (see Para 6.38).

6.42 The Review Team examined the systems and information established by the Belfast Trust to enable it to ensure that patients in MAH were receiving high quality, safe, and effective care. The Trust organisational structure in 2012/13 comprised a Central Nursing and Midwifery Team which was led by the Executive Director of Nursing comprised Co-Directors and Associate Directors of Nursing. The Co-Directors were full time members of the Central Nursing and Midwifery Team fulfilling a pan-Trust professional role in respect of the nursing and midwifery workforce, nursing education, and governance. The Associate Directors of Nursing held managerial roles within the Directorates of the Trust. It was envisaged that they would dedicate 70% of their time to their Directorate role and 30% to their professional role as Associate Directors of Nursing.

6.43 This structure remained in place until 2016/17 when it changed following a review by the HSC Leadership Centre, commissioned to assess the effectiveness of the Associate Director role in providing professional assurance to the Executive Director Nursing. It introduced Divisional Nurses who had no operational responsibilities. They were appointed into leadership roles to provide nursing and midwifery assurance to the Directorate and Executive Director of Nursing.

6.44 The Executive Director of Nursing met formally on a monthly basis with Co-Directors and senior nurse leaders. The meeting provided regular reports from Divisional Nurses on nursing and midwifery practice, workforce issues, regulation, and any other issues of concern. Since 2016 reports focused on three key areas namely:

- patient, quality and safety;
- patient experience; and
- professional nursing.

Nurses in Difficulty meetings were held quarterly and were chaired by the Executive Director of Nursing. These meetings were attended by Divisional Nurses and provided an opportunity for the Executive Director of Nursing to discuss, advise, and seek assurance that all follow-up actions to ensure onward referral to the regulator or internal capability processes had been taken forward.

6.45 Directors of Nursing, according to A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery (2010-2015), were required to be proactive in identifying future nursing workforce requirements. The Executive Director of Nursing in a Trust is also responsible for advising the Trust Board and its Chief Executive on all issues relating to nursing workforce requirements. On a bi-monthly basis the Executive Director of Nursing held a Nursing and Midwifery Workforce Steering Group. This group comprised senior nurse leaders, the Co-Director for Workforce and Education, and a representative from HR, Finance, and staff-side organisations. This meeting addressed all workforce issues relating to nursing and produced a workforce trends analysis.

6.46 In addition to the Workforce Steering Group meetings, the Trust had processes in place to provide assurance to the Executive Director of Nursing on all issues relating to the nursing workforce requirements in MAH. Learning Disability Nursing workforce issues were discussed regularly at the senior nurse meetings which were held on a monthly basis in MAH and at the Core Group meetings chaired by the Co-Director for Learning Disability services. Discussion also took place at Divisional Nurse meetings chaired by the Executive Director of Nursing.

6.47 During the period under review, professional nursing governance arrangements existed within MAH, as indicated by the previously noted senior nurse meetings, which took place on a monthly basis. Those in attendance included senior nurse managers, ward managers, and the nurse development lead. Additionally, there was a Professional Senior Nurse Forum. These meetings were chaired by the Service Manager for Hospital Services and included senior managers from MAH and the Directorate along with the Nurse Development Lead. The agenda for these meetings focused on nurse-sensitive indicators including supervision, appraisal, and mentorship along with training, education, and staff development.

6.48 The Nursing and Midwifery Council (NMC) sets the standards of practice and behaviour applicable to all registered nurses. These standards are outlined in the Code (2015).[41] They are a means to promote safe and effective practice.

6.49 The commitment to professional standards is fundamental to nursing and reinforces professionalism. As such all nurses and healthcare assistants in MAH are required to:

- prioritise people;
- practice effectively;
- preserve safety; and
- promote professionalism and trust.

6.50 The NMC Code established a common standard of practice for all those on its register. Guidance to nurses was also provided by the Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) as professionally they continued to be accountable for the tasks delegated by them to healthcare assistants. Nurses are required to ensure that delegated tasks are completed to a

[41] The Code: Professional Standards of Practice and Behaviour for nurses, midwives and nursing associated, NMC, https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

satisfactory standard.[42] The framework supports the healthcare staff in becoming competent to complete delegated record keeping on the care they have provided and maintaining these records.

6.51 Standards for Nursing Assistants employed by HSC Trusts published by the Department In February 2018 apply to all healthcare assistants. This document recognised that nursing assistants 'are an essential part of the healthcare team. They provide a vital role supporting the registered nursing workforce to deliver high quality nursing care.'[43] In MAH it was apparent that at times healthcare assistants made up a greater proportion of staff on wards due to the difficulties experienced in recruiting and maintaining an adequate number of nursing staff. This matter is discussed further in paragraph 6.96.

6.52 The Trust collated and analysed a range of information as a means to identify nursing concerns. The Review Team considered the Trust's wide range of information, along with the minutes of professional and operational management meetings. The key sources of information were:

- Professional Governance Frameworks;
- RQIA Inspection findings;
- Nurses in Difficulty reports;
- Risk Registers;
- Vulnerable Adult reporting;
- Use of Physical Intervention;
- Quality Improvement Plans;
- Key Performance Indicators;

[42] Support Resources for Record Keeping Practice Framework for Nursing Assistants. NIPEC https://nipec.hscni.net/download/projects/previous_work/highstandards_practice/record_keeping_practice_framework_for_nursing-Assistants/SUPPORT-RESOURCE-NA-Framework-Final.pdf

[43] Standards for Nursing Assistants employed by HSC Trusts. Foreword, https://nipec.hscni.net/download/professional_information/resource_section/nursing_assistants/standards-for-nursing-assistants.pdf

- Commissioned Education;
- Staff absence management and recruitment;
- Professional Nursing Reports; and
- Alerts or issues for escalation.

6.53 Since its formation in 2007 the Trust's Model of Governance has been an integrated approach where clinical and wider organisational risks are managed within a single integrated Assurance Framework. Key elements of clinical governance include:

- clinical audit and research;
- incident reporting;
- education and training;
- supervision and appraisal; and
- the adoption of evidence-based practice to ensure safe and effective care.

Arrangements are also in place within the Trust for the management of professional concerns about nurses and midwives. Issues relating to healthcare assistants were dealt with through line management arrangements.

6.54 Capacity for the integration of professional governance into the Directorate's governance arrangements was evidenced in the regular multidisciplinary meetings convened by the Trust's Co-Director who had a social work background and comprised the Clinical Medical Director, the Nursing Service Manager, and the Service Improvement and Governance manager at MAH. Attendance by other professionals or Operational Managers was dictated by the agenda for each meeting.

6.55 The nursing governance arrangements within the Trust were deemed fit for purpose by the Review Team on its examination of processes and the information

detailed above. The Review Team was however concerned that the effectiveness of these governance arrangements was undermined by ongoing staffing issues at MAH.

6.56 Professional Accountability for medicine arrangements were outlined as follows:

'All substantive doctors including consultants are accountable via the line management structure. That is to the Service Manager/Co-Director. Professionally they are accountable via the medical line management structure which is Clinical Lead to Clinical Director to Associate Medical Director to Medical Director. Where concerns are raised about medical staff these concerns are shared by the Clinical Director with the Associate Medical Director and are managed using Maintaining High Professional Standards Guidance, a framework set out by the Department of Health in 2003. Where appropriate the Trust will also invoke the services of the National Clinical Assessment Service.'

6.57 The Review Team had no access to medical workforce data. A review of senior staff meetings referenced however, a range of the workforce issues faced by the medical team on site. Between 2012 and 2016, minutes of the Core Group meetings highlight issues regarding the medical team's ability and capacity to provide 24-hour cover at the hospital. There were efforts over an extended period of time to commission GP services and a GP out-of-hours service. Concerns were also noted about the ability of on-call doctors to complete the admission criteria assessment. A GP out-of-hour service was commissioned in November 2013.

6.58 Consultant medical staff shortages were also evident and were raised frequently by the Clinical Director at Core Group meetings. The management of sickness absence among medical staff was also difficult. Records indicate that locum cover was hard to secure.

6.59 In July 2103 the Clinical Director wrote to the HSC Board to secure additional consultant sessions. The resettlement assessment process placed additional demands on medical staff and the Review Team noted ongoing concerns expressed by the Clinical Director about patient safety resulting from the mix of patients on some wards and the consequent demands placed upon medical staff.

6.60 Nursing staff advised of some difficulties in securing timely access to medical review once an episode of seclusion was activated. There were also difficulties in securing Multidisciplinary Team (MDT) input into comprehensive risk assessments.

6.61 In respect of social work since 1994 Executive Directors of Social Work in Trusts and Boards have been required to hold a social work qualification and to be included on Trust Management Boards[44]. Arrangements for professional oversight are designed to ensure that statutory functions are discharged[45] in accordance with the law and to relevant professional standards within a system of delegation. Executive Directors of Social Work are accountable to their Chief Executives for compliance with legislative requirements and for ensuring that systems, processes, and procedures are in place to effectively discharge statutory functions in respect of:

- child care;
- mental health services;
- disability services,
- community care; and
- the social work and social care workforce.

[44] Health and Personal Social Services (Northern Ireland) Order, 1994

[45] Para. 1.2 CIRCULAR (OSS) 3/2015: 'Relevant' statutory functions, include all functions under the Adoption (NI) Order 1987; the Disabled Persons (NI) Act 1989; the Children (Northern Ireland) Order 1995 (with the exception of the Children's Services Plan) and the Carers and Direct Payments Act (NI) 2002. Other relevant functions are specified under the Health and Personal Social Services (Northern Ireland) Order 1972; the Chronically Sick and Disabled Persons (NI) Act 1978 and the Mental Health (NI) Order 1986.

6.62 Executive Directors of Social Work have a number of specific areas of professional responsibility including:

- professional governance;
- standards and practice across all services for children, families and adults;
- development of the social work workforce;
- management and/or development of social work and social care services generally; and
- oversight of statutory functions discharged by the HSC Trust.

6.63 In addition to the aforementioned areas of professional responsibility, social workers also have a role in the general management of the HSC Trust, including sharing in corporate responsibility for policy making, decision making, and the development of the HSC Trust's aims and objectives.

6.64 HSC Trusts are accountable to the DoH through the HSC Board for their performance which includes accountability for the discharge of delegated statutory functions. Schemes of Delegation of Statutory Functions[46], which are documents sealed by the Department, the HSC Board, and each HSC Trust, provide a specific legal mechanism to monitor and report on the discharge of statutory functions on an annual basis. The Scheme of Delegation requires that there are unbroken lines of professional accountability from frontline social work practice in HSC Trusts through the HSC Board to the Chief Social Services Officer (CSSO) and ultimately to the Health Minister.

6.65 Paragraph 3.1 of Circular (OSS) 4.15 clarifies that: 'Accountability is a key element in the discharge of Delegated Statutory Functions (DSF). The Department, as the parent sponsor body of the HSCB and Trusts, carries ultimate responsibility for the

[46] CIRCULAR (OSS) 4/2015: Statutory Functions – Professional Oversight

performance of these organisations, including the discharge of DSFs within a system of delegation. This responsibility is not transferable to any other body.' Paragraph 3.2 also notes that, 'responsibility for the performance of the HSCB and Trusts in respect of DSFs rests fully with each organisation's Accounting Officer who is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs [Arms Length Bodies].'

6.66 All social care workers and professional social workers receive supervision within the organisation. A Supervision Policy exists to inform practice. In unidisciplinary teams, professional social work supervision must be provided by professionally qualified senior social workers, ensuring opportunity to review an individual's professional practice and accountability for the standard of his/her practice. Within integrated teams social workers received monthly supervision from their line managers. Where the manager was not a social worker, professional supervision was required from a social work manager on a three-monthly basis. Both managers were required to meet with the social worker to discuss operational and professional practice on a bi-annual basis. The Review Team was advised that audits relating to social work supervision were conducted. The audits did not confirm compliance with all aspects of the supervision policy, particularly in relation to the bi-annual meetings with managers.

6.67 Audits were also conducted at MAH which were independently commissioned by the Trust.[47] In respect of the deprivation of patients' liberty this report found: 'It is a major concern that aspects of the 'key evidence base' used to underpin these policies were out of date when the policy was written; e.g. NMC and NICE Guidelines.' The audit found that the Seclusion policy 'should have been reviewed in November 2016 and this was not completed.' The Review Team noted that the draft DHSSPS guidance on Restraint and Seclusion had not been used to inform

[47] Cannon F. & Barr O, Report of Independent Assurance Team Muckamore Abbey Hospital, June 2018

Trust policies in these areas.[48] The Review Team noted that the Southern HSC Trust had used the draft guidance to inform its policy. The DHSSPS draft guidance contained helpful advice on: patients' rights; training; and monitoring. It is unfortunate that final guidance was not provided by the Department.

6.68 Arrangements were in place to promote social work practice across client groups. The Executive Director of Social Work chaired the Trust's Adult Safeguarding committee which was established in 2015, although managerially he did not have responsibility for this client group until June 2016 when the Trust as a cost improvement measure removed a number of senior management posts at headquarters and MAH levels.

6.69 The Adult Safeguarding committee was modelled on child protection arrangements which were well established within the Trust and provided a model for improving safeguarding arrangements for vulnerable adults. A Professional Social Work Forum was also in place within the Trust prior to 2012. Managers at Grade 8B and above, attended by the Trust's social work governance lead, chaired the forum which addressed professional development and performance across the Trust. The 8B staff member with responsibility for social work services at MAH also attended the Professional Forum. The Trust's Safeguarding Specialist attended this Forum, at times, to provide updates on adult safeguarding issues.

6.70 There was an unbroken professional line from the frontline social worker to the Trust's Executive Director of Social Work as required legislatively. There were however, insufficient numbers of social workers at MAH to provide a service to all wards or to have the time to visit the wards regularly thereby acquiring an overview of patient care and treatment.

[48] Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services, August 2005

6.71 The Review Team was informed that there was a picture of the safeguarding social worker and contact details on ward notice boards so that patients and family members would have had details of a contact point should they have concerns. The Executive Director of Social Worker also outlined a number of walk-around visits he made to MAH during his period in post (from June 2016 to August 2017), during which he met with staff and patients. He acknowledged that from these visits he was conscious of tensions in managerial relationships within the hospital, unease about its future, and low staff morale. He stated that he had no indication of the patient care issues which subsequently emerged once CCTV footage came to light.

iii. The Effectiveness of Corporate and Clinical/Professional Governance

6.72 The Trust identified delivering safe, high quality care as a key priority. It measured and collected a wide range of data as a means of learning from and improving outcomes and experience for service users. To consider effectiveness of professional governance the following section considers:

a. audit;
b. KPIs;
c. discharge of statutory functions;
d. workforce planning;
e. education training and continuing professional development; and
f. overview.

a. Audit

6.73 During the period covered by the Review, 2012 - 2017, the Trust held bi-monthly Mental Health and Learning Disability Audit meetings. It was intended that the agenda for these meetings would be informed by two audit forums, one representing Learning Disability, the other Mental Health. From 2012 to 2015 a total of 14 audits were completed:

- six audits - led by medical staff;
- five audits - led by an Occupational Therapists;
- one audit - led by a forensic Psychologist;
- one audit - led by a safeguarding officer who was a social worker; and
- one audit - led by a resource nurse.

6.74 Audit activity undertaken by nursing staff outside the formal clinical audit cycle was not noted in minutes of professional nursing meetings but referenced in RQIA reports. These audits are inclusive of Nursing Care Plans, risk assessments, and behaviour support plans.

6.75 Minutes from the Audit meetings show that they were poorly attended, and that Mental Health dominated audit topics. Staff representing Learning Disability services frequently acknowledged difficulty in engaging staff to gather data. Completed audits often failed to produce Action Plans capable of providing future measurements to demonstrate improvement and impact over time. During 2014 the Audit Forum for Learning Disability was stood down due to poor attendance and engagement. It subsequently merged into a single forum with Mental Health.

6.76 At a subsequent Governance meeting chaired by the Co-Director for Learning Disability, it was acknowledged that the lack of engagement and the failure to

contribute to the prioritisation of audit topics was a missed opportunity to address areas of concern within learning disability services.

b. KPIs

6.77 Key Performance Indicators (KPIs) are measurable indicators that demonstrate progress towards a specific target. They are essential in order to drive improvements in safety, efficiency, quality, and effectiveness as well as evaluating performance. During the period under review there were a number of KPIs against which nursing care at MAH was monitored. These were corporate KPIs used across all care settings. There were no person-centred or care specific KPIs for inpatient learning disability services. Additional performance indicators were identified by learning disability staff. These included nursing supervision, appraisal, mandatory training, and workforce.

6.78 The Trust also used NICE Guideline (NG11)[49] which were published and endorsed by the Department of Health in 2015. NICE guidelines are accepted as best practice. These guidelines cover interventions and support for adults with a learning disability and behaviour that challenges.

6.79 Workforce Steering Group minutes indicate that in 2015, MAH was progressing through The Quality Network National Peer Review. This is a standards-based quality network that facilitates the sharing of good practice. At the same time efforts were being made to introduce ward-based outcome measurement tools.

6.80 In January 2016 there was an agreement between senior nursing staff that the hospital should sign up to the Restraint Reduction Network[50]. The Network exists to support organisations to reduce reliance on restrictive practices.

[49] https://www.nice.org.uk/guidance/ng11
[50] Restraint Reduction Network @THERRNETWORK

6.81 During the period under review the Trust achieved a high rate of compliance with the Corporate Nursing KPIs. This is reported in the annual report of the Director of Nursing on the Key Challenges and Achievements which are reported to the Trust Board on an annual basis.

6.82 The Standards for supervision in nursing were met with exceptions recorded for some Bank and Agency staff. These reports were presented annually to the Trust Board and sent to the Chief Nursing Officer.

6.83 Data pertaining to vulnerable adults, physical intervention, restraint, and seclusion was collected and discussed generally on a fortnightly basis at Governance and Core Group meetings. There was no evidence of an analysis of the data or the production of trend data. At times it was noted that staffing levels, the admission of a new patient, or ward changes impacted upon the number of incidents recorded. There was no evidence that the information collated was used in a proactive manner to address factors known to relate to challenging behaviours on wards. There was also no reference to measurement of compliance with the NICE Guidelines in the documentation provided to the Review Team. The failure to use information to affect changes in practice led, in the opinion of the Review Team, to the over-use and misuse of physical intervention, restraint, and seclusion as found in the *A Way to Go* report (November 2018).

6.84 Regular audits of Nursing Care Plans, Risk Assessments, and Behaviour Support were not discussed at professional or operational meetings. Those topics were however, subsequently introduced into these meetings as part of findings emerging from RQIA inspections. Routine audit findings were not evident in any of the documentation examined by the Review Team.

6.85 The *A Way to Go* Report considered 61 RQIA reports and found that, 'the RQIA inspection reports and Patient experience interviews do not provide a single

overview of Muckamore Abbey Hospital. They present dispersed and sequential information about individual wards and the observations of some patients.' It further noted that, 'it is difficult to draw conclusions from 61 narrative texts and hundreds of recommendations, the process would reveal more about repeated recommendations than in understanding the Hospital as a whole, its contexts and the explanatory frameworks of involved parties than about ways of abating or controlling abuse and harm.'[51] RQIA reports, audit reports, and an ongoing analysis of the range of data collected by the Trust provided professional leads with the opportunities to work preventatively rather than reactively to events at MAH. One manager described to the Review Team 'a sensation of always fire fighting' at MAH.

6.86 Senior nursing staff advised the Review Team that Care Plans were often incomplete and activity records at various times were poor. From the documentation available to the Review Team it was unclear whether the Quality Network National Peer Review initiative was pursued to completion (see Para 6.75).

6.87 Membership of the Restraint Reduction Network was to be discussed at the Core Meeting in Feb 2016. The Review Team found no reference to this discussion or that membership was ever taken up. It is clear however, from the *A Way to Go* report that in 2018 restraint, physical interventions, and seclusions were still being used extensively. It commented: 'Three other [RQIA] reports noted the marked absence of an agreed, consistent, proactive behavioural management strategy...physical environment not conducive to the patients' needs, particularly concerning noise levels...the importance of developing and implementing a system of governance to ensure that incidents that result in the use of physical intervention, seclusion or PRN administration are comprehensively reviewed.' [52] References to boredom, the environment, and/or the absence of proactive

[51] A Way to Go, December 2018, par. 7 - 8, Pages 7 - 8
[52] Ibid, Para. 95, Page 29

behavioural support strategies were regularly noted when incident data were reviewed. Yet the information did not inform revised ways of working with patients with complex and/or challenging needs.

c. Statutory Functions Reporting

6.88 The Review Team reviewed the Trust's Discharge of Statutory Functions (DSF) Reports from 2012 to 2017. The legal significance of these reports has been set out in paragraphs 6.58 and 6.59. The reports were largely repetitive and gave little sense of the extent of compliance with statutory functions. A Safeguarding Report was provided separately from the Discharge of Statutory Functions Reports. Despite repeated requests the Review Team did not receive copies of these associated reports.

6.89 The DSF Reports gave no specific details about how statutory duties under the Mental Health Order 1986 were discharged. Article 121 of the Order addresses the ill-treatment of patients.[53] The Review Team considered the absence of information on DSF Reports providing assurances on the treatment of patients to be an omission. The DSF Reports did not report to the HSC Board on the Ennis Report, on its conclusions, or how recommendations were being taken forward. The 2014 DSF report did not report on approval for the installation of CCTV at three wards in MAH to improve safeguarding arrangements. Neither was the subsequent installation of CCTV during July 2015 reported.

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[53] Mental Health Order 1986, *Ill-treatment of patients*

121.—(1) Any person who, being an officer on the staff of or otherwise employed in a hospital, private hospital or nursing home or being a member of the[F1 Board or a director of the [F2HSC trust] managing] a hospital, or a person carrying on a private hospital or nursing home —

(a)ill-treats or wilfully neglects a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or nursing home; or

(b)ill-treats or wilfully neglects, on the premises of which the hospital or nursing home forms part, a patient for the time being receiving such treatment there as an out-patient,

shall be guilty of an offence.

6.90 The Review Team was informed that during the period of its review there had been discussion about altering the structure of the DSF Reports due to their repetitiveness. The view then was that the DSF Reports needed in the future to be a more outcome-focused reporting system. In the absence of a new DSF structure, reporting continued to lack specificity.

6.91 The HSC Board met annually with Belfast HSC Trust to review its DSF report. The Review Team had access to extracts of reports from the HSC Board to the Trust. Comments regarding MAH related to missing resettlement targets. The emphasis on resettlement is a recurrent theme in the management of MAH, at times to the detriment of the core hospital and the quality of patient care (see Para 5.21). There was no information in DSF Reports regarding the uncertainty about the hospital's future which was causing problems in staff recruitment and retention. The associated issues surrounding the use of bank and agency staff and the implications for the quality and continuity of care for patients was not evident in DSF reports.

6.92 As currently structured and reported upon, the DSF Reports examined by the Review Team did not provide sufficient assurances about the discharge of statutory functions as they related to learning disabled patients.

d. Workforce Planning

6.93 From the Review Team's examination of minutes and discussions with senior nursing staff it is evident that nursing staff shortages were directly impacting on the hospital's ability to provide safe and effective care. In March 2012 this was deemed to be a red risk and was added to the hospitals risk register. Minutes of the monthly Senior Nurse meetings held in 2012 - 2017 make frequent reference to:

- staffing at crisis level;
- staff working excessive hours;
- high reliance on bank and agency staff;
- qualified staff not being in place;
- high levels of sickness absences;
- poor staff morale;
- high levels of staff turnover;
- early ward closures designed to relieve staffing pressures;
- staffing deficits recorded on the Datix information system;
- day care activities restricted for patients to maintain safe staffing levels on wards; and
- the increase of adult safeguarding incidents which was attributed to staff shortages.

6.94 RQIA inspection reports also reported on staff shortages and resulted in a number of whistle-blowing concerns being raised with RQIA during the period under review. The Review Team did not have access to workforce plans or documentation identifying safe or minimum staffing levels and associated skill mix ratios for years 2012 - 2017. Senior nursing staff did report the use of the Telford assessment tool but recognised that this did not take into account the complexity and acuity of patient needs. Nonetheless there is no evidence in any of the documentation reviewed of any systematically applied objective assessment of staffing needs across the hospital. The *A Way to Go* Report also noted that 'the appropriate complement of staff for the wards remains unclear.'

6.95 Short term workforce planning resulted in the recruitment of staff on temporary contracts, reflecting the assumption that the required staffing establishment would be exceeded post resettlement. This strategy was in place from 2012-2016. This approach to staffing resulted in high levels of staff turnover and recruitment difficulties. A competitive recruitment market to establish a new community

infrastructure further compounded the downward trend in staff retention. This was matched with the absence of a career development framework. This resulted in Learning Disability Nurses leaving the service to train as Health Visitors.

6.96 Failures in recruitment resulted in changes to skill mix on wards. The Director of Nursing advised the Review Team that she believed the skill mix at its lowest was 40:60. The Service Manager advised the Review Team that on some wards the skill mix was as low as 20:80 making it difficult to ensure that there was more than one registrant on the ward at any given time. The Review Team noted that healthcare assistants rather than nurses dominated staffing on some wards. The Review Team considered this ratio to be material in determining the quality of professional oversight available over the 24/7 work roster.

6.97 The Review Team was advised by the Director of Nursing that she was not assured that the staffing ratios were sufficient to provide safe and effective care. She issued a directive stating the need for a minimum of at least two registrants per shift. When interviewed she advised the Review Team that she believed current ratios and the skill mix were not an accurate reflection of the acuity of the remaining patients. This will undoubtedly result in poorer outcomes for patients and inhibit nursing innovation and improvement. The Review Team noted that the Director of Nursing was not the financial budget holder for the nursing workforce.

6.98 Throughout the period under review there was clear evidence of recurrent recruitment drives for staff at MAH. The regional challenges associated with recruiting Registered Learning Disability Nurses was noted by the Review Team. The Trust's investment in supporting staff to undertake the Specialist Practitioner programme was also noted. The staffing crisis meant that those specialist staff were needed to meet the core staffing needs of the wards. Their skills and expertise were not therefore available to use in developing and supporting person-centred nurse developments.

6.99 The uptake of training was also adversely affected by staffing shortages. During a 2017 Listening Exercise the Trust found 'cancelled training sessions resulting in poor compliance with mandatory training updates.' The Review Team considered that the high vacancy and turnover rates also impacted upon the Trust's ability to develop staff to meet new and emerging best practice developments.

6.100 An examination of correspondence between the ward Sister of Ennis and her line manager confirmed that on a number of occasions the level of staff available on the ward and their skill set was, in her opinion, inadequate to meet the needs of patients or to progress the resettlement agenda. The issue of staffing numbers had been placed on the Learning Disability Services' Risk Register during the Spring/Summer of 2012 as a high risk. Yet this risk was not placed on the Trust's Corporate Risk Register as per the Trust's policy.

6.101 Immediately after the Ennis complaint (November 2012) came to light the Executive Director of Nursing asked a Co- Director of Nursing with a Trust-wide remit for nursing workforce and education to work in support of the Service Manager and to provide assurance to its Executive Team on the Ennis Investigation. This staff member had regular supervision with the Director of Nursing throughout this deployment. An assessment of nursing within the Ennis Ward was undertaken. This assessment identified a number of shortcomings around matters which included:

- staff induction;
- the student learning environment;
- staffing;
- care planning; and
- monitoring.

A number of improvements were put in place which included enhanced staffing, staff appraisal, and training while remedial action was taken to improve the ward environment.

6.102 While there was an agreed formula (The Telford Formula) to determine staffing levels in learning disability hospitals, it is evident from documentation considered by the MAH Review Team that there were ongoing issues relating to the adequacy of staffing numbers and qualifications. CCTV footage showed patients being harmed by staff in the Psychiatric Intensive Care Unit (PICU), which had the highest staffing levels and ratios of qualified staff. Yet no safeguarding referrals were made and no members of staff spoke out.[54] There is therefore no straightforward linkage between staffing levels and abuse. That being said, over-stretched and tired staff are more likely to be less resilient when dealing with patients with complex and/or challenging needs.

6.103 Inspection reports from RQIA and minutes of senior staff meetings confirmed that the hospital was operating without the full range or availability of a multidisciplinary team (MDT). In 2012 it was reported that the hospital had:

- no Occupational Therapists;
- only 1.5 whole time equivalent (WTE) Speech and Language Therapists based in Day Care;
- 0.5 WTE Dietician,
- one psychologist;
- two WTE Physiotherapists, which was subsequently reduced to 1.5 WTE to meet cost improvement targets.

In addition there were three social workers and a small number of behaviour support nurses or assistants.

[54] Op. Cit. par. 4, Page 4

6.104 Senior staff advised the Review Team that much of the focus of the MDT was directed to the resettlement wards. Psychology input was evident in PICU but efforts to secure funding to extend psychology services across the hospital were unsuccessful. The Review Team found that restricted access to psychology had a detrimental effect on the ability to develop, educate, and support nursing staff to deliver therapeutic interventions. The Review Team acknowledged the role of the Behaviour Support Service but noted that staff and RQIA both reported inconsistent availability of these staff, evidenced by patients' behaviour management plans which were poorly documented.

6.105 Minutes of senior nurse managers meetings recorded difficulties in accessing MDT input into comprehensive risk assessment.

e. Education Training and Continuing Professional Development

6.106 The Trust has committed to building the capacity of its workforce through education, learning, and development with a range of clinical and leadership opportunities.[55] An integral part of good governance is education, training, and continuing professional development activities for staff. These are also essential in enabling the Belfast HSC Trust to achieve its objective to deliver safe and effective care. Access to continuing professional development and leadership opportunities support the Trust's ambition to become a leader in providing high quality care through a relentless focus on quality improvement.

6.107 The Trust has in place structures and processes to support education training and induction for all staff including Health Care Assistants (HCAs). These are translated into functions within the HR Directorate and embedded in professional

[55] https://belfasttrust.hscni.net/working-for-us/staff-development/

assurance structures. These structures include a Co-Director of Nursing for Education and Learning who is a member of the Central Nursing and Midwifery Team along with a senior nurse for Nursing Research and Development. Similar arrangements are in place for the medical profession where a Deputy Medical Director is employed with responsibility for education and workforce issues.

6.108 For social work the Trust employed a governance specialist at Director level with responsibility for the professional development of social workers and for wider governance assurances and policy developments in respect of social work and social care issues. By chairing a Professional Forum of social work managers at Level 8B and above, the Executive Director of Social Work was able to promote consistency of professional social work practice across all Directorates. This also provided an opportunity for updates on professional practice by, for example, input from the Trust's safeguarding specialist.

6.109 Professional regulators, such as the NMC, the General Medical Council (GMC), and the Northern Ireland Social Care Council (NISCC) also require Continuous Professional Development of their registrants. Professional development in the Trust must be offered to comply with such requirements. A wide range of Education Programmes and learning opportunities are available to staff which are accessed through Queen's University Belfast, the Ulster University, the Open University, and a range of other providers such as the Royal Colleges, the Clinical Education Centre, and the Leadership Centre.

6.110 Service led education commissioning for nurses in the Trust is translated into a learning needs analysis. This needs analysis is informed by:

- individual review/appraisal;
- incidents and accidents;
- service developments; and

- professional developments and complaints.

6.111 Additionally, education delivered by the Clinical Education Centre was also available to staff under a Service Level Agreement with the Trust. This education was provided under the auspices of full or half-day programmes, short courses, or bespoke education at the request of the Trust.

6.112 The Belfast Trust has a long history of promoting and supporting Practice Development as a means of changing and improving practice. Much of this work is undertaken in partnership with the Ulster University. It is widely published and is recognised on an international level. Practice Development is seen as a complex intervention and one that embraces attitudinal and behavioural change. The ultimate purpose of practice development is the development of person-centred culture delivering safe and effective person-centred care.[56]

6.113 Post-Registration Education Commissioning for nursing was a robust process undertaken on an annual basis. It is difficult from the information provided to discern what education was commissioned specific to staff at MAH as records refer only to Learning Disability. Trust records of commissioning requests between 2012 and 2017 include a range of requested programmes:

- the Management of Actual and Potential Physical Aggression (MAPPA) Training;
- Developing Practice in Health Care;
- Principles of Assessing People with Learning Disability and Mental Health problems;
- Contemporary issues in Learning Disability;
- Fundamentals in Forensic Healthcare;
- Specialist Practitioner Learning Disability (2015 and 2016); and

[56] McCance T. & McCormack B. Person Centred Nursing: Theory and Practice, Wiley, 2010

- A range of RCN programmes to support the development of ward managers.

6.114 The number of places requested was small with the exception of MAPPA Training which had approximately 50 places and the Specialist Practitioner Programme which had 12 places and required staff to be released from practice to study full time during the academic year.

6.115 The Review Team commend the commissioning of the Specialist Practitioner programme and MAPPA training. The Review Team noted, however, that little priority was given to therapeutic, evidence-based learning. This is against the backdrop of the 2015 NICE Guidelines and a growing body of evidence to support therapeutic intervention.

6.116 At the beginning of 2016 minutes of a senior nurse managers meeting at MAH reflected discussions and a desire to strengthen positive behaviour support. Reinforce Appropriate, Implode Disruption (RAID) training was discussed and training offered to Band 6, Band 7, and Band 8A staff. The Review Team noted that further training was planned but staffing on the wards remained challenging and psychology support was insufficient because of limited resource. The Review Team noted that the RAID approach like MAPPA is reactive in nature to short term management of violence and aggression and is less relevant to NICE Guideline 11 (NG11) (see Para 6.78) which promotes preventative approaches leading to a reduction in restrictive interventions. Approval of the policy to support the roll-out of the Positive Behaviour Strategy in MAH was not received until October 2017.

6.113 The Review Team further noted that whilst Practice Development was encouraged and supported across other programmes of care, the opportunities for staff in MAH were very limited. The Review Team found no evidence of Practice Development Initiatives other than the Productive Ward/Releasing Time to Care series in 2012.

6.114 Induction Training was predetermined for all staff working in MAH and was essential for the preparation of Health Care Assistants. The review team did not access training records for these staff but noted in 2012 that the Co-Director of Nursing for Education and Workforce reported there was little evidence of adequate induction and staff lacked knowledge of the safeguarding framework. The Service Manager was asked to put in place an appropriate induction plan, which was monitored and reported upon, in subsequent RQIA Inspections. The findings of these inspections confirmed that induction training was available but often compromised because of staffing shortages.

6.115 Mandatory training was also specified for all staff working in MAH. Compliance was monitored by the ward managers and formed part of the appraisal process. It was also reviewed by RQIA during its inspections which found that the uptake of mandatory training was inconsistent across the hospital site. The *A Way to Go* Report supports these findings, as does the Listening Exercise with staff conducted in 2017.

f. Overview

6.116 At corporate and clinical levels the Belfast HSC Trust had in place a range of structures, reporting arrangements, professional managerial systems, risk monitoring, educational and professional development processes, and information systems capable of ensuring good governance at MAH. RQIA in its 2016 Report (Review of Quality Improvement Systems and Processes),[57] noted that the main areas of activity for the Belfast Trust were acute hospital care, community care, and social care. The limited focus on a learning disability hospital was also evident on the Trust's website which was only updated in July 2020 to include MAH as one of the Trust's hospitals.

[57] https://rqia.org.uk/RQIA/files/cc/cc11ffbd-7f69-4605-b637-ab763e049b1e.pdf

6.117 The Review Team in its meetings with senior Trust personnel and MAH staff formed the view that MAH was not only geographically distant from the Trust but was largely 'outside its sightline' as one staff member stated. The review of minutes from Trust Board meetings and Executive Team meetings up until until August 2017 showed that the hospital operated with minimal attention at Trust level.

6.118 The values of the Belfast Trust are:

- working together;
- excellence;
- compassion; and
- openness and honesty.[58]

These values did not pervade the care provided by some staff at MAH to vulnerable adults as evidenced by the Ennis investigation and the events captured on CCTV during 2017. The reasons for such lapses are complex and the Review Team considers it too simplistic to attribute it solely to staffing difficulties when one considers that the events in PICU in 2017 occurred on the ward with the highest staff to patient ratio and a greater number of registrants to healthcare assistants. Similarly, governance arrangements do not adequately answer why problems occurred and went undetected and un-remedied.

6.119 RQIA listed a number of specific drivers to embed a Quality Improvement (QI) culture in MAH which included:

- learning from Serious Adverse Incidents (SAI)

[58] **Working Together - We work together to achieve the best outcome for people we care for and support.** Excellence - We deliver safe, high quality, compassionate care and support to everyone including you. Openness and Honesty - We are open and honest with each other and act with integrity and sincerity. Compassion - We are sensitive, caring, respectful and understanding towards people we care for. https://belfasttrust.hscni.net/working-for-us/hsc-values/

- the ability to meet Key Performance Indicators
- listening and learning from patient experience and service user feedback
- empowerment and ownership by staff to innovate and improve based on clinical evidence.[59]

6.120 The Review Team saw limited evidence of a learning culture from the minutes it reviewed or of a willingness to interrogate the significant amount of information which was collated regularly and brought to Governance and Core Group meetings at MAH. An Executive Director noted a 'lack of curiosity' amongst senior clinicians at MAH. The fact that MAH information, staffing, or performance were rarely on the agenda for Trust Board or Executive Team meetings showed that a lack of curiosity. Any focus at Trust and HSC Board levels on MAH appeared restricted to resettlement matters and failure to meet these targets.

6.121 In commenting on the closed nature of relationships at MAH the *A Way to Go* Report states that 'some staff are very comfortable in each other's presence...the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore... the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients.' (see Paras 6.27 and 6.29) This could potentially explain why despite the systems which were in place at corporate and professional levels, abuse at MAH went largely unreported and appeared normalised. The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust.

[59] Op Cit. Review of Quality Improvement Systems and Processes, RQIA, Page 13

Summary Comments and Findings

- **The Trust is one of the largest integrated health and social care organisations in the UK. Its governance structures were complex and appropriate.**

- **The organisational governance structures remained largely consistent between 2012 and 2017. Had they been used appropriately, they had the capacity to alert the Executive Team and Trust Board to matters of concern at MAH.**

- **Complaints about professional practice in Ennis ward in November 2012 were not raised as an SAI or a complaint.**

- **Inspection findings from RQIA were Ward specific. A single overview of the hospital was not provided. RQIA reports resulted in multiple recommendations which were frequently repeated. There was no indication of wider learning or action plans to implement the recommendations from inspection reports. RQIA did not serve Improvement Notices on the Trust in respect of MAH until November 2019.**

- **Clinical audit was dominated by mental health services. Learning disability services were reluctant to engage with audit. This was a missed opportunity to address issues of concern with this directorate.**

- **KPIs were generic rather than specific to inpatient learning disability services and lacked a person-centred focus.**

- **Discharge of Statutory Functions (DSF) Reports were largely repetitive**

narrative documents which provided limited information regarding the discharge of functions under the Mental Health Order 1986. Generally, comments on these reports from the HSC Board related to resettlement targets. There was insufficient challenge at Trust Board, HSC Board, and Departmental levels to ensure DSF Reports were outcome focused.

- Staffing shortages and the lack of an MDT directly impacted on the provision of safe and effective care.

- Wards closed earlier than planned without due regard to the impact on patients or the required skill mix within the staff team. A low ratio of nurses to healthcare assistants was reported. The dominance of healthcare assistants compromised the quality and scope of professional nursing oversight.

- Patient activities were curtailed due to staffing shortages which resulted in increased levels of boredom and behavioural challenges with an over reliance on restrictive practices.

- Consistent recruitment drives resulted in temporary appointments due to the moratorium on recruitment which was driven by the plan to close large portions of MAH under the resettlement agenda.

- The lack of a career development pathway resulted in staff leaving to take up positions in Health Visiting.

- The hospital operated without the full range or availability of a multidisciplinary team which reduced the behavioural support available to patients.

- The focus on education and training was on mandatory training rather than therapeutic evidenced based learning. The lack of investment in staff training and development meant that challenging behaviours were poorly understood. Staff attendance at mandatory training was also poor because of staff shortages.

- A comprehensive range of data was collected on a monthly basis and presented at Governance and Core Group meetings. There was no evidence of analysis or triangulation of this data or its use to inform patient care or staff training.

- There was a clash of values between MAH and the Trust.

7. Review of Leadership

7.1 This section considers leadership in the Belfast Trust at the following levels:

i. leadership requirements for a HSC Trust;
ii. leadership and management arrangements within the Belfast HSC Trust; and
iii. leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels.

i. Leadership Requirements for a HSC Trust

7.2 The Belfast HSC Trust was established in April 2007 as part of the Review of Public Administration (RPA): a major reorganisation of public sector bodies in Northern Ireland. Prior to this reorganisation there were 19 HSC Trusts, with four commissioning HSC Boards providing integrated health and social care services to the population of Northern Ireland on behalf of the Department of Health under the provisions of the Health and Personal and Social Services (Northern Ireland) Order 1972. The RPA resulted in the reconfiguration of the 19 Trusts into six Trusts. The four HSC Boards were replaced by a regional HSC Board.

7.3 When established the Belfast HSC Trust was the largest of the new Trusts with a budget of £1.1billion, employing more than 20,000 staff. Four of the six Trusts which merged to create the Belfast HSC Trust were acute hospital Trusts: the Royal Group of Hospitals, the Belfast City Hospital, the Mater Infirmorum Hospital, and Greenpark Trust. The remaining two Trusts were community health and social care Trusts serving the North and West Belfast and the South and East Belfast

populations of Belfast. Prior to the RPA Muckamore Abbey Hospital had been managed by the North and West Belfast Community Trust.

7.4 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 established the Regulation and Quality Improvement Authority (RQIA) (Article 3). Article 35 of the Order defines the role of RQIA. The legislation also conferred a statutory duty of quality on each health and social care organisation in Northern Ireland (Article 34(1)[60].

7.5 In 2006 the Department published standards[61] (Quality Standards) to support good governance and best practice within the HSC. The five key quality themes within these Standards are:

- corporate leadership and accountability of organisations;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social wellbeing; and
- effective communication and information.

7.6 In publishing the Standards the Department stated that, 'RQIA in conjunction with HSC organisations, services users and carers, will agree how the standards will be interpreted to assess service quality. Specific tools will be designed to allow the RQIA to measure that quality and assist HSC organisations to assess themselves. RQIA will provide a report on its assessment of governance from 2006-2007 onwards.'

[60] 34.—(1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of —
(a) the health and personal social services which it provides to individuals; and
(b) the environment in which it provides them.
[61] Quality standards for health and social care https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

7.7 The Review Team's remit relates to governance and leadership within the Belfast HSC Trust. In this regard the first quality standard, Corporate Leadership and Accountability, is most relevant to the Review. This standard establishes a number of criteria by which RQIA and HSC organisations can determine the degree to which each organisation complies with it. Relevant criteria when reviewing leadership and determining compliance levels include:

- 'Has a coherent and integrated organisational and governance strategy appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability.

- Has structures and processes to review and action its governance arrangements.

- Ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory function and in relation to interagency working.

- Undertakes systematic risk and risk management of all areas of its work.

- Has a workforce strategy in place that that ensures clarity about structure, function and roles and ensures workforce development to meet current and future service needs in line with Department policy and the availability of resources.'

7.8 Section 6 of this report examined the range of governance issues within Belfast HSC Trust relevant to Standard 1 of the Quality Standards, namely: the governance structures; risk management arrangements; assurance in respect of the discharge of statutory functions; and workforce strategy.

ii. Leadership and Management Arrangements in the Belfast HSC Trust

7.9 *The Belfast Way* was published by the Belfast Trust in 2008. It set out a strategic direction for the Trust. Its objective was to offer guidance and motivation to all those involved in serving its resident population. It stated that the Trust would work within government policy to secure the purpose of the Trust which was to improve the health and wellbeing of its population and to reduce health inequalities. *The Belfast Way* had five strategic objectives:

i) Safety and Quality - continuous improvement in the quality of our services and a focus on safety is a priority for all our people, from the Board of Directors to the teams providing care and services.

ii) Modernisation - We believe it is timely to modernise the way we deliver our health and social care. We want to reform and renew our services so that we can deliver care in a faster, more flexible, less bureaucratic and more effective way to our citizens.

iii) Partnerships - working in partnership with individuals and communities leads to more appropriate care and treatment, improved outcomes, better experience by our service users, improved health outcomes and wellbeing for communities and greater social inclusion.

iv) Our People - Our vision is to be seen as an excellent employer within the health and social services family and beyond. Our people will feel valued, recognised and rewarded for their endeavours. They will be supported in their development and their worth as individuals will be respected in the application of their skills in delivering our vision and purpose.

v) Resources - Our financial strategy will ensure that the income we receive from Government provides services which add value, are affordable and set within the organisations overall risk and assurance framework. The organisations duty of care to the public is paramount in all expenditure decisions.'

7.10 These strategic objectives were underpinned by a set of values which include:

- respect;
- dignity;
- accountability;
- openness;
- trust; and
- learning and development.

7.11 In 2009 the Trust set out its approach to leadership in a document titled 'Leadership and Management Strategy 2009-2012'. The Review Team was advised that this strategy document was replaced in 2016 by a Leadership and Management Framework known as 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels.' (see Para 7.25)

7.12 The Leadership and Management Strategy sets out how it supported the Trust's five corporate objectives contained in *The Belfast Way*. It also considered the distinction between leadership and management. It stated that: 'The key purpose of leadership and management is to provide direction, gain commitment, facilitate change, and achieve results through the efficient, creative, and responsible deployment of people and other resources.' It provided definitions of each:

- 'Leadership is an interpersonal relationship and process of influencing, by employing specific behaviours and strategies, the activities of an individual

or organised group towards goal setting and goal achievement in specific situations.

- Management, in contrast refers to the co-ordination and integration of resources through planning, organising, directing and controlling to accomplish specific work related goals and objectives.'

7.13 The strategy included a management and leadership charter. The charter set out the principal actions, knowledge, and guiding behaviours required of leaders and managers in the Belfast Trust and reiterated the values that were set out in *The Belfast Way*, (see Para 7.10). During the period under review (2012 - 2017) the Trust had three different Chief Executives, one of whom served on a part time basis. There was also a six month period during which an Interim Chief Executive was in place pending the appointment of the new Chief Executive. During the review period responsibility for learning disability services also rested with three different Directors.

7.14 In 2007 the Trust Board approved the management structure to provide leadership within the new organisation. Responsibility for MAH was included in the Directorate of Social Work, Children's Community Services, and Adult and Primary Care Services. This was a huge Directorate which accounted for approximately a quarter of the total spend of the Trust. When the Director retired in 2012 the post was split into two with the creation of a Director of Social Care and a Director of Adult and Primary Care. Under each Director were a number of Co-Directors, each of whom had responsibility for a discrete service area. MAH came under the remit of the Co-Director for Mental Health and Learning Disability Services. In addition to the Director with operational responsibility for MAH, the Executive Director of Nursing was responsible for professional matters in respect of nursing.

7.15 The Trust's Executive Team and MAH managerial structures remained in place until the Director of Adult and Primary Care retired in the summer of 2016. At that time the Director of Children's Community Services was asked to lead both Directorates. He was reluctant to do so but agreed to undertake the role for an initial period of six months during which time he would prepare a position paper on the proposed structure. The Review Team was not able to test out the rationale for this proposal with the then Chief Executive. The Review Team had access to the position paper which set out a range of significant shortcomings associated with the conflation of both Directorates. These included:

- The structure had been tried before, prior to 2012, and senior staff in both Directorates felt the portfolio was unworkable;
- It diluted the community voice within the organisation and specifically at Trust Board level;
- It unbalanced the make-up of the Executive Team;
- The job was huge in volume and complexity (comprising a third of the Trust's business area) resulting in the post-holder considering that at times he was 'skimming over issues and information';
- The span of control with 11 direct reports was too great;
- Other Trusts had three persons in post discharging the functions required of the post-holder.

7.16 The Director recommended a return to two Directorates which occurred in the latter part of 2017. In addition to merging the two Directorates in June 2016, the Co-Director Learning and Disability Services post was surrendered when that post-holder retired circa September 2016 as a cash releasing exercise. A Band 8B post at MAH was also surrendered in 2016 on the retirement of the incumbent. The Review Team was advised on the effort taken by the Director of Social Work, Children's Community Services, and Adult and Primary Care Services to secure the re-instatement of both these posts.

7.17 There was no evidence available to the Review Team that having one Director specifically with an Adult and Primary Care remit resulted in MAH being afforded a greater level of attention. The Director did hold a number of meetings on site but according to interviewees, staff at MAH were not aware of who was responsible for the hospital at Executive Team and/or Trust Board levels. The Review Team was told that the decision to surrender the Co-Director Learning Disability Service and the Band 8B posts for cash releasing purposes in 2016 was made by the Director of Adult and Primary Care immediately prior to her retirement without any discussion with staff at MAH or Executive Team colleagues. There is no evidence available relating to how the decision to release staff was made. The incoming Director stated that he spent much of the next year working to have these posts reinstated; an objective which he secured. The Co-Director post was filled during October/November 2016 by MAH's Service Improvement and Governance manager.

7.18 There is no information from Executive or Trust Board minutes of a greater focus being afforded to MAH when the Director Adult and Primary Care was in post from 2012 to 2016. The Review Team had the benefit of interviewing this retired staff member. Although the Ennis investigation took place during 2012/13, the Director of Adult and Primary Care could not recall any engagement she had with the investigation process. She did, however, state that she had read the report. The Report had not been tabled at Executive Team or Trust Board meetings as the Director of Adult and Primary Care considered the matters to have been appropriately addressed. Much of the focus of the Director of Adult and Primary Care related to the resettlement agenda at MAH and the cash releasing targets set by the Department at that time.

7.19 The Executive Director of Nursing was aware of the Ennis investigation. She was aware that approximately £500,000 was provided to fund the 24/7 monitoring on

that ward as a consequence of the investigation. Like the Director of Adult and Primary Care, the Director of Nursing did not bring the Ennis investigation or the subsequent report to the attention of Executive Team colleagues or the Trust Board. The Review Team was concerned that multiple alleged abuses of patients by more than one perpetrator was not considered of significant enough priority to bring it to the attention of the Executive Team or the Trust Board.

7.20 Structural changes at Executive Director level had an impact on the operational oversight and support available to managerial staff based at MAH. The fact that one Executive Director described being uncomfortable about having time only to skim over issues and information (Para 7.15) concerned the Review Team. This Director attempted to be visible at MAH through a series of 'walkabouts' during which he engaged with staff and patients in an effort to identify issues relating to tensions among the hospital's managers which had been brought to his attention. The staff team were reported to have low morale with anxieties about their future given the resettlement agenda and planned closure of wards. His efforts to elicit information directly from staff and/or patients proved unsuccessful. He advised the Review Team that he thought this failure to acquire information was possibly due to staff's lack of trust. The Director of Nursing also advised the Review Team that she made several visits to MAH during the period under review but detected no issues of concern.

7.21 The Review Team found a 'culture clash' at MAH (see Para 8.20). It was also informed of dysfunctional working relationships among the MAH management team. An anonymous letter was sent in January 2017 in respect of the performance of the Service Manager indicating the views expressed were those of a number of staff. This led to a period of supervised practice with support provided by the Co-Director of Nursing for Workforce and Education and the Leadership Centre.

7.22 Documentary evidence confirmed that efforts by the Service Manager to highlight the staffing difficulties through the hospital's risk register created tension between her and the Service Improvement and Governance manager who asked her to downgrade it from a serious to a moderate risk . The Service Manager also provided a SAI to the governance department on 1st September 2017 in respect of the incident of 12th August 2017 which was returned to her because it was deemed not to meet the criteria (see Para 8.104). The Trust's policy was that red risks at service level should be escalated to its Corporate Risk Register. The reason for this omission in respect of staffing at MAH was, in the view of the Review Team, a failure of the Service Improvement and Governance manager to escalate it appropriately.

7.23 At the end of August 2017 the Director of Social Work, Children's Community Services and Adult and Primary Care Services retired. The post, as per his Position Paper recommendation, was split again into two Directorates.

7.24 In 2016 the Trust introduced collective leadership under its 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels' strategy.[62] The purpose was to 'grow a culture of collective leadership where everyone at every level has the capability to deliver improvements for the Trust as a whole, not just in their own roles or work areas.' The Trust stated that its ambition was 'to make Belfast Trust a world leader in the provision of health and social care' and that the Trust be recognised as a high performing organisation. Our focus is on continual learning and the improvement of care that is safe, effective, high quality, and compassionate.' The Collective Leadership strategy also was designed to align with the Trust's learning and development strategy, 'Growing Our People today for tomorrow – living our value of maximising learning and development.'

[62] Leadership & Management Framework

7.25 The Collective Leadership strategy aimed to embed leaders at all levels in the organisation working towards high performance and improvement: 'the ethos is not dependent on position, grade or role and has the potential to more effectively transform the organisation and our Trust Ambition. All staff can be leaders and can demonstrate leadership qualities and behaviours.' The strategy sought to place responsibility for the success of the Trust as a whole while being successful in their work roles. The strategy acknowledged that it would take time to 'review our current culture, look at what works well and identify what needs to be improved. This will inform our new collective leadership strategy.'

7.26 The characteristics of culture set out in the strategy were:

- an inspiring vision;
- clear objectives and priorities at every level;
- supportive people management and leadership;
- high levels of staff engagement;
- learning and innovation the responsibility of all; and
- high levels of genuine team working and cooperation across boundaries.

7.27 The values expected of staff set out in the strategy were:

- 'being respectful to others;
- showing compassion for those who need our care;
- acting fairly;
- acknowledging the good work of others;
- supporting others to achieve positive results;
- communicating openly and consistently;
- listening to the opinions of others and acting sensitively;
- being trustworthy and genuine;
- ensuring that appropriate information is shared honestly;

- actively seeking out innovative practice;
- participating in new approaches and service development opportunities;
- sharing best practice with others;
- promoting the Trust as a centre of excellence;
- acting as a role model for the development of others;
- continuing to challenge my own practice;
- fulfilling my own statutory and mandatory training requirements;
- actively support the development of others;
- taking responsibility for my own decisions and actions;
- openly admitting my mistakes and sharing learning from others;
- using all available resources appropriately; and
- challenging failures and poor practice courageously.'

7.28 The Review Team was informed that the community sector of the Trust did not respond well to the collective leadership strategy. The reaction was described by a former Director as the community sector being 'up in arms.' The view was that the strategy was more appropriate to the acute sector. Interestingly, in reference to medical engagement the Leadership Framework stated that, 'there is clear and growing evidence that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins the argument that medical engagement is an integral element of the culture of any healthcare organisation and the system and therefore one of the highest priorities within an organisation.' The Review Team found little evidence of proactive engagement between managers and medical staff on the MAH when it came to the quality and safety of patients.

7.29 The Review Team saw no evidence of work being undertaken at MAH on a review of culture or of a learning and staff development programme to support the implementation of the Collective Leadership strategy. The practices which were captured by the CCTV footage from August 2017 also were not informed by

the value statements set out in the strategy. Training and staff development have been addressed at Section 6 (Paras 6.106 - 6.115).

iii. Leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels

7.30 There were at various times four Executive Directors with professional and managerial responsibilities for staff based at MAH namely: the Director of Adult and Primary Care; Director of Social Work; Director of Nursing; and clinical leadership which was provided by the Clinical Director. There was limited information on the documentation examined of the extent of the role at MAH. A copy of the Clinical Director's Job Description references the role in clinical leadership. The post-holder was accountable to the Co-Director of Learning Disability Services and professionally accountable to the Trust's Medical Director and from 2016 to the Associate Medical Director.[63]

7.31 The Clinical Director regularly attended a range of senior management meetings, including Governance and Core Group meetings. In his evidence to the Ennis investigation he stated that he completed a weekly ward round whereas the specialist doctor for the ward would have had a daily presence on the ward. Overall, he concluded that the ward was effectively managed by nursing personnel. There is evidence that at times the Clinical Director was not supportive of approaches recommended by ward staff and the Service Manager in relation to developing care and protection plans for patients. His view was that the suggested

[63] Extract from Job Description: 'The appointee will provide clinical leadership and contribute to the strategic development of the Service Group across the Trust and participate as a member of the clinical service senior management team. He/ she will provide professional advice to the Co-Director and Associate Medical Director on professional medical issues of the service. He/she will have a key role in developing clinical leadership and ensuring ownership of new strategies and policies within the clinical service area and of ensuring excellent communications between clinicians and the management team of the Clinical Service area as well as Service Group. The appointee will be professionally accountable to the Associate Medical Director for medical professional regulation within the service.

approach was required for forensic patients only. The follow-up action required of medical staff as part of policy when patients were subject to restraint, seclusion, or physical intervention was not always evident. The staffing pressures on the medical side and the difficulty in recruiting medical staff, which was regularly documented, likely contributed to a number of these omissions.

7.32 There is limited evidence of the Clinical Director promoting positive behavioural support approaches to patient care or of challenge to the high levels of restraint and seclusion which were used regularly especially in respect of a small cohort of patients. It is evident from minutes of meetings attended by the Clinical Director that he was aware of these matters and was very familiar with specific patients and their needs. The Clinical Director regularly attended Core Group meetings at the hospital where data regarding these practices were routinely shared. There is no evidence of a challenge function being exercised in an effort to change practice as a means of reducing incidents. The *A Way to Go* Report found that:

- 'There was a culture of tolerating harmful and disproportionately restrictive interventions.
- The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic.'
- Reference to patients' mental capacity adopts an all or nothing approach with some clinicians determining whether patients may contribute to investigations and even attend "Keeping Yourself Safe" training.'[64]

These findings confirm for the Review Team that clinicians at MAH did not contribute to ensuring that safe and effective treatment was available at all times on site.

[64] Op. Cit. par. 4, Pages 4 - 5

7.33 The Review Team also found the absence of either medical or nursing staff at MAH competent to address the physical health needs of patients to be concerning. The Review Team identified a number of instances where patient's physical health needs remained undiagnosed and untreated for unacceptable lengths of time. The health inequalities which exist between learning disabled and the general population are well recognised.[65] There is evidence in the documentation examined of efforts made to procure GP and out-of-hours medical cover from services local to MAH. There was significant delay in procuring such services. As a hospital service the Review Team are of the view that greater pressure should have been applied to ensure the Trust took corrective action in respect of this shortcoming.

7.34 The Clinical Director briefed the Trust's Medical Director on 20th September 2017 immediately after viewing the CCTV footage at the PICU of the assault on a patient on 12th August 2017. He also informed the Medical Director that the footage also showed ill-treatment of another patient and the inaction of other staff. The Medical Director's notes of the meeting draw a conclusion that 'the whole staff team [at PICU was] complicit.' On learning of events on PICU the Medical Director requested that an independent SAI be established to review events at MAH; she extended this review to other wards.

7.35 When the Review Team met with Clinical Director he stated that in addition to his role at MAH, he also held the regional lead for forensic services and provided outpatient clinics. He was managerially responsible for medical personnel at MAH until after 2017 when his role changed. He advised that he had submitted requests to the commissioning Board for additional medical input. He was unsuccessful in securing additional staffing in either case. He noted the significant delay in

[65] People with a learning disability have worse physical and mental health than people without a learning disability. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017). Mencap https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

discharging patients due to the absence of a sufficient range of community resources. At the time of interview he noted that there were fewer than 60 patients in the hospital of whom around five required treatment or assessment. In discussing the use made of data provided at meetings which he attended regarding incidents involving vulnerable adults; physical intervention, seclusion, and restraint, the Clinical Director agreed that prior to 2017 information was viewed on a meeting by meeting basis rather than trend data analysed to inform alternative strategies or training. He noted that recent presentation of data was more trend focused. The Review Team found little evidence that the Clinical Director played a proactive leadership role in the management team.

7.36 The Review Team considered leadership at a range of levels across the Belfast HSC Trust in respect of MAH. An examination of Trust Board and Executive Teams' minutes showed that MAH rarely featured on the agenda. There was no reference to it in the Trust's Annual Quality Reports or within the Discharge of Statutory Functions Reports (DSF). The Review Team considered the repetitiveness of the DSF reports and the general absence of assurance regarding the degree to which statutory functions were discharged should have resulted in challenges at Trust Board and HSC Board levels.

7.37 Neither the vulnerability of the patients cared for at MAH nor an awareness of the likely risks associated with institutional living brought MAH into focus at any level at Trust Board or Executive Team levels. The Review Team concluded that for a number of reasons MAH was perceived, as one Co-Director noted, as a self-contained community with its own culture and identity. Its geographic distance from the Trust and the resettlement plan for the hospital led in the Review Team's opinion, to it being viewed as a place apart. MAH had no champions at either the Executive Team or at Trust Board levels with a curiosity about it and those for whom it cared. The Review Team concluded that the Trust's values (see Para 7.10) and the objectives established in *The Belfast Way* (see Para 7.9) were not

guiding principles at MAH. The Review Team identified a cultural divide between the Trust and MAH.

7.38 Organisational culture is a set of shared assumptions that guide what happens in organisations by defining appropriate behaviour for various situations.[66] Organisational culture affects the way in which people and groups interact with each other, with clients, and with stakeholders. Additionally, organisational culture may influence how much employees identify with their organisation.[67] A deeply embedded and established culture illustrates how people should behave, which can help employees achieve their goals. This behavioural framework in turn ensures higher job satisfaction when an employee feels a leader is helping him or her complete a goal.[68] Organisational culture, leadership, and job satisfaction are all inextricably linked.

7.39 The Review Team found low levels of staff morale reported by a range of interviewees and by staff whom they met during the visit to MAH in February 2020. It also found significant leadership issues in that events which occurred at MAH were seldom brought to the attention of the Executive Team, the Trust Board, the HSC Board, or the Department of Health. The culture at MAH appeared not to be influenced by the Trust's modernisation agenda or its value base. It also found expression in the reluctance of a number of managers to embrace the resettlement agenda by accepting the implication for the hospital's future and to learn from good practice to ensure a higher proportion of patients made a successful transition to community living. Such an approach may also have served to allay the fears and

[66] Ravasi, D. & Schultz, M. Responding to organizational identity threats: Exploring the role of organizational culture. *Academy of Management Journal*, 2006, 49 (3): 433–458

[67] Schrodt, P. The relationship between organizational identification and organizational culture: Employee perceptions of culture and identification in a retail sales organization". *Communication Studies* 2002, 53: 189–202

[68] Tsai, Y. "Relationship between Organizational Culture, Leadership Behavior and Job Satisfaction." *BMC Health Services Research BMC Health Serv Res,*, 2011 (11)1, 98

apprehensions of family and carers of patients who were understandably concerned about changes to the living environment of their loved ones.

7.40 The lack of Trust Board and Directors engagement with MAH is understandable given the scale and complexity of the Belfast Trusts and the degree to which the acute agenda dominated Executive and Trust Board meetings. It is not however, an excuse for having MAH operate under the radar with little effective challenge at the failure of its leaders to bring issues relating to the service to the attention of the Trust Board. A closed institution carries associated risks regarding the wellbeing of residents. This has been well established in institutions such as prisons, children's homes, and other learning disability services.[69] Visible leadership with regular engagement with a service and its staff is an important means not only of being alert to possible problems in a service but also of communicating the organisation's values and objectives for the service.

7.41 In the Review Team's opinion, how the physical environment was maintained conveyed a message to staff about how the hospital was valued by the Trust. Much of the hospital had been allowed to deteriorate over time and problems which emerged were addressed in-house in reactive fashions. For example, to solve issues relating to staff shortages wards were closed earlier than planned with insufficient attention afforded to the mix of patients in the amalgamated wards. Similarly, staff shortages resulted in fewer activities for patients which had negative consequences in relation to their management and behavioural challenges.

7.42 In the opinion of the Review Team the role of leaders is to interrogate and analyse information to develop approaches to proactively address root causes. Yet the absence of behavioural support staff meant there was no strategy in place capable of reducing incidents of physical intervention, restraint and/or seclusion. From a

[69] The Winterbourne Review, 2012 https://www.nhs.uk/news/medical-practice/winterbourne-view-failures-lead-to-care-system-review/#:~:text=The%20report%20into%20the%20events,reports%20of%20abuse%20were%

number of correspondences between one Ward Sister and her line manager it is apparent that she stopped raising issues of concerns because it made no difference and her concerns remained unanswered. Addressing one's own difficulties without support obviously caused this Ward Sister to feel ignored and frustrated. The degree to which her views were representative of opinions across MAH is not known.

7.43 The Review Team concluded that a number of MAH senior managers attempted to deal with issues in-house, rather than escalate them to Director level. The Review Team considered that this was one possible explanation for why an SAI was not competed in November 2012 in respect of the Ennis Investigation by MAH staff (see Para 8.30)

7.44 A culture which separated MAH from its parent Trust is evident. The Review Team noted MAH staff's desire to train on-site rather than at Trust locations. When patients became ill or needed hospital treatment staff also elected to attend at a Northern HSC Trust facility rather than one of Belfast Trust's hospitals. There was no sense that MAH staff felt a loyalty to the Belfast Trust.

7.45 In 2012 the Trust Board agreed to meet at each of its facilities to increase its visibility with staff groups and to apprise itself on the range of services it provided. The first Trust Board meeting at MAH was held in 2016. The priority afforded to MAH is possibly reflected on the Trust's website which until July 2020 did not list MAH as one of its hospitals.

7.46 When events of August 2017 were brought to the attention of the Trust Broad on 20th September 2017 it decided to appoint an External Assurance/Support Team. The purpose of the Team was to provide independent assurance to the Trust Director lead Governance and Improvement Board in relation to the response to the serious safeguarding concerns in Muckamore Abbey Hospital. The Team

consisted of the Trust's Adult Safeguarding Specialist, a Professor of nursing and learning disability (Ulster University), and a senior professional officer at the Northern Ireland Practice and Education Council (NIPEC). Proposed priority areas for the Team to review were:

- model of service delivery;
- advocacy arrangements;
- nursing staffing levels, skill mix, training and education;
- enhanced monitoring;
- Adult Safeguarding processes; and
- the viewing of CCTV footage.

7.47 A Director's Oversight Group was also established. The group met on a weekly basis to review the Action Plan for Protection of Patients with the service management team, provide support, and offer an 'open door' to any staff member who wished to speak to the Directors. Directors have also visited clinical areas. The current action plan considered actions under the following headings:

- enhanced monitoring;
- improving staffing;
- communication;
- reflection and learning;
- adult safeguarding; and
- disciplinary investigations.

7.49 The Trust Board also established in January 2018 an independent Review Team under the leadership of Margaret Flynn to investigate adult safeguarding at MAH as a Level 3 SAI. The resulting report was published in November 2018.

7.50 An examination of the Executive Team and Trust Board's minutes since CCTV footage came to light demonstrated the higher priority afforded to MAH. The senior

leadership team, which has since been deployed at MAH, represents personnel with significant expertise. The Review Team considered that this level of attention will be required in the future to ensure that safe, effective, and compassionate care is available to patients who are some of the most vulnerable citizens in Northern Ireland.

Summary Comments and Findings

- **The Belfast Trust made significant efforts after the RPA to develop clear strategic direction and sought to communicate this to its staff and citizen.**

- **The Executive Team and the Trust Board accepted MAH as a place apart from the rest of the Trust. The scale and complexity of the Trust and its focus on acute services meant that there was a lack of engagement with or curiosity about MAH. There is no evidence of senior people championing the hospital.**

- **There was a lack of evidence that the Trust Board or Executive Team displayed interest or curiosity about MAH. The site was rarely visited.**

- **The frequent changes in Trust management structures did not provide stability for those trying to provide learning disability services. Staff at MAH were at times unclear about who the Directors were with responsibility for the service.**

- **The Trust's focus was on resettlement of patients in MAH. This came at the cost of scrutiny of the safety and quality of care of those in the hospital.**

- **Issues of real concern such as staffing matters were not escalated by the Director of Adult and Primary Care or the Director of Nursing to the**

Corporate or Principle Risk Registers.

- The appointment of the Service Manager in 2012 from outside Learning Disability Services was met with hostility by some managers in MAH. There was a lack of support for her at times from her superiors and evidence of a dysfunctional senior team at MAH.

- There was reluctance within Learning Disability to let other parts of the Trust know what was going on in the hospital. The reluctance to use appropriately the SAI procedures was an example of this.

- Leadership on the MAH site was ineffective and did not prevent or challenge a culture of institutional abuse towards patients.

- There was limited evidence of effective medical leadership on the MAH site.

- The Trust's values and corporate objectives did not inform practice at MAH.

- There was a culture divide between the parent Trust and MAH which developed over many years.

- Trust Board members were not well served by those Directors who did not escalate matters such as the Ennis investigation to it.

- The absence of adequate medical cover to address the physical health needs of patients and behavioural support services to manage their behaviours resulted in harm being caused to some patients.

- Neither Directors nor Board members grasped the scale of the historic

CCTV footage or its implications in the latter part of 2017 until 2019.

- Steps taken since August 2017 have contributed positively to improvements to patients' care and wellbeing.

8. Key milestones of the Review

8.1 The Review Team's approach to the three key events which occurred within the timeframe covered by its Terms of Reference is set out at paragraph 1.5. These events inform the structure of this section under the following headings:

i. the Ennis Report;
ii. CCTV; and
iii. the complaint made by a patient's father in August 2017.

8.2 The Review Team acknowledges that the three key stages may not fully represent standards of leadership and governance from 2012 to 2017. They do, however, provide the Team with robust information upon which to base its conclusions and recommendations.

i. The Ennis Report

8.3 The Review Team focused on the substance of the Ennis report and its subsequent influence on practice, culture, leadership, and governance at MAH rather than on any events subsequent to media involvement in October 2019. The following sub-sections reflects this approach:

a. a summary of the events which led to the Ennis Report;

b. the Ennis ward context - November 2012;

c. The Safeguarding Investigation

d. the processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same;

e. outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care;

f. governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations; and

g. observations and conclusion.

a. A Summary of the events which led to the Ennis Report

8.4 On the 8th November 2012 the Trust received allegations that four patients at Ennis Ward were the subject of verbal and physical abuse. The allegations were initially made by a staff member employed by a private provider. Other staff from this provider made similar allegations following the initial allegations. The external staff were working in Ennis to familiarise themselves with a number of patients who were scheduled to be resettled in a facility owned by the private provider.

8.5 The nature of the allegations made included:

- rough handling of some patients;
- alleged assaults;
- staff speaking inappropriately to patients;
- a patient being encouraged to hit back when she was attacked by another patient;
- patients hitting out at staff and each other without appropriate intervention; and

- issues relating to the management of patients around meal times which appeared distressing to some of them.

8.6 On receipt of the allegation three staff members (two nurses and a healthcare assistant) and a student nurse were immediately placed on precautionary suspension pending further investigations. The nurses were referred to the Nursing and Midwifery Council. The healthcare assistant was referred to the Disclosure and Barring Service.

8.7 A Vulnerable Adult Safeguarding Review was established immediately. The review was led by a Designated Officer (DO) not based at MAH, who was assisted by two social workers from the Trust's community learning disability team who acted as Investigating Officers (IOs). The investigation was conducted under the Trust's Safeguarding of Vulnerable Adults policy. Given the alleged criminal nature of a number of the allegations the investigation was conducted jointly by the Trust and the PSNI. The Trust's DO ensured that interviews took place with staff from:

- the Private Provider;
- Ennis ward;
- several patients who were potentially injured parties along with their relatives/carers;
- the Clinical Director; and
- the Specialist doctor for the ward.

Records indicate that interviews took place between 19th November 2012 and 15th May 2013.[70] The Review Team had access to witness statements which were taken as part of the Trust's investigation, excluding statements taken by the PSNI.

[70] There were 6 interviews with MAH staff which were undated and they are excluded.

8.8 The report into the Ennis investigation was completed in October 2013. Appendix 1 of the Ennis Report lists 63 incidents. In its examination of the incidents the Review Team was unable to determine the exact number of incidents. From its review of the records the Review Team identified a significant degree of duplication (see Appendix 6). Dates when the incidents allegedly occurred were not available. This made it difficult to deduce whether the same incident was referenced more than once using different terminology or whether there was more than one occurrence.

8.9 The Review Team found it difficult at times to determine the precise nature of the allegation being made. This difficulty was compounded by the statements provided by four staff from the Private Provider made to the Trust's Human Resources personnel in 2014. Information available from the IOs and the Human Resource department meant that the Ennis Review Team identified conflicting information on a number of matters. These included the level of induction available to the private provider's staff, the nature of interaction with patients, and the assistance provided by Ennis staff. A significant number of alleged incidents were deemed by the Review Team to be of a practice nature and related to the care of patients by both nurses and healthcare assistants. They indicated the likelihood of a culture prevalent in the ward at that time.

8.10 As a result of its investigation the PSNI charged a nurse and a healthcare assistant with a number of common assaults and ill-treatment of patient. At trial the nurse was acquitted while the healthcare assistant was found guilty on one count of common assault which was subsequently overturned on appeal.

8.11 The healthcare assistant retired and resigned from the MAH bank pool of staff at the conclusion of the police investigation. A disciplinary investigation was commissioned in respect of the nurse. The Review Team was advised that only one of the allegations made against this staff member was capable of being taken

to a disciplinary hearing. The nurse returned to work for a short time, although not in Ennis ward, and retired shortly afterwards.

b. The Ennis Ward Context - November 2012

8.12 Ennis was a resettlement ward caring for 15 patients. The Review Team considers the circumstances under which patients lived and staff worked at the time of the allegations as significant. This is because they provide a context to assist an analysis of the day to day running of the ward. The *A Way to Go* report commented that, 'the ward environments impact on patients, their families and staff.'[71] Similarly, Prof Ian Kennedy, who chaired the Kennedy Review into the practice of the breast surgeon Ian Paterson, noted that: 'at times of stress in an institution, the first people who are overlooked are patients.'[72]

8.13 Documentation examined by the Review Team noted that Ennis staff had expected the ward to close in December 2012 and had already held some events to mark the planned closure. Similarly, the ward environment had not been maintained due to its imminent closure. The ward was described as overcrowded and lacking in space. Challenging behaviours were at a level which caused difficulties on the ward.[73]

8.14 The Review Team was advised that MAH was exempt from cash releasing measures in 2012/13 as it was envisaged that the £1m it was required to release would be achieved by ward closures. The Review Team was further advised that MAH on an annual basis had an operating surplus which was used to offset overspends in the community learning disability services.

[71] A Way to Go, Page 43, par. 2
[72] Seven Organisational Weaknesses – Prof Ian Kennedy on the Ian Patterson Report
[73] Ennis Investigation File Page 62

8.15 The nurse to patient ratio was also reported to be low in Ennis with a high ratio of healthcare assistants. The Review Team was advised that a staff ratio of 20:80 nurses to healthcare assistants pertained at times in Ennis. RQIA in its response to the draft Ennis Report stated that, 'staffing shortages appear to be a significant contributory factor to the allegations. There are issues of redeployment and concerns expressed regarding bank and agency staff.' More concerning was an RQIA comment in the same document that, 'the issue of staffing levels is a recurrent theme and particularly as staff move more frequently from Ennis to other wards.'

8.16 The uncertainty around the hospital's future caused recruitment difficulties. Coupled with staff shortages this resulted in a high reliance on bank and agency staff for cover. The Review Team was told that some staff worked bank hours resulting in a working week of 70 - 80 hours. At times, the ratio of registrants on duty was as low as 20% of those on duty. Staffing concerns were not unique to Ennis. By March 2012 hospital managers had escalated the staffing situation by placing it on the MAH Risk Register at red, which the Service Manager told the Review Team meant it had been brought to the attention of the Trust Board. The examination of the Trust's Corporate and Principle Risk Registers[74] found, however, no reference to the staffing crisis at MAH.

8.17 Staff shortage resulted in the curtailment of patient activities in Ennis. RQIA stated that it 'was not aware of activities happening at Ennis during previous inspections.'[75] In the documentation examined by the Review Team, the lack of activities correlated with behavioural issues. It also meant that at times it was impossible to maintain agreed observation levels. The ward manager reported these concerns to her line manager.[76] The Telford Formula was employed in MAH

[74] Corporate Risk Register – Trust Executive Team. Principle Risk Register – Trust Board.

[75] RQIA response to draft Ennis Report 2nd August 2013

[76] Op. Cit., Page 67

to agree staffing levels. The Ennis Report voiced concerns about its appropriateness, as did RQIA, especially given the mix of patients requiring care on the ward.

8.18 The Ennis ward was structured in two halves; upper and lower. The upper half having six patients who were deemed to be more able than the nine patients cared for in the lower half. Patients in the lower half of the ward had complex needs and challenging behaviours; this area was locked as a means of protecting them. The Review Team had access to internal correspondence from the Ward Sister to her line manager expressing concerns about the mix of patients and the skill mix of the staff team, which she deemed to be inappropriate to meet the patients' needs. Other correspondence stated that there was insufficient staff to enable the ward to progress its remit as a resettlement ward.

8.19 The Review Team was advised that in November 2012 Ennis Ward had four patients to a bedroom. Although the ward was overcrowded, therapeutic space for patients had nevertheless been reassigned by the Ward Sister to provide additional accommodation for staff. The furniture in the ward was described as very old. There were few chairs and sofas and furniture reportedly did not meet the mobility needs of a number of patients. An Internal Audit of the Ward undertaken on 12th December 2012 and updated on 19th February 2013 comprehensively reviewed the ward. Its subsequent 17-page report lists a range of environmental shortcomings. The ward was described as dull, dismal, and un-stimulating by staff from the private provider's service.

8.20 MAH was registered as a hospital. Efforts to bring the Ennis ward up to hygiene and infection control standards meant changes were made, for example, to the display of patients' artwork and arrangement of ward decorations. This caused a culture clash between those who viewed the ward as the patients' home and those seeking to apply the standards required of a hospital. There is no information on

the records examined of discussion with RQIA to inquire in what ways patients' living space could be maintained.

8.21 The service manager when appointed in 2012 had an objective to resettle where appropriate patients into community settings. This would allow the hospital to have a core focus on treatment and assessment. Her agenda, which was in keeping with that of the Bamford Reviews, the Department of Health, the commissioning HSC Board, and the Trust was met with resistance from a number of staff as well as from patients' carers and relatives who had come to view MAH as a home setting. As many patients had lived there for decades, concerns expressed about resettlement are understandable. The idea of a hospital as a home is not a sustainable way forward for those with learning disabilities.

8.22 Ennis was not viewed as an environment fit for its purpose as a resettlement ward according to information provided to the Review Team; this conclusion was not unique to Ennis. In respect of the other resettlement wards examples provided were of wards with dormitory sleeping arrangements of up to 10 patients with no potential for individualisation.

8.23 As activities in the ward were limited a number of sources referred to resulting boredom and lack of stimulation among patients. The removal of the ward's car also denied the opportunity for patient outings. The *A Way to Go* report reported the views of a patient advocate who observed that: 'there's a lack of 1:1 to go out and do activities. The patients are bored a lot of time on the wards.'[77] Often staffing difficulties, which was a common feature across MAH, limited patients' ability to attend the onsite day care centre as there were insufficient staff to take them there.

[77] Op. Cit. Page 25, par. 87

8.24 The physical environment on the ward as described to the Review Team was considered to be un-conducive to the promotion of a patient centred approach to care. It is apparent from witness statements accessed by the Review Team that staff who worked in the lower part of the ward felt less favourably treated. It is likely, in the opinion of the Review Team, that patients may also have experienced similar sentiments.

8.25 In addition to a dated and un-stimulating physical environment, Ennis also largely functioned on a uni-disciplinary basis. The Review Team was told that a multi-disciplinary approach was absent within the ward, that there were no occupational, behavioural, speech and music therapies, nor social worker attached to the ward. The Review Team was informed that in contrast, MAH in November 2012 had:

- 1.5 speech and language therapists;
- 0.5 dieticians;
- a psychologist;
- two physiotherapists;
- a technical assistant responsible for aids and appliances; and
- three social workers.

There was no pharmacy cover at the hospital. GP services were contracted from an Antrim practice to meet patients' physical health care needs. On site input from psychiatric services was also limited as the psychiatrists also had duties in respect of outpatient clinics across the region. The absence of an agreed medical model reportedly resulted in tension between psychology and psychiatry services within the hospital according to information provided to the Review Team. It is noteworthy that at this time (2012) there were some 250 inpatients in MAH.

8.26 The Ennis ward's staff and patients faced significant challenges across a range of measures. The private provider's staff who complained about patient care in Ennis,

had come to work in an environment very different from the modern facility to which they were accustomed.

c. The processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same

8.27 The allegations received by the Trust on the 8th November 2012 could have been dealt with potentially as:

- a complaint;
- a Serious Adverse Incident (SAI); and/or
- an adult safeguarding investigation.

8.28 On receipt of the allegations the decision was made to process them as a safeguarding matter under the Trust's safeguarding vulnerable adults' policy. This decision in the opinion of the Review Team had a number of consequences. It meant that the allegations were then all classified as being of a safeguarding nature, although this was not the case. It also meant that there was no formal arrangement to bring the safeguarding investigation to the attention of the Executive Team of the Trust's Board. In the case of complaints and Serious Adverse Incidents, arrangements exist to apprise the Trust Board of such complaints and incidents through relevant reporting arrangements.

8.29 A review of Appendix 1 of the Ennis Report shows that a number of the complaints related to poor practice and issues of care. Concern was expressed about the level of induction for staff from the private provider and the degree to which patient information was shared with them, as well as the level of support provided to them by MAH staff. In the opinion of the Review Team, allegations should have been disaggregated in such a way as to ensure the safeguarding investigation's focus

was maintained which would have enabled practice issues to have been addressed more expeditiously.

8.30 In its wider consideration of structural issues in Ennis and across MAH, the Review Team concluded that in addition to the safeguarding investigation, the allegations should also have triggered an SAI. An SAI is defined as 'any event or circumstance that led or could have led to serious unintended or unexpected harm, loss, or damage to patients. This may be because:

- It involves a large number of patients;
- There is a question of poor clinical or management judgment; …
- It is of public concern;
- It requires an independent review.

The Health and Social Care Board, with input as appropriate from the Public Health Agency (PHA) and the Regulation and Quality Improvement Authority (RQIA), reviews each incident and decides whether any immediate action is required over and above that which has already been taken by the reporting organisation. The reporting organisation is required to carry out an investigation into the incident and forward a report within 12 weeks to the Health and Social Care Board.'[78]

8.31 The Review Team had access to correspondence between the HSC Board and the Belfast HSC Trust where the former asked on multiple occasions from the 6th February 2013 until the 3rd September 2015 for an SAI to be submitted in respect

[78] NI healthcare: What is a serious adverse incident? 6th October 2016 https://www.bbc.co.uk/news/uk-northern-ireland-37563833#:~:text=A%20serious%20adverse%20incident%20is,loss%20or%20damage%20to%20patients.

of the Ennis allegations. [79] On the 7th September the Trust accepted that it was in breach of both the 2010 and 2013 SAI procedures but was content to live with the procedural breaches as the allegations were not substantiated by the safeguarding investigation. The Review Team was concerned that acceptance of such a breach would have occurred without the approval of the Trust Board. In its discussion with Trust Board members it is apparent that they were not aware of this admission. Similarly, the Review Team considers that the HSC Board should seek to assure itself that any such admission has been endorsed by the Trust.

[79] Request 6th February 2013 asking if the Early Alert is closed as no SAI has been received. 4th March 2014 email noting no SAI has been received and asking if the Early Alert is closed. 6th March 2014 email requesting to Trust notify the Trust given the serious nature of the allegations and in the public interest the Board views this as an SAI, apologies for not picking up earlier that an SAI had not been received; notes the Early Alert remains open. The Trust replied on 28th January 2015 stating the Early Alert remains open and the matter has been investigated under safeguarding arrangements not as an SAI. Advises the Early Alert should be closed. HSC Board replies stating the incident appears to meet Criteria 4.2.5 and 4.2.8 of the SAI Procedures for Reporting and Following up of SAI (October 2013). It notes while appropriate to delay SAI on the request of the police that Section 7.3 of the procedures expects that the SAI will run as a parallel process. 'The intention and scope of the SAI is therefore different from the police criminal investigation and the Adult Safeguarding Investigation.' The Trust is requested to formally notify the HSC Board of the incident as an SAI and conduct a review of this case in respect to care planning, staff supervision, training etc or any cultural or environmental features in the care setting that could be addressed to reduce the likelihood of future reoccurrence. The Trust responded on the 13th May 2015 stating that the y had made the decision on the basis of the 2010 procedures which were extant at the time of the incident. The HSC Board responded on the 23rd July 2015 noting that under Section 3.3 of the 2010 procedure an SAI should have been completed. The Trust was again asked to submit an SAI in respect of the incident. The Trust responded on the 5th August 2015 stating the matter had been investigated by the PSNI and an 'extensive safeguarding process' and that 'there was no evidence of any of the allegations made.' The Trusts requested that the Early Alert be closed. 28th August 2015 HSC Board responded it would prefer to keep the Early Alert open until an SAI was received from the Trust. 1st September 2015 the Trust's explanation for its decision not to submit an SAI as requested 'the safeguarding investigation found the allegations were not substantiated and as such does not meet the SAI criteria.' The Trust acknowledged that it should have been dealt with as an SAI at the time but would have been deferred pending the conclusion of the safeguarding investigation. If it had been reported as an SAI it would then have been de-escalated given the unfounded allegations. If the Trust did now submit it would also be asking for it to be de-escalated due to the unfounded allegations. Trust felt referral now would be a paper exercise. The Board agreed to close on the following wording from the Trust: 'HSCB are content to close this early alert on the basis BHSCT have advised the safeguarding investigation found the allegations were not substantiated. It should be acknowledged at the time the early alert was reported, a SAI notification should also have been submitted, which could subsequently have been deferred pending the outcome of the safeguarding investigation.' The Board replied on the 3rd September noting if the Trust could live with the breach in respect of SAI reporting the HSCB could. The Trust replied on the 7th September 2015 stating it could live with this breach.

8.32 As a result of the criminal investigation led by the PSNI, two members of staff faced criminal charges. One staff member was acquitted at initial hearing while the other's conviction was overturned on appeal. The standard of proof in criminal trials is defined as being beyond reasonable doubt. On the other hand, the balance of probability test means that a matter is more likely to have happened than not. This lower standard of proof is usually used by social services in determining the likelihood of harm/risk in safeguarding cases. The Trust repeatedly advised the HSC Board that the safeguarding investigation was unable to substantiate the allegations even though the Public Prosecution Service determined that charges should be brought. The Review Team was concerned about the Trust's approach due to the threshold applied in this matter. The definition of evidence and a decision on whether the Ennis allegations constituted institutional abuse were still unresolved at the time of the last Adult Safeguarding Case Conference held on the 28th October 2013. An internal email dated 24th January 2013 which was copied to the DO leading the safeguarding investigation, stated that, 'there is a concern of possible institutional abuse and a full understanding in terms of culture and past history on Ennis is relevant.' These matters are analysed in paragraphs 8.36 to 8.62 as part of its wider consideration of the adult safeguarding investigation.

8.33 The Review Team considers that the Ennis allegations merited the submission of an SAI either to operate in parallel with the safeguarding investigation or to have taken place at its conclusion. The SAI policies for 2010 and 2013 would have facilitated either approach. The Review Team concluded that:

- the Trust failed adequately to interpret the SAI reporting criteria;
- the potential existed for a fuller investigation of events at Ennis, which could have identified many of the issues described in the *A Way to Go* report (2018); and that
- factors contributing to the situation subsequently captured on CCTV during 2017 included: the staffing crisis, the focus on resettlement, ward closures,

patient mix, the lack of a multidisciplinary approach, and excessive levels of seclusion, restraint and staff overtime.

8.34 The Review Team could find no explanation as to why the Trust opposed an SAI in respect of the Ennis allegations. The capacity existed for local managers on the MAH site to control this aspect of the investigation as the safeguarding aspects were being managed off-site. In discussions with Trust Board members the Review Team was told that MAH was 'not in their line of sight' of the Trust Board and that a lack of curiosity pertained among its senior managers, the consequence of which was a lack of scrutiny or analysis of events at the hospital, in the Review Team's opinion. The Board members expressed their profound regrets and shame for the events at MAH. The Trust Board has since made efforts across a range of systems to ensure the safety and wellbeing of patients. While the 2018 - 2020 period falls outside of the Review Team's Terms of Reference, access to pertinent documentation and personnel offered reassurance to families and carers that the Trust had learned from events of 2017 and taken a range of remedial actions.

8.35 Wider structural accountability could, in the opinion of the Review Team, have identified from the Ennis allegations the hazards associated with inadequate staffing, the deficient governance and leadership arrangements, and the potential for institutional abuse. Such awareness might have led to the introduction of mitigating strategies which in turn could have prevented the abuse captured on CCTV and the complaint of abuse by a patient's father in August 2017.

d. The Safeguarding Investigation

8.36 The following section considers the conduct of the safeguarding investigation. The initial safeguarding referral resulted from disclosures from a care assistant employed by a private provider who had been working on the ward on 7th

November 2012. She then 'witnessed patients [sic staff] being verbally and physically abusive to four named patients.' Three of these patients were from the BHSC Trust and one from the NHSC Trust's areas.[80] The Care Assistant identified three staff and one student nurse in her allegations. Her concerns were reported to her employer's team leader at ten o'clock that evening. Steps were taken the following day to ensure the Trust was alerted to the care assistant's allegations.

8.37 The decision to conduct an adult safeguarding investigation was taken upon receipt of the allegations on the 8th November 2012 by the Operations Manager for the Trust's Community Learning Disability Treatment and Support Services. In the absence of her line manager, the Operations Manager decided to lead the investigation. She took appropriate action to ensure the immediate safeguarding of patients and notified the PSNI as per the Trust's protocol for the Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults. Staff members implicated in the alleged abuses were immediately subjected to precautionary suspension.

8.38 On 29th November 2012 the Operations Manager drafted a letter to family members/ carers of Ennis patients seeking to furnish them with an update on the safeguarding investigation. The Co-Director for Learning Disability when provided with a draft of this letter determined that further discussion was required before an update could be produced. On 18th and 19th January 2013 a shorter, less informative letter was issued.

8.39 The Investigation Officers (IOs) contacted relatives/carers of patients in Ennis to ascertain if they had any concerns about the care provided. This resulted in

[80] In an email dated 29th November 2012 the NHSC Trust confirmed that it would be represented at adult safeguarding case conferences but 'responsibility for updating families by phone and letter should remain with BHSCT ensuring a consistent approach.'

minimal supporting evidence for the investigation. Family members and carers were advised that they would be kept up to date with the investigation's progress.

8.40 In an email dated 17th December an IO wrote to the DO stating that of the eight families contacted, one had expressed concern about patient care. In that instance a relative noted that his sister had claimed to have been taken by 'the scruff of the neck ... to her bedroom'. He felt it was unlikely that his sister would tell lies but 'may not want to say anything that would get her into trouble.' None of the others expressed concerns about care on Ennis ward although two raised concerns about the future of the ward and their worries over its closure. One man noted the potential of any resettlement to disrupt his sister who had lived at the hospital for 30 years. Another interviewee related in a telephone interview on 8th January 2013 a number of concerns she had relating to low staffing number. She felt there was a need for staff in dayrooms at all times and was anxious about the level of supervision available for her sister. She was also concerned that her sister's money was not being spent on her. She felt her sister's clothing was shabby and that her sister was being over-medicated as she slept all afternoon. The overall assessment of the ward from this interviewee was, however, that 'the good outweighs the bad.'

8.41 Another telephone interview on 15th January 2013 took place with a patient's mother in which she reported that in her opinion the staff 'are very good'. She did however, express concerns about the number of incidents of peer assaults on her daughter. Another relative telephoned on the same day noting that there was in her opinion a lack of communication amongst the staff. The engagement with patients, relatives and carers made by the investigation staff in an effort to keep them informed and to seek their views was viewed positively by the Review Team.

8.42 Interviews with 17 MAH staff were subsequently undertaken and recorded. Six of the records are undated and most were unsigned. From the dates available it is

apparent that the majority of interviews (seven (64%)), took place between 8th and 15th May 2013: some seven months after receipt of the allegations. Two earlier interviews with MAH staff took place on 21st December 2012 with the remaining two taking place on 21st February and 8th April 2013.

8.43 The Review Team was concerned at the length of time taken to complete interviews with MAH staff. It was also perturbed at the timescale for the completion of clarification interviews with a patient who was an injured party who was deemed probably capable of giving evidence. This interview finally took place on 23rd January 2013. At that time the patient had no recollection of events of 7th November 2012 and did not want to engage in conversation about them. The Review Team was advised of a lengthy process involved in determining if patients have capacity and then acquiring necessary consent to be interviewed. Accepting that there are inevitable delays in completing such tasks, the Review Team concluded that a three-month delay with a learning disabled patient was not likely to result in good recall of past events.

8.44 An undated discussion between medical personnel, the PSNI, the Speech and Language Therapist, and the DO to determine capacity of Ennis patients identified 12 who could possibly give evidence. On 19th April 2013 an email from the DO to the Clinical Director sought his views on interviewing Ennis patients. The response was that one of the five patients had moved and that one patient's mental functioning had deteriorated. Given that Ennis patients have significant intellectual impairment, the Review Team considered the delay in interviewing them as likely to have further impaired their ability to contribute meaningfully to the safeguarding investigation.

8.45 Similarly, there was significant delay in police interviews with the two suspects. These interviews took place on 20th and 28th February 2013. An undated PSNI

report on interviews, which must postdate the 28th February, provided a summary of the evidence furnished by:

- the four private provider's staff;
- two relatives;
- the Forensic Medical Officer;
- the absence of evidence from the injured party; and
- the two suspects.

The report concludes with the PSNI's recommendation to the Public Prosecution Service to prosecute. The initial police interview with the complainant took place on 9th November 2012 with interviews of suspects not completed until 28th February.

8.46 There were eight case conferences or strategy discussions convened between 9th November 2012 and 28th October 2013. Appendix 7 sets out the information base for the Review Team's analysis of these meetings.

8.47 The second strategy discussion on 15th November 2012 did not commence with consideration of how aspects of the initial Protection Plan had operated. A revised Protection Plan was agreed. The staffing component of this was to be addressed by the DO with senior Trust managers. Professional practice at Ennis was the focus of much of discussion at this meeting. The Review Team considered that preliminary discussion with MAH managers and delegation of the staffing issue to them would have been a more inclusive working arrangement.

8.48 The third strategy discussion on 12th December 2012 addressed the issue of pending interviews. Considerable discussion took place around staffing on the Ward and the 24/7 monitoring arrangements. The Review Team considered that

greater focus was required on the handling of alleged incidents so that the safeguarding investigation could be brought to an early conclusion.

8.49 The fourth strategy meeting was held on 20th December 2012. Discussion at this meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run parallel. Additionally, in the view of the Review Team, it underlined the fact that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considered it essential that at the outset each allegation should have been assessed on the basis of the existing information. They should have been categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

8.50 In the fifth strategy meeting convened on 9th January 2013 initial focus was given to a consideration of progress against the actions established at the previous meeting. The Review Team considered such an approach commendable as it served to focus attention on any outstanding matters. The Co-Director of Learning and Disability Services, raised his concern about the list of allegations presented by the DO, some of which were specific while others were imprecise, negative comments. He stressed the need to obtain clear evidence and facts. The Review Team considered that had the initial allegation been disaggregated (see Para 8.29), the safeguarding investigation would have been able to focus its energies on abusive issues.

8.51 The sixth strategy meeting was held on 29th March 2013. This was almost two months later than initially scheduled. The focus of this meeting was the provision of an update from the PSNI and to plan further for the investigation. The first references to the potential for institutional abuse is recorded in these minutes. At the meeting it was agreed that all staff in the Ennis were to be interviewed by the two IOs. At this stage, five months after receipt of the allegations, neither patients

nor all of the staff working at Ennis had been interviewed by Trust staff. The Review Team considered this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

8.52 The seventh strategy meeting was held on 5th July 2013 during which copies of the draft final report were circulated. The Public Prosecution Service at this point still had to assign a public prosecutor to the case. One of the patient's interviews remained outstanding due to the absence of a Speech and Language therapist during July. The issue of initiating disciplinary proceedings was raised given the cost to the public purse. It was noted that the investigation had dealt with 'a broad range of issues which were not part of the original allegations but arose during interviews with private provider staff.' The DO noted that 'no evidence had been found to substantiate the allegations' but that 'the investigating team felt the [private provider staff] were credible.' Having read the minutes of the Case Conference of 28th October 2013, the Review Team concludes that there were sufficient concerns found to suggest a culture of bad practice. It is also evident that the private provider's staff identified good practice which the Case Conference considered 'would suggest that any poor practice was not totally widespread.'

8.53 The Review Team noted that:

- the report was not provided in a sufficiently timely manner to facilitate an informed discussion of it during this meeting;
- six months after the initially allegations were received patients had not been interviewed;
- the issue of staff disciplinary action and when it could be progressed had not been dealt with in a more timely fashion;
- the additional allegations made may have added considerably to the length of time for the investigation team to report without adding anything further to the body of available information;

- after such a lengthy review a more definitive conclusion about the culture of practice on Ennis ward had not been reached.

8.54 The final case conference meeting (for which minutes are available on case records) was held on 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation on Ennis ward. The DO noted the difficulty experienced by the investigation team in weighing the 'very different evidence provided by the two staff teams' [MAH and Private Provider staff]. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the private provider's staff's reports as evidence.

8.55 The Co-Director, Learning and Disability Services, noted at that Case Conference that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' The RQIA representative supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked to review minutes of previous meetings for any discussion of institutional abuse before the case conference would conclude on this issue. A further meeting was arranged for 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

8.56 The Review Team was of the view that there was significant delay in bringing the Ennis Report to a conclusion given that the draft report had been tabled for discussion at the strategy discussion convened on 5th July 2013. Action in relation to staff disciplinary proceedings was also delayed, and on the basis of this meeting was likely to remain so pending court hearings. In the Review Team's opinion, consideration of disciplinary action should, where possible, be pursued at the commencement of any investigation. Reasons for a decision on any deferment

should be provided in writing and be subject to monthly review. Such an approach would demonstrate greater regard and accountability for the public purse.

8.57 The Review Team was particularly concerned that at this late stage in the investigation process consideration was being afforded to the issue of whether or not the abuse was of an institutional nature. In the opinion of the Review Team this discussion should have occurred early in the investigation process to assist with informing the subsequent nature of the investigation. Such an approach would also have assisted the Trust to comply with the SAI procedures which it acknowledged it had breached (see Paras 6.19 and 8.31). In discussions with Trust specialists working with vulnerable adults the Review Team were advised by one individual that the allegations were unambiguously of an institutional nature while the other felt a decision centred on the way institutional abuse was conceived. The DO felt she was being pressurised by the Co-Director to state the investigation had not identified institutional abuse. In the DO's opinion she did not have enough evidence to reach a definitive conclusion.

8.58 From the case records examined the Review Team considered that:

- the Strategy Meeting extended its remit through its detailed consideration of the operation of Ennis ward rather than in establishing a broad framework to inform the safeguarding of patients. In the Review Team's opinion, concerns noted by the regulator (RQIA) in respect of staffing would have been better progressed through its usual regulatory functions rather than via the strategy discussion process;

- the DO appeared to have adopted an oversight function in respect of the operation of the Ennis ward by, for example, emailing the Service Manager at MAH on 5th March 2013 noting that from the nursing monitoring reports she could not identify whether or not staffing levels were appropriate. It is the

opinion of the Review Team that the action of the DO in this respect was not appropriate. It carried the potential to undermine the managerial system at MAH. The Review Team's view was that to report on the implementation of recommendations was the proper way to seek to monitor levels of compliance or non-compliance; and that

- the safeguarding investigation took from 8th November 2012 until 23rd October 2013. This is much longer timescale than one would have expected, especially given the nature of the complaints. Allowing for the significant amount of work carried by the DO, the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation. The time delay had significant implications for Ennis staff and the costs associated with precautionary suspensions.

8.59 The safeguarding investigation took some 11 months to complete. There is evidence of initial feedback on the investigation being furnished to relatives and carers. An extensive number of interviews took place with MAH nursing and clinical staff, staff employed by the private provider, patients deemed to have capacity, and the relatives/carers of Ennis patients. Many of these interviews were held some five and six months after the start of the investigation. The delay in interviewing patients was of particular concern to the Review Team as it reduced the likelihood of evidence being forthcoming. Given the general level of social functioning among patients, any delay reduced the likelihood of evidence being forthcoming. In the opinion of the Review Team the absence of dates and signatures from six of the interviews with MAH staff is a significant omission. There can be no certainty as to when these interviews took place. Five or six months into the investigation appear a likely timescale as the majority of MAH staff interviews were held in that period.

8.60 It is apparent from an examination of the records of those interviewed that no clear consistent picture emerged from any of the groups interviewed. The Review Team considered that the allegations made in November 2012 should have been disaggregated to allow for safeguarding issues to be the sole focus of the investigation. Other matters should have been dealt with under the Trust's complaints procedure or its disciplinary processes which are in place to deal with poor practice concerns.

8.61 The Review Team views the failure to identify the failings reported at Ennis as an SAI as a missed opportunity to identify wider problems within MAH. Subsequent events confirm that a number of wider structural and cultural issues arising in the Ennis safeguarding investigation were not confined to that ward.

8.62 The Review Team concluded that the safeguarding investigation involved multiple victims and multiple perpetrators, as such it could have been identified as institutional abuse. At the last recorded case conference which was convened on 28th October 2013, the multidisciplinary team failed to reach a definitive conclusion regarding its status. In discussions with the DO, the Review Team was advised that the status of the review was the subject of numerous discussions with her line manager. She clearly felt under pressure to conclude that it was not institutional abuse. In the absence of comment from the Co-Director, the Review Team can reach no final determination as to his motivation. The reason provided by the DO for not classifying the Ennis allegations as institutional abuse was the absence of a definition of institutional abuse in the 2006 and 2010 safeguarding policies extant at the time of the investigation. While there is no definition in either policy, both refer to abuse in institutions.[81] In the opinion of the Review Team the history of previous inquiries at MAH provided a context supportive of an early consideration of the potential for institutional abuse.

[81] Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance, par. 3.3, Page 11, 2006 and the Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements, par. 13, Page 7, NIO / DHSSPS, March 2010

e. Outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care

8.63 During the course of the Ennis investigation a requirement was established for 24-hour monitoring of staff working on the ward as a protective measure for patients. The monitoring staff were employed at Band 6A levels at a minimum. They were in place for a period of some 9 months. The cost to the Trust was estimated to be in the region of £500,000. The Review Team was informed by the Trust's Director of Nursing that these monies were available from the in-year MAH budget. Approval of the Trust Board for this level of expenditure was not required. A weekly support meeting was established to discuss any concerns arising from the monitoring arrangements. The monitoring reports were also provided to the Operations Manager who was leading the safeguarding investigation as DO. There is evidence in the case records of discussion between the Operation Manager and MAH Service Manager to agree on action required as a consequence of the monitoring reports.

8.64 The establishment of 24/7 monitoring role meant that information on wider patient care issues were identified. These included:

- patient privacy;
- lack of stimulus/ lack of visual stimuli;
- no attempts to engage in therapeutic activities;
- overcrowding in the bottom dayroom; and
- lack of quiet space for patients;

8.65 As a result of the allegations a number of remedial actions were taken to improve the care and the quality of the environment on Ennis Ward. The Review Team noted that this included:

- an additional Ward Sister who was redeployed to Ennis for an initial period of two months from 8th November 2012 with a Deputy Ward Sister appointed from 25th November 2012;
- a review of the Telford staffing formula for Ennis ward which resulted in a subsequent increase in staffing levels;
- assurance to provide a minimum of six staff on duty during day shifts with additional resources deployed where possible. Night duty, up until 11pm, would also comprise six staff reduced to two for overnight duty; and
- a monthly monitoring of staffing ratios to ensure an appropriate skill mix in the staff team.

8.66 Service Improvement Action Plans were created for Ennis. Key steps included:

- leadership walk-arounds and viewing the environment with fresh eyes;
- safeguarding materials to be shared with staff and where required staff supported with training to facilitate and sustain improvements in practice;
- to uplift staff knowledge on current policy relevant to the environment as well as information governance/patient property;
- commissioning training restating the strategic objective of resettlement;
- reviewing the ward's learning environment for student placements.

8.67 A multidisciplinary team was introduced to Ennis to improve patient care with the appointment of a psychologist and improved access to behavioural support services. Greater focus was also afforded to stimulating patients through increased levels of activities. The enhanced staffing numbers further improved the 1:1 contact between patients and staff. A review of each patient's care plan and a functional behavioural analysis was also undertaken.

8.68 Despite the plan to close Ennis Ward, environmental improvements were made to enhance the living and sleeping arrangements in the ward. This was not only at a cosmetic level but a capital bid was approved to facilitate structural improvements.

8.69 Safety and hygiene checks were also undertaken on the ward with Estates Department to assist with improving the dignity and privacy of patients.

8.70 Considerable improvements occurred as an appropriate response to the allegations made in November 2012 and the staffing and environmental factors which in the opinion of the Review Team contributed to the events then noted.

f. Governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations

8.71 To deliver on improvements the Trust developed a series of monitoring arrangements in respect of the operation of the Ennis ward. In the opinion of the Review Team the secondment of a Co-Director of Nursing (Education and Learning) to MAH with a responsibility to monitor practice and to analyse information was a key means of ensuring not only an oversight function, but also a dynamic analysis of information. The support role to the Service Manager was also critical given the additional demands and challenges resulting from the safeguarding investigation.

8.72 The Co-Director of Nursing undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files, and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;
- consideration of progress against draft improvement plans; and

- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

She provided written reports of her findings. On the case records examined by the Review Team a comprehensive report was provided of her second monitoring analysis in January 2013. In the opinion of the Review Team this role provided both support of MAH leadership and provided governance assurances to the Trust.

8.73 It is also evident that a previous consideration to fit CCTV in MAH, which was first raised in August 2012, was given added impetus as it was viewed as a means of addressing the factual discrepancies which emerged from the Ennis investigation. This matter is addressed further in the CCTV section from paragraphs 8.81 to 8.112.

8.74 No information was available in case records on how the safeguarding investigation was subject to governance controls. The DO's line manager attended a significant number of the strategy meetings/case discussions. From recorded comments it was apparent to the Review Team that there was no agreed approach about the nature of the investigation, what constituted evidence, and when disciplinary action should be initiated. The Review Team considered that while the DO must act independently, leadership support is required in discharging this challenging role.

8.75 There was no apparent reason for a number of the delays evident in the safeguarding investigation. From July to October 2013 the aim of the final two strategy discussions was to focus on the conclusions and recommendations of the Ennis report. A three-month period between reviews is within the policy requirements. The Review Team deemed that arrangements should have been put in place to ensure that no drift occurred in the investigative process. Delays in interviewing patients, and MAH and the private provider's staff, which the Review Team deemed unacceptable, should have been identified and remedied.

g. Observations and conclusion

8.76 The Review Team considers that the Ennis safeguarding investigation was hampered from the outset by the fact that the allegations were not disaggregated into complaints and abusive incidents. Such an approach would have led to a sharper focus on the safeguarding elements of the allegations and the potential for more timely reporting.

8.77 The extensive delay taken to complete relevant interviews compounded the time taken to produce the draft Ennis Report. From the dates available to the Review Team, interviews with MAH staff concluded on 15th May 2013. The draft report was then available for the strategy meeting convened on the 5th July 2013. At that time, one patient interview remained outstanding. In the opinion of the Review Team, all interviews should have taken place more proximate to the events which were the subject of the complaints in order to ensure that memories were fresh and that discussion over time had not coloured staff's perceptions of the issues being investigated.

8.78 The Review Team's opinion is that from the outset, the Ennis investigation should have considered whether the allegations were of an institutional abuse nature. The discussion at the last recorded case conference, nearly one year after receipt of the allegations, as to whether it was institutional abuse, remained unresolved at the end of that meeting. This lack of decision was unacceptable to the Review Team.

8.79 The failure to notify the HSC Board of the incident as an SAI, despite repeated requests from the HSC Board, was a missed opportunity to investigate the wider structural, staffing, and cultural issues within MAH. An SAI investigation had the potential to identify the nature of the issues which contributed to the allegations

made in November 2012 and to enable early remedial action to have been taken. It is conjecture to suggest that this might have prevented the events of 2017 captured on CCTV; but given that this was a potential outcome, the Review Team has not discounted this possibility.

8.80 The range of improvements in the environment, staffing, and care of patients during the Ennis investigation was considerable and did much to improve the ward as a living and working space. It is a matter of deep regret to the Review Team that the implementation of these changes came about only as a consequence of the harm caused to vulnerable patients. Our review of the records and discussion with staff confirm that the shortcomings in staffing, the ward environment, lack of access to a multidisciplinary team, and the conflicting needs of patients on the ward were known but not acted upon prior to the Ennis investigation.

Summary Comments and Findings

- **The Ennis investigation took an extensive period of time to complete which diluted its impact. The completed report was not brought to the attention of the Executive Team or the Trust Board.**
- **There was little evidence of multidisciplinary working in Ennis or patient activities. The absence of activities resulted in boredom, a lack of stimulation, and served to contribute to the management challenges of caring for patients with complex and at times conflicting needs.**
- **Nurse to patient ratio were low in Ennis. A staff ratio of 20:80 of nurses to healthcare assistants pertained at times. This compromised the ability of staff to provide safe and effective care for patients.**
- **Staffing difficulties were added to the MAH risk register as a serious Risk (red). This risk was not escalated further.**

- The culture clash between staff who viewed the ward as a home and those who viewed it as a hospital resulted in tension between senior managers and ward managers and staff delivering care.
- The allegation should have been dealt with as an SAI. This would have ensured wider scrutiny.
- The Trust advised the HSC Board repeatedly that the safeguarding investigation was unable to substantiate the allegations, even though the Public Prosecution Service determined that in two cases the threshold for prosecution was met.
- The Review Team considered that the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards.
- One year after the report was completed the DO advised that she was proposing to update families. There is no evidence of feedback or the case having been closed.
- The DO's operational oversight into the day-to-day functioning of the Ennis ward served to weaken the focus on completing the investigation within an acceptable time frame.
- The tension between the DO and her line manager put the DO under pressure and led to imprecise conclusions in respect of the nature of the abuse.
- Positive changes were made to staffing and the environment in Ennis as a result of the Ennis investigation.
- The Review Team believed that not to have held an SAI investigation in respect of these allegations either in parallel or at the conclusion of the investigation constituted a missed opportunity to improve safeguarding

arrangements for vulnerable patients.

- **There is no evidence of learning emerging from the safeguarding investigation as feedback was provided neither to staff, the Executive Team nor the Trust Board.**

ii. CCTV

8.81 The following section is divided into two sub-sections:

(i) a history of CCTV installation at MAH and the Assault on a Patient on 12th August;
(ii) the involvement of the PSNI; and
(iii) subsequent Trust handling of CCTV.

(i) A History of Implementation and the Assault on a Patient on 12th August

8.82 One of the first references that the Review Team could find regarding the installation of Closed-Circuit Television (CCTV) in the wards at MAH was in the minutes of the MAH Core Group meeting of August 2012. At that meeting the Senior Social Worker spoke of the 'amount of incidents involving patient on patient and patient on staff.' He suggested the installation of CCTV in communal day spaces, corridors, and quiet rooms. The Senior Manager Service Improvement and Governance manager agreed to look at existing policies around CCTV, check with the Directorate of Legal Service, and whether other Mental Health services used CCTV.

8.83 In 2013 a business case application was prepared by the MAH Clinical and Therapeutic Manager for the use of CCTV within the 'Core' hospital. The business case proposed that CCTV would be installed in communal areas used by patients and staff in Sixmile and Cranfield male, female, and Intensive Care wards. The overall purpose was: 'CCTV surveillance is required on the basis that they will make the hospital environment safe and secure for patients, staff and visitors. In 2012/13 there were 667 reported assaults to the PSNI from Muckamore Abbey Hospital.' Belfast Trust's Capital Evaluation Team approved a funding bid for the installation of internal CCTV in these wards at an estimated cost of £80k on 13th January 2014. This allocation was approved in principle by the Trust's Executive Team on the 22nd January 2014. In 2014 a detailed business case was prepared, led by the Business and Service Improvement Manager for Learning Disability Services.

8.84 Funding became available In the later part of the 2014/15 financial year. After the appropriate procurement processes concluded, contracts were awarded to architects, design consultants, and contractors to proceed with the installation of CCTV. Work on CCTV installation commenced in February 2015 in Cranfield, comprising Cranfield 1 and 2 and the Psychiatric Intensive Care Unit (PICU), and in the Sixmile wards. The Business and Service Improvement manager and the Clinical and Therapeutic manager from MAH were in contact with the contractors throughout the installation and commissioning processes.

8.85 On 21st April 2015 the contractors informed the Business and Service Improvement Manager that the CCTV had been installed in Cranfield and Sixmile wards and was now recording; a demonstration of the equipment was offered. The contractor explained the need for a period of recording prior to the demonstration to allow the full system's functions to be illustrated at the demonstration. At this time there was also discussion about the need to add additional cameras to cover

the gardens that were attached to each building. These additional cameras were added to the schedule of work.

8.86 The Service and Improvement Manager responded immediately suggesting that he be accompanied at the demonstration by the Operations/Nurse Manager and the Adult Safeguarding Officer. The contractor confirmed that the demonstration would take place on Wednesday 13th May 2015.

8.87 From the information provided by the contractor, the Review Team can summarise that the CCTV installation comprised the installation of large fixed cameras mounted in the public areas of the wards. The cameras were motion activated which meant that they were not in continuous record mode, which made it more practical to view playback. Cranfield and Sixmile wards each had their own CCTV recording systems which were in locked communication rooms. Each of the recorders had at least two screens to facilitate viewing. The recording arrangements provided for 120 days storage of the video footage. It is not clear from the specification whether the system was designed to overwrite recorded video after 120 days or whether 120 days was the minimum time for the storage of video. In the opinion of the Review Team it is highly likely that the system stored video beyond 120 days. This view is confirmed by a Trust briefing paper dated September 2018 which stated that: 'all available CCTV footage was preserved from 1st March 2017 until 30th September 2017'; a period of 184 days.

8.88 Records show that the CCTV project was commissioned and handed over to the Trust on 9th July 2015. It is not clear from the records examined who represented the Trust at the handover. Reference is made however to the need for the Business and Service Improvement Manager to be in attendance.

8.89 An examination of MAH Senior Nurse Meeting minutes shows that the introduction of CCTV to the wards had been the subject of discussion and consultation for

some time. The Senior Nurse Meeting was chaired by the Service Manager for the hospital. It was attended by the Ward Sisters/Charge Nurses for each ward and other senior nurses on the MAH site. In April 2014 there was reference in these minutes to a webcam presentation and the benefits it could bring. No other details are given about the proposals. In May 2014 the Service Manager stated that webcams would be installed on the wards. The Review Team concluded that the reference to the webcams was a reference to CCTV. In June 2104 the Service Manager told those attending that webcams had been ordered for all wards.

8.90 In May 2015 the MAH Safeguarding Officer reported that there had been a demonstration of CCTV and it had been shut down until policies were agreed to support its use. In June 2015 he stated that CCTV was still not operational. He added that they would be helpful for adult safeguarding. The Review Team asked the company responsible for the installation of the CCTV cameras when cameras started recording. The company responded that: 'recording started at handover.' Handover was at 9th July 2015.

8.91 In December 2015 the Trust entered into a contract with the CCTV contractor to provide routine servicing, callout, and repair of security systems in their community facilities which included MAH. The contractor confirmed that this contract included CCTV in MAH. The Trust was paying for this maintenance contract from December 2015.

8.92 From August 2015 until August 2017 mention was made at the Senior Nurse meetings about the drafting of CCTV policies and the consultation process for its operation. In August 2017 attendees of the meeting were told that the CCTV policy had been approved and would be rolled out in Cranfield and Sixmile wards on the 11th September 2017. The meeting heard that communications sessions were planned for staff and patients and signage would be going up. There was a delay of 25 months between the commissioning of the CCTV in May 2015 and the

Trust's decision to post signs about the cameras becoming operational in September 2017.

8.93 In June 2017 the Trust approved a policy (ref SG 09/17) for the implementation of CCTV within MAH. Its purpose was to assist with investigations related to adult safeguarding issues. The front page of that document shows that consultation and finalisation of the policy began in September 2015 and was not completed until June 2017. The pathway towards approval was as follows:

- 24 September 2015 - Initial Draft of the policy
- May 2016 - Amended after first round of consultation
- 11 August 2016 - Amended after 2nd round of consultations and approved by Clinical and Social Care Governance Committee
- 1 March 2017 - Approved by the Standards and Guidelines (Committee)
- June 2017 - Approved by the Trust Policy Committee
- 28 June 2017 - Approved by the Trust Executive Team.

The review team could find no evidence that the Executive Team queried why it had taken so long for the draft policy to reach it for its final approval.

8.94 The Review Team heard a number of different versions of what happened following approval of the policy. It has been difficult to be specific about a timeline from 28 June 2017 to the meeting between MAH managers and Mr. B, a complainant, in August 2017. Several managers from the Trust who are now retired and who had central roles to play in the implementation of CCTV did not meet with the review team.

8.95 It was agreed that the CCTV would go live from September 2017, probably 11th September. The Service Manager told the Review Team that work had to be completed on a Communications Strategy with staff in August before the system

went live. The complaint by Mr. B in August 2017 resulted in the discovery that CCTV had been recording for some time previously.

8.96 Mr. B., the father of a young man who was a patient in PICU ward, received a call from the Belfast Trust to inform him that his son had been physically assaulted by a member of staff. Mr. B. advised that he was notified on 21st August 2017, although Trust correspondence suggested this could have been 22nd August. Mr. B was told that the assault occurred on 12th August. Mr. B. told the Review Group that he immediately got into his car and drove to MAH to ascertain what had happened. He told the Review Team that he could not understand why it had taken 9 days to inform him of the incident; normally he would have been contacted on the day of any incident concerning his son.

8.97 Mr. B raised the issue of the assault with the RQIA on his way to a meeting at MAH on 25th August 2017. At the MAH meeting Mr. B met with the Operations Manager and the Safeguarding Officer who explained to him what had happened to his son. Mr. B was accompanied to this meeting, at his request, by a patient advocate from Bryson House. Mr. B did not accept the explanation provided. He inquired whether there was CCTV coverage of the incident. As a regular visitor to MAH since his son's admission in April 2017, Mr. B had noticed the presence of CCTV cameras on the ward. After the meeting he sent a formal complaint to the Belfast Trust. The complaint that Mr. B subsequently raised and how it was dealt with is an important aspect of this review and is dealt with in this report (see Paras 8.113 to 8.126).

8.98 The Manager informed Mr. B that the cameras were not recording. Mr. B challenged this response. He told the Review Team that he had observed CCTV notices on the walls of the hospital and had assumed that there must be CCTV coverage. He also informed the Review Team that prior to his son's admission to

MAH he had been given assurance in relation to his son's safety at MAH by the his son's social worker who told him that that the CCTV in MAH was operational.

8.99 The Belfast Trust sent an Early Alert about the assault on Mr. B's son on 8th September 2017 to the DoH and HSC Board. There was no reference to CCTV in the Early Alert. An update on the Early Alert was provided on 22nd September 2017 which stated that: 'CCTV footage has now been viewed by Senior Trust Personnel. There are grave concerns regarding the contents of the CCTV footage.' This appears to be the first acknowledgement from Trust HQ that there was CCTV footage at MAH.

8.100 Almost all those who were interviewed from the Belfast Trust were asked about the CCTV. Why was it introduced? When did recording start? No one was able to tell the Review Team when recording started. The assumption by local MAH managers was that it would go live in September 2017 following the period of consultation with staff. At Director level the Review Team could not find any knowledge of how or when CCTV would be the introduced.

8.101 The Review sought to establish how managers at MAH became aware of the existence of historical CCTV recordings and when these were first viewed in relation to the events of 12th August 2017. The person with most knowledge about the CCTV, the Business and Service Improvement Manager who is now retired did not communicate with the Trust or the Review Team. It is difficult, therefore, to establish a precise timeline.

8.102 When the Service Manager for MAH was interviewed she recalled that she was told by the Business and Service Improvement Manager two days after the meeting with Mr. B at MAH that there might be CCTV footage of the incident that occurred on 12th August. The Review Team concluded that the Business and Service Improvement Manager's comment was prompted by Mr. B's challenge

regarding whether CCTV was recording. It is evident that some senior managers at MAH must have viewed some of the historic CCTV footage as Trust records show that legal advice from the Directorate of Legal Services (DLS) was sought on the 4th September to clarify if they could 'view the footage as part of an investigation'. The DLS replied on 19th September 2019 that the recording could be viewed. The Review Team has no doubt that some senior managers at MAH viewed some of the historic recording in late August/early September 2017. The information about its the contents was not however, provided to a Trust Director until 20th September.

8.103 The Service Manager told the Review Team that she viewed the recordings on 20th September and immediately phoned the Trust's Director of Nursing to inform her of the content. The Director of Nursing advised her to phone the Chief Nursing Officer at the DoH to inform her of these matters. The CNO was advised the next day. The Trust subsequently submitted an SAI notification to the DoH and the HSCB on 22th September 2017.

8.104 The Service Manager told the Review Team that she wanted to raise an SAI as soon as she heard about the assault on Mr. B's son. She completed an SAI form on the 1st September 2017 which was returned to her by the Learning and Disability Directorate's Governance department. She stated that she was dissuaded from pursuing an SAI by the Co-Director Learning Disability Services as it did not meet the criteria for an SAI.

8.105 The complaint that Mr. B subsequently raised and how it was dealt with was an important aspect of this review; it is dealt with further at par. 8.113 – 8.126 below.

(ii) The Involvement of the PSNI

8.106 The PSNI were alerted to the allegations of assault on Mr. B's son on 22nd August 2017 under the Trust's Adult Safeguarding Policy and the Joint Protocol. The PSNI became aware of the existence of historic CCTV recordings by mid-September 2017, when notified of this by the Service Manager at MAH. Initially the police worked with the Trust and the RQIA under the Joint Protocol procedures. The police was not informed of the volume of CCTV footage that had been recorded until significantly later in the viewing process. The Review Team was told by the PSNI that due to frustration with the manner in which the Trust was handling the CCTV in February 2019 they seized the recordings. It eventually emerged that there was more than 300,000 hours of recording from CCTV in MAH.

8.107 The PSNI set up a large team to scrutinise the recordings, the largest team ever assembled for such work in Northern Ireland. The CCTV recordings viewed by the PSNI dated back to March 2017. There is no explanation as to why there was six months of CCTV footage when the specification for the retention of CCTV stated that footage would be retained for 120 days before being overwritten (see Para 8.87).

8.108 In 2019 the PSNI expressed concern about the presence in the investigation of the former Business Service Improvement Manager for MAH who had retired but had been brought back by the Trust on a temporary basis to look after CCTV cameras and security on the site. The Trust terminated this arrangement. The Review Team emphasises that there is no suggestion of impropriety in respect of this individual. The Review Team tried to speak to this retiree through the Belfast HSC Trust. He did not acknowledge any of the communication sent to him.

8.109 When asked about the level of co-operation they had received from staff in the Belfast HSC Trust, the police said it was mixed. The police seized the CCTV

recordings. Copies were however returned to the Trust to enable it to recommence viewing of the footage.

8.110 At the time of writing the PSNI had not yet completed viewing all of the historic recordings. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions. Sixty-two staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV.

(iii) Subsequent Trust handling of the historic CCTV recording

8.111 In a written report to the Trust Board in January 2018 the Director of Adult and Social Care reported that work was underway to install CCTV in the remaining wards at MAH and the swimming pool on the site. She went on to state that the team that was set up to view the historical CCTV had viewed 25% of the footage. This was inaccurate. It is clear that the Trust had still not grasped the enormity of the CCTV recordings that still had to be viewed.

8.112 By September 2018 a team of ten external viewers working five days a week were employed by the Trust to carry out retrospective viewing of CCTV. The Director of Adult and Social Care told the Trust Board on 6th September 2018 that the viewing of PICU footage would be completed by early September and that the remaining three wards (Cranfield I and 2 and Sixmile) would be completed by the end of September. The same Director reported to the Board in February 2019 that viewing was still not complete with an estimated 20% yet to be watched. Senior staff in the Belfast Trust consistently underestimated the task of viewing the retrospective recordings. This partially accounted for the PSNI's frustration about the Trust's approach which resulted in recordings being seized and taken off site.

Summary Comments and Findings

- **Evidence points to CCTV recording since July 2015.**
- **The Trust was paying a maintenance contract for a system that they had installed but did not make use of for over two years.**
- **It took 22 months, an inexplicably long time, to produce a policy to implement CCTV in MAH. Most of the delay was at local level where the Business and Service Improvement Manager was the lead.**
- **Had CCTV been operationalised earlier, harm to patients may have been prevented.**
- **It is the Review Team's view that had Mr. B not queried CCTV recording and persisted with his enquiries it is likely that the scale of historical CCTV would not have been discovered.**
- **There was an unacceptable delay in bringing matters to the attention of the HSC Board and the DOH despite the situation being known to senior managers on the MAH site. It was not escalated off the MAH site for two or three weeks after footage came to light.**
- **The Trust Board consistently failed in 2017 and 2018 to identify the scale of CCTV footage as the information provided to it was incomplete and at times inaccurate.**
- **The Review Team is critical of the reaction of the Co-Director of Learning and Disability Services in resisting the suggestion to raise an SAI. It formed the view that this was an attempt to contain the matter**

within the MAH management team. This manager declined to meet with the Review Team. In the absence of an account from this staff member the Review Team is content to accept the account of the Service Manager.

iii. Mr. B's Complaint – August 2017

8.113 On 21st August Mr. B was advised that on 12th August 2017 his son, AB, had been the victim of an assault by a member of staff. Mr. B was concerned that it had taken nine days to advise him of the assault on his son, particularly as he was used to having early alerts regarding his son's behaviour since his admission to PICU in April 2017. Mr. B was understandably concerned about the delay and not unnaturally was fearful that the delay was to enable any bruising on his son to fade.

8.114 The Review Team examined a range of documentation and interviewed senior staff at MAH and Trust Board levels in an attempt to ascertain the events around the assault on Mr. B's son and the reason for the delay in bringing matters to the attention of parents, safeguarding staff, and the Co-Director of Learning and Disability services.

8.115 A timeline in respect of Mr. B's complaint was developed by the Review Team (see Appendix 8). The Review Team identified no duplicitous or surreptitious reason for the delay in notifying Mr. B about the assault on his son, AB. The incident of 12th August 2017 was immediately reported by the staff nurse who witnessed it to the Nurse in Charge. Thereafter, there was a failure to comply with the Trust's Safeguarding policy and procedures.

8.116 It was not acceptable for the Nurse in Charge to have emailed the Deputy Charge Nurse (DCN) requesting a meeting to discuss a concern. This caused delay in reporting an assault on a vulnerable patient and prevented the establishment of a protection plan for AB and others on the ward.

8.117 The delay was further compounded as the requested meeting with the DCN did not take place until 17th August. The DCN considered the information provided about the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN therefore emailed him, requesting more details about the incident. This caused further delay in invoking the Trust's adult safeguarding procedures. The incident was not escalated at that time to senior managers within MAH nor was advice sought from MAH social work staff who carried safeguarding responsibilities within the hospital.

8.118 On 20th August 2017 the DCN received a further allegation in respect of the healthcare support worker involved in the incident with AB on 12th August. This allegation was of verbal abuse of a patient. The DCN then emailed the Charge Nurse seeking advice. On the Charge Nurse's return from leave, immediate and appropriate actions were taken in respect of both allegations made in respect of the healthcare support worker (see Appendix 8 for details).

8.119 The Review Team understands Mr. B's reaction to such information being provided to him nine days after the incident. The delay has done much to undermine Mr. B's confidence in the Trust. The handling of his requests for information and details about the CCTV in PICU and his complaint to the Trust has further diminished his lack of confidence in the Trust's managers and processes.

8.120 The handling of Mr. B's subsequent requests for information about his son's care and details about the CCTV in PICU also further eroded his confidence in the

Trust's management. Mr. B resorted to his Member of Parliament and the Information Commissioner in an effort to resolve matters to his satisfaction. The Review Team considered that more responsiveness to Mr. B's requests, with due regard given to the data protection rights of others who may have appeared on the recordings, would have been appropriate.

8.121 Mr. B met with MAH's Operations Manager and a Safeguarding Officer on 25th August 2017, as arranged by him on 21st August 2017 following notification of the assault on his son. To ensure he had support, Mr. B arranged for an advocate to accompany him. At that meeting Mr. B asked about the potential for CCTV footage in respect of the assault in respect of his son. He was advised that the CCTV was not yet operational and would be going live on the 11th September 2017. Mr. B, whose work involves the use of CCTV cameras in an institutional setting, did not accept the information provided. He stated that since his son was admitted to PICU he had seen signage advising that the ward was covered by CCTV. Mr. B subsequently attempted to acquire details about when the CCTV was operational.

8.122 The Review Team appreciated that the absence of information must have caused Mr. B considerable frustration. The Review Team, as already stated (see Paras 8.81 to 8.112), experienced considerable difficulties tracking down the information that Mr. B sought about the installation and operation of CCTV at PICU. The Review Team did not have the benefit of information from the Business and Service Improvement Manager at MAH, now retired, who it considered the individual most likely to have intimate detail of the CCTV system from the initial concept during 2012, through to the approval of the business case, and the system eventually being installed in July 2015. The Review Team considered it unacceptable for information about the operation of the CCTV system not to have been provided to Mr. B. The Review Team concluded that the CCTV was operating from July 2015.

8.123 Immediately following the meeting of 25th August, Mr. B emailed a complaint to the Trust in respect of his son's care. As he received no acknowledgement of his email, he contacted the HSC Board on the 29th August enquiring about when he could expect a response. It transpired that the original email had been sent to an 'incorrect' email address within the Trust. Once the Trust located the email on the 29th August it took immediate action through its Complaints Department with MAH's Governance Department.

8.124 From the exchange of emails between the Complaints and the Governance Departments, the Review Team identified two distinct approaches to how Mr. B's complaint would be handled. The Governance Department's view was that as the matter was of a safeguarding nature, it was not a complaint. The Complaints Department correctly interpreted the safeguarding and complaints policies by recognising that the safeguarding investigation would conclude at which stage, 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009).'

8.125 The Complaints Department's letter to Mr. B dated 30th August 2017 confirmed to him that his complaint could be addressed at the conclusion of the safeguarding investigation. The independent external Stage 3 SAI investigation commenced in January 2018 and reported in November 2018 in the *A Way to Go* report. There is no information in the documentation examined by the Review Team that Mr. B received individualised updates on the progress of the independent review. There was no information showing that Mr. B was contacted at the conclusion of the safeguarding investigation to ascertain if there were outstanding matters from his complaint which he wished to pursue further. The Review Team considered that best practice would have dictated that Mr. B be afforded an opportunity to pursue his complaint further from November 2018.

8.126 As matters currently stand, there is no resolution of Mr. B's complaint. The Review Team considered that the omission of the Complaints Department in this regard was unhelpful and did not conform with the assurance provided to Mr. B in its letter to him dated 30th August 2017.

Summary Comments and Findings

- **There was no deception associated with the delay in notifying Mr. B of the assault on his son, AB.**
- **There were breaches in compliance with Trust's reporting arrangements under the adult safeguarding procedures.**
- **Immediately the matter came to the attention of the Charge Nurse timely and appropriate responses were instigated informed by the Trust's adult safeguarding procedures.**
- **Mr. B's requests for information were not responded to in a timely or inclusive manner guided by the requirements either of Data Protection arrangements or the police investigations.**
- **Mr. B asked relevant questions about CCTV. At that time the Business and Service Improvement Manager was still employed at MAH. This retiree did not respond to requests to meet with the Review Team and it has no information about his recollections.**
- **Once Mr. B's emailed complaint was located within the Trust he received a timely response. The commitment to address any outstanding issues at the conclusion of the safeguarding investigation**

has not yet been honoured. The complaint remains open until closure is brought to the process.

- The persistence of Mr. B in respect of the CCTV was significant. It is noteworthy that at the end of August, MAH wrote to the Department of Legal Services seeking legal advice on the use of CCTV footage. The Review Team was unable to ascertain whether at that time some MAH staff had identified that footage relating to the assault on AB was available (see Appendix 8).

- The involvement of Mr. B with a range of agencies including his MP may not have been required had the Trust shown more willingness to engage with him, and to share relevant information appropriately.

- The Trust Board was not provided with information about the existence of CCTV footage until 20th September 2017. The failure to escalate information to the Trust Board earlier was unacceptable professionally and managerially.

9. Best Practice

9.1 The Review Team had planned to visit a number of centres of excellence to inform and develop recommendations. The lockdown caused by the Covid-19 pandemic necessitated a change of plans in this respect. The Review Team, therefore, has conducted a literature review which it considers pertinent to best practice developments.

9.2 Joe Powell, the CEO of All Wales People First which refers to itself as, the united self advocacy group for advocacy groups and people with learning disabilities in Wales, stated in the Foreword to the *Improving Care Improving, Lives* report, 'that we still deem it acceptable to house some people with learning disabilities within the hospital system, when it is no longer appropriate. If this situation is not remedied, we cannot truly claim that we have eradicated the unjust and deficit-centred culture of the long-stay institutions of the past.'[82] The Review Team was particularly struck by Powell's comments relating to 'the unjust and deficit-centred culture' as it underscored for Team members the need for a human rights based, patient-centred approach to planning with and for learning disabled patients. The Review Team regrets that due to the lockdown situation it was not in a position to meet more patients and their relatives and carers to assist in completing this review. We apologise that greater engagement was not possible. The Review Team will however, in its review of the literature, pay particular attention to the voice of service users and their families and carers.

9.3 As the history of MAH shows (Section 5), considerable change has occurred since it first opened its doors in 1949. A large institution caring for adults and children with at one time a maximum of some 1,400 inpatients, now cares for fewer than 60 patients. The resettlement agenda has placed considerable pressure on relatives,

[82] Improving Care, Improving Lives February 2020 https://gov.wales/sites/default/files/publications/2020-03/national-care-review-of-learning-disabilities-hospital-inpatient-provision.pdf

some of whom were anxious about their loved one's leaving the 'home' they had lived in for decades. Some staff also had anxieties as to their own future employment as the number of wards continued to reduce at the hospital. The Review Team heard evidence from one parent about the enhanced quality of care afforded to his son since he was provided with a tailored community care package.

9.4 The Review Team in the following discussion articulates principles which it believes will better meet the assessment and treatment of people with learning disabilities as well as informing the required community infrastructure and supports. The *Improving Care, Improving Lives* report made 70 recommendations targeted at: providers (35 recommendations); commissioners (33 recommendations) and the Welsh Government (2 recommendations). This was a more extensive review of learning disability services than the current review. The key learning from it which the Review Team considered relevant to MAH are summarised below:

- 'patients, not subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards, have the capacity to consent to being an inpatient. Detained patients should be aware of their rights';

- 'hospital support plans are reviewed regularly, within a maximum time period of three months. All care plans and hospital support plans are developed with specific objectives, measurable outcomes and clear timescales';

- 'a safe, effective, and therapeutic environment of care, [is in place] in order to reduce frustration and boredom which could lead to behaviours that challenge.. [S]taff are trained to recognise escalating behaviours and to deliver positive and preventative interventions. ... [A]ll patients have a plan in place identifying the outcomes to be achieved in order to transition to the next step on their care journey';

- 'any restrictive intervention involves the minimum degree of force, for the briefest amount of time, and with due consideration of the self-respect, dignity, privacy, cultural values, and individual needs of the patient. A restraint reduction plan [should be] in place for each patient';

- 'patients, families, and carers have a voice in service design.... [M]easures of patient satisfaction are obtained and used as indicators of responsive and quality services';

- 'Commissioners ensure a sufficient level of staffing to provide safe and progressive care';

- 'Commissioners should consider investment in early intervention and admission prevention community services.'

9.5 In 2015 NICE published guidelines titled 'Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges'[83] The guidelines, which have been endorsed in Northern Ireland by the Department of Health, 'cover intervention and support for ... adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and interventions for family members and carers.' The general principles which underpin the Nice Guideline include:

1. 'Working in partnership with ... adults who have a learning disability and behaviour that challenges, and their family members of carers, and:

[83] https://www.nice.org.uk/guidance/ng11

- involve them in decisions about their care;
- support self-management and encourage the person to be independent;
- build and maintain a continuing, trusting, and non-judgmental relationship;
- provide information:

    - about the nature of the person's needs, and the range of interventions ... and services available to them;
    - in a format and language appropriate to the person's cognitive and developmental level...;

- develop a shared understanding about the function of the behaviour;
- help family members and carers to provide the level of support they feel able to.

2. When providing support and interventions for people with a learning disability and behaviour that challenges, and their family members of carers:

- take into account the severity of the person's learning disability, their developmental stage, and any communication difficulties or physical or mental health problems;
- aim to provide support and interventions:

    - in the least restrictive setting, such as the person's home, or as close to their home as possible; and
    - in other places where the person regularly spends time....;

- aim to prevent, reduce, or stop the development of future episodes of behaviour that challenges;
- aim to improve quality of life;
- offer support and interventions respectfully;
- ensure that the focus is on improving the person's support and increasing their skills rather than changing the person;
- ensure that they know who to contact if they are concerned about care or interventions…;
- offer independent advocacy to the person and to their family members or carers.

3. Everyone involved in commissioning or delivering support and interventions for people with a learning disability and behaviour challenges … should understand:

    - the nature and development of learning disabilities;
    - personal and environmental factors related to the development and maintenance of behaviour challenges;
    - that behavioural challenges often indicate an unmet need;
    - the effect of learning disabilities and behaviour that challenges on the person's personal, social, educational, and occupational functioning;
    - the effect of the social and physical environment on learning disabilities and behaviour that challenges (and vice versa), including how staff and carer responses to the behaviour may maintain it.

4. Health and social care provider organisations should ensure that teams carrying out assessments and delivering interventions recommended in this guideline have the training and supervision needed to ensure that they have the necessary skills and competencies.

5. If initial assessment ... and management have not been effective, or the person has more complex needs, health and social care provider organisations should ensure that teams ... have prompt and coordinated access to specialist assessment, support, and intervention services....

6. Health and social care provider organisations should ensure that all staff working with people with a learning disability and behaviour that challenges are trained to deliver proactive strategies to reduce the risk of behaviour that challenges.

7. Health and social care provider organisations should ensure that all staff get personal and emotional support ....

8. Health and social care provider organisations should ensure that all interventions for behaviour that challenges are delivered by competent staff....

9. A designated leadership team of healthcare professionals, educational staff, social care practitioners, managers, and health and local authority commissioners should develop care pathways for people with a learning disability and behaviour that challenges for the effective delivery of care and the transition between and within services. ...

10. The designated leadership team should be responsible for developing, managing, and evaluating care pathways, ...

11. The designated leadership team should work together to design care pathways that promote a range of evidence-based interventions and support people in their choice of interventions.

12. The designated leadership team should work together to design care pathways that respond promptly and effectively to the changing needs of the people they serve, ...

13. The designated leadership team should work together to design care pathways that provide an integrated programme of care across all care services ...

14. The designated leadership team should work together to ensure effective communication about the functioning of care pathways. There should be protocols for sharing information ...

15. GPs should offer an annual physical health check to ... adults with a learning disability in all settings, using a standardised template... This should be carried out together with a family member, carer, or healthcare professional or social care practitioner who knows the person ...

16. Involve family members or carers in developing the support and intervention plan for ... adults with a learning disability and behaviour challenges. Give them information about support and interventions in a format and language that is easy to understand, including NICE's 'Information for the public.' ...

17. When assessing behaviour that challenges shown by ... adults with a learning disability, follow a phased approach, aiming to gain a functional understanding of why the behaviour occurs. ...

18. Explain to the person and their family members or carers how they will be told about the outcome of any assessment of behaviour that challenges. Ensure that feedback is personalised and involves a family member, carer, or advocate to support the person and help them to understand the feedback if needed.

19. If the behaviour that challenges is severe or complex, or does not respond to the behaviour support plan, review the plan and carry out further assessment that is multidisciplinary and draws on skills from specialist services...

20. Carry out a functional assessment of the behaviour that challenges to help inform decisions about interventions ...

21. Vary the complexity and intensity of the functional assessment according to the complexity and intensity of behaviour that challenges, following a phased approach, ...

22. Develop a written behaviour support plan for ... adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour.

23. Consider personalised interventions for ... adults that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time.

24. Ensure that reactive strategies, whether planned or unplanned, are delivered on an ethically sound basis. Use a graded approach that considers the least restrictive alternatives first. Encourage the person and their family members or

carers to be involved in planning and reviewing reactive strategies whenever possible.

25. Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long-term behaviour support plan, to reduce the use of and the need for restrictive interventions.'

9.6 The NICE guideline address the range of issues found by the Review Team in relation to: staffing levels and skills; the availability of safe, effective and compassionate care; the absence of behavioural support services resulting in over-use of restraint, seclusion and physical interventions with patients; the effectiveness of care planning and transition arrangements for patients; and the poorly developed multidisciplinary approach to patient care.

9.7 The use of seclusion and physical interventions with patients has been commented on throughout this report. Best practice in working with learning disabled patients who presented with aggressive and/or challenging behaviours did not underpin strategies relating to their management at MAH. Future practice in these areas was considered by the Review Team in terms of:

- RCN Advice issues in 2017, which is scheduled to be reviewed in 2020, which adopted a rights based approach to consideration and review of restrictive practices.[84] It states that, 'restrictive practices are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practices is therapeutic, ethical, and lawful.' It also acknowledges the benefit of early interventions

[84] [84] Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions, RCN, 2017 https://www.rcn.org.uk/professional-development/publications/pub-006075

and an understanding of the cause of such behaviours. The rights-based approach is seen as a means of placing the person at the centre of care;

- HM Government guidance of 2019 on reducing the need for restraint and restrictive practices[85] is directed at children and young people. The recognition in it of the traumatising effect of restrictive practices on children, young people, families, and carers, and the potential for long-term consequences for health and wellbeing are messages which are also relevant to adults. The core values, and principles upon which the guidance is based are also pertinent to adults:

  - 'uphold children and young people's rights;

  - treat children and young people with learning disabilities ... as full and valued members of the community whose views and preferences matter;

  - respect and invest in family carers as partners in the development and provision of support; and

  - recognise that all professionals and services have a responsibility to work together to coordinate support ...'

  In regard to restraint, the values stated:

  - 'every child or young person deserves to be understood and supported as an individual;

[85] Reducing the Need for Restraint and Restrictive Interventions HM Government, 27 June 2019 https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention

- the best interests of children and young people and their safety and welfare should underpin any use of restraint;

- the risk of harm to children, young people and staff should be minimised. The needs and circumstances of individual children and young people... should be considered and balanced with the needs and circumstances of others....; and;

- a decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned,' ...[86]

- The Mental Welfare Commission for Scotland in 2019 issued a good practice guide to inform the use of seclusion. The purpose of the guide 'is to provide clear guidelines for the consideration and use of seclusion and to ensure that, where this takes place, the safety, rights and welfare of the individual are safeguarded.'[87]

9.8 NICE has also developed a number of guidelines and quality standards specific to individuals with challenging behaviours and learning interventions. In developing inpatient and community care services for such individuals, the Review Team considered that the following literature should be used to inform a service model in Northern Ireland:

- Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges;[88]

- Learning disabilities: challenging behaviour;[89]

[86] Ibid, Pages 17 - 19
[87] Use of Seclusion: Good Practice Guide, Mental Welfare Commission for Scotland, October 2019, Page 5 https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf
[88] Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guideline, 29 May 2015 nice.org.uk/guidance/ng11

- Mental health problems in people with learning disabilities: prevention, assessment and management;[90]

- Learning disabilities: identifying and managing mental health problems;[91]

- Learning disabilities and behaviour that challenges: service design and delivery.[92]

9.9 A selected range of other resources which Commissioners and Providers of services for individuals with learning disabilities may find informative are listed below with links to the publication for reference purposes:

- Royal College of Psychiatry

    - People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services;[93]
    - Enabling people with mild intellectual disability and mental health problems to access health care services;[94]
    - Care Pathways for people with intellectual disability;[95]
    - Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results;[96]

[89] Learning Disabilities: challenging behaviours Quality standard, 8 October 2015, nice.org.uk/guidance/qs101
[90] Mental health problems in people with learning disabilities: prevention, assessment and treatment, NICE guideline 14 September 2016, nice.org.uk/guidance/ng54
[91] Learning disabilities: identifying and managing mental health problems, Quality standard 10 January 2017 nice.org.uk/guidance/qs142
[92] Learning disabilities and behaviour that challenges: service design and delivery, NICE guideline, March 2018, nice.org.uk/guidance/ng93
[93] People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services, July 2013 https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-03.pdf?sfvrsn=cbbf8b72_2
[94] Enabling people with mild intellectual disability and mental health problems to access health care services, November 2012 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr175.pdf?sfvrsn=3d2e3ade_2
[95] Care Pathways for people with intellectual disability, September 2014, https://rcpsych.itnerislive.co.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-05.pdf?sfvrsn=11e73693_2

- Standards for adult inpatient learning disability services;[97]

- The Joint Commissioning Panel for Mental Heath's guidance for commissioners of mental health services for people with learning disabilities;[98]

- Local Government Association, ADASS (adult services), and NHS England publication: Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition;[99]

- The National Quality Board publication: An improvement resource for learning disability services: Safe, sustainable and productive staffing:[100];

- British Journal of Psychiatry article: Impact of the physical environment of psychiatric wards on the use of seclusion;[101]

- Journal article: Evaluation of seclusion and restraint reduction programs in mental health: A systematic review.[102]

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[96] Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results, 2015, https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-06.pdf?sfvrsn=5a230b9c_2

[97] Standards for adult inpatient learning disability services, July 2016 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-standards-3rd-edition-2016.pdf?sfvrsn=b181aa51_2

[98] The Joint Commissioning Panel for Mental Heath, Guidance for commissioners of mental health services for people with learning disabilities, May 2013, https://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf

[99] Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, October 2015, https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

[100] Safe, sustainable and productive staffing: An improvement resource for learning disability services, January 2018 https://improvement.nhs.uk/documents/588/LD_safe_staffing20171031_proofed.pdf

[101] Schaaf van der P.S. et al Impact of the physical environment of psychiatric wards on the use of seclusion, 2013. 202, 142 – 149, https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/impact-of-the-physical-environment-of-psychiatric-wards-on-the-use-of-seclusion/ECF01A965156AF94A632E8436F13FD9D

[102] Goulet M-H, et al, Aggression and Behavior, 34 (2017) Pages 139 – 146 Evaluation of seclusion and restraint reduction programs in mental health: A systematic review https://www.sciencedirect.com/science/article/abs/pii/S1359178917300320

9.10 The future model of inpatient services for individuals with a learning disability requires that best practice guidance, standards, and models are considered and developed to inform a modern, person-centred, rights driven service approach. This review found that dysfunctional management and a lack of a shared vision impacted negatively on patient care. The initiatives taken by the Trust to engage patients, carers, and families in care planning and the oversight arrangements within MAH require further development to ensure that meaningful engagement can be maintained and promoted.

9.11 The *A Way to Go* Report stated that 'the CCTV has given the Hospital a decisive edge. Visual evidence of assaults endured by patients who cannot describe what has happened was an impetus for the crisis management response.' [103] In the future, CCTV needs to be considered as a tool to prevent harm to patients rather than a means to ensure safe and compassionate care.

9.12 Finally, the above list of available materials has been selected in order to help inform a future commissioning and delivery agenda which promotes respect, dignity, care, and compassion for individuals with learning disabilities who are among some of society's most vulnerable citizens.

Summary

- Providing safe, effective, and compassionate care requires sufficient staff, with appropriate skills and ongoing access to training and professional development if it is to be more than a meaningless mantra.

- Services must be patient-centred informed by individualised assessment, planning and review processes to develop tailored care, protection, and

[103] Op. Cit par. 52, Page 18

transition plans for each patient.

- Patients, their families, and carers should be actively involved in decision making and in developing approaches to address behavioural or safeguarding concerns.

- Transition planning requires the active engagement of the patient, family/carers, and community support services to plan for a phased transition to life outside the hospital.

- The culture in the hospital should respect and promote patients' rights under the European Convention on Human Rights (ECHR).

- Advocacy services and family/carers and patients should regularly be asked to provide feedback on the standard and quality of care provided.

- All restrictive practices should be a last resort and used for the least time possible to comply with Article 5 of the ECHR (the Right to Liberty and Security).

- Locked doors for patients who are not detained under the provisions of the Mental Health Order are likely in to be in breach of Article 5 and such practices should be reviewed by the Trust to ensure compliance with legislative requirements.

- CCTV is an important tool in preventing abuse, however, it cannot be relied upon to ensure a culture of compassionate care.

- Clinical Leadership is essential for the promotion of patient safety and service quality.

- Multidisciplinary working and a strong leadership team are essential to the future provision of inpatient services for learning disability patients.
- An infrastructure of community support services is required to obviate, where possible, inappropriate admissions to hospital and to ensure that discharged patients' placements are well supported and sustained.
- Hospital as a permanent home for patients' capable of living in the community is no longer an option and every effort should be made to ensure phased, planned, and well supported discharges occur for patients who are inappropriately cared for within a hospital setting.
- Greater focus is required to working together with patients, relatives, carers, and community resources to ensure that in the future MAH is no longer a place apart.

10. Conclusions and Recommendations

10.1 The Review Team concluded that:

1. The Trust, given its size and scale, had extensive governance systems in place:

- the complexity of its governance systems hindered its agility and ability to be responsive;

- any system is dependent on those who implemented it, therefore in itself it cannot provide assurance;

- changes of senior management arrangements and titles resulted in confusion for front line staff, some of whom were unclear of arrangements which existed in the Trust in respect of MAH;

- the governance system became a tick box exercise at MAH;

- the Trust as an organisation championed practice development and quality improvement, as well as safer patient initiatives. There was however, limited evidence of how it influenced patient care at MAH;

- the SAI group was stood down in 2013 as a stand-alone Committee of the Trust Board. The Review Team was unable to ascertain to what degree, if any, this may have impacted on the priority given to adherence with SAI procedures or feedback to the Executive Team or Trust Board;

- there was a lack of escalation of issues from MAH to the Executive Team of the Trust Board. No issues regarding MAH were escalated to the Trust

Board or Executive Team between 2012 and 2017 despite its ongoing difficulties in relation to staff recruitment and retention;

- an extensive array of policies and procedures existed within the Trust. An external review of a number of policies and procedures relating to seclusion and restraint found the extant policies were out of date and that more recent best practice developments had not been taken into account;

- In 2005 the Department issued in draft form its Guidance on the use of Seclusion and Restraint. The Review Team knows that this Guidance was used to inform the Southern HSC Trust's policies in these areas. As the 2005 draft consisted of extensive guidance on monitoring arrangements, it is unfortunate that the Draft Guidance was not issued in final form by the Department as it had, through its monitoring mechanism, provided an opportunity to highlight and remedy excessive use of physical interventions.

- there was limited evidence of Executive or Board engagement with MAH prior to the events identified in August 2017. Walkabouts scheduled for all Trust facilities in 2012 did not result in a site visit to MAH until 2016.

2. Discharge of Statutory Function (DSF) Reports were provided annually by the Trust to the HSC Board:

– these were largely repetitive documents which did not provide assurance neither in relation to the discharge of Statutory Functions, nor to the standard of practice in relation to same;

- there was no reference to the Ennis investigation within the DSF Reports;

- there was insufficient challenge from the Trust Board and the HSC Board in relation to DSF Reports. Feedback provided to the Trust from the HSC Board related to failings in meeting resettlement targets;

- there was a recognition that the reporting format was leading to repetitive reports which lacked outcome data. Despite this, the reporting structure was not amended.

3. There was limited evidence of multidisciplinary working at MAH:

- nurses, including healthcare assistants, were for operational purposes the key workforce on site;

- there was evidence of nurses feeling unsupported by medical staff;

- there were ongoing problems relating to the identification and diagnoses of physical healthcare needs of patients which were not addressed until a service was procured from a local GP's practice;

- there was insufficient multidisciplinary team working with patients across the MAH site;

- the general absence of behavioural support staff, in particular psychologists, had a detrimental impact on patient care and contributed to challenging behaviours.

4. Failure to use data and learn from it:

   - information regarding physical interventions, restraint, vulnerable adults, and seclusion were regularly presented to Governance and Core Group meetings at MAH. There is no evidence of data being analysed or triangulated to inform practice, staff learning, or the workforce strategy. There was also no evidence of trends being analysed;

   - information from RQIA inspection reports was not used proactively to develop staff or improve patient care;

   - RQIA had no joined up approach to inspecting wards at MAH but neither had the Trust a joined up approach to identifying trends from such reports or in learning from the Iveagh Report where it had relevance to the adult hospital sector.

   - there was evidence that priority was afforded to completing information returns rather than learning from them;

   - there was limited evidence of how patients' and carers/relatives' views were sought and used to inform patient care.

5. There were staffing difficulties in MAH particularly relating to nursing and Consultant posts:

   - inadequate nursing staff resulted in a heavy reliance on bank and agency staff which resulted in a skill mix ratio of nurses to healthcare assistants which at times was as low as 20:80 on wards. There was an absence of

clinical oversight of practice, particularly of healthcare assistant level on a 24/7 basis;

- the staffing difficulties were hindered by the moratorium on posts compounded by the lack of a workforce strategy;

- there was limited investment in staff training and development activity, with a focus on mandatory training. There was little evidence based upon: therapeutic education; education and development; or national strategies promoting reductions in seclusion and promoting behavioural support;

- wards were closed prematurely to cope with staffing shortages. Insufficient attention was afforded to the impact this would have on patients or the skill mix of staff;

- patient activities were restricted due to staffing deficits which resulted in boredom and heightened levels of challenging behaviours;

- medical staff were at times not available in sufficient numbers to support nursing staff or to drive up standards within wards;

- nursing workforce shortages were not escalated within the Trust or to the Department.

6. The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost:

- the physical environment in wards scheduled for closure was allowed to deteriorate, resulting in a living and work environment not conducive to high standards of practice;

- relatives/carers of patients and hospital staff's anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients' transition to care in the community;

- there was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community.

7. MAH had its own culture which was not informed by the leadership values of its parent organisation:

- the Trust had its values set out in *The Belfast Way* and in a range of other documents. There was no evidence that these had been cascaded successfully to staff at MAH;

- there was a culture clash within MAH between those who viewed it as a home for patients rather than a hospital with treatment and assessment functions;

- staff were more focused on maintaining the status quo at MAH rather than adopting the values of the Trust. The *A Way to Go* Report commented on the loyalties which existed within the staff team to each other rather than to their employer;

- there was a practice in MAH of keeping issues and their management on-site. Evidence of this is found in the failure to bring the Ennis investigation and subsequent report to Trust Board. Similarly, by dealing with it solely as a safeguarding issue, it meant that it could be addressed on-site;

- the HSC Board repeatedly sought an SAI in respect of Ennis from 2012 to 2015. This request was never implemented by the Trust which eventually accepted that it was in breach of the SAI procedures. The admission of breach was not brought to Trust Board level by Trust personnel or the HSC Board;

- the Review Team was unable to ascertain why Ennis had not been escalated to Trust Board or the Executive Team by the Governance Lead or the Co-Director of Disability and Learning Services or the Directors of Nursing and Adult Social Care;

- an absence of visible leadership from Trust Board and Directors which resulted in MAH being viewed as a place apart.

Recommendations

10.2 In making recommendations the Review Team has considered actions taken by Belfast HSC Trust since 2017 to ensure safe, effective, and compassionate care in MAH. To avoid repetition recommendations are not made where action has already been taken. The following recommendations are made to assist the Department, the HSC Board/PHA, and the Trust to enhance the care provided to learning disabled citizens in a manner which builds on their strengths and supports them to reach their fullest potential.

The Department of Health

1. The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.

2. The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.

3. The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.

The HSC Board/PHA

1. The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the Trust Board.

2. Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.

3. Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.

The Belfast HSC Trust

1. The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.

2. The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust

considers sustaining these arrangements pending the wider Departmental review of MAH services.

3. Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

4. The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.

5. In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

6. The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

11. Acknowledgements

11.1 The Review Team wishes to thank all those who gave so generously of their time to meet with it. Without the assistance of parents, carers, advocates, past and present staff of the Department, HSC Board/PHA and the Trust, and RQIA, the PSNI, political representatives (MP and Health Minister) and the PCC the Review Team's task would have lacked both depth and insight. The Review Team also benefited greatly from input from one of the Professional Nursing Officer at the Department of Health in relation to best practice guidance.

11.2 The Review Team benefited from a site visit to MAH in February 2020 when it had the opportunity to meet with staff and patients. Due to the Covid-19 situation it was regrettably not possible for the Review Team to make further contact with patients and a wider number of relatives and carers.

11.3 The HSC Leadership Centre provided accommodation and technical support for the Review Team which was much appreciated.

11.4 Considerable documentary evidence was provided by the Department and the Trust. The Review Team wishes to thank those staff who supported it so ably by the timely provision of requested documentation.

Appendix 1

Terms of Reference - A Review of Leadership and Governance at Muckamore Abbey Hospital

Background

A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital (November 2018) is the report from the Independent Serious Adverse Incident Review of Adult Safeguarding incidents occurring at Muckamore Abbey Hospital between 2012 and 2017. Belfast Health & Social Care Trust (BHSCT) has commenced work on an action plan to improve the care, safety, and quality of life for patients in the hospital, and the Department of Health have developed an action plan to address the regional and strategic issues identified in the report. The three Trusts whose populations use Muckamore Abbey Hospital are also prioritising work to facilitate the discharge of people who no longer require inpatient care.

It is felt that the review did not fully explore the leadership and governance issues in the hospital. Therefore, the Independent Review of Leadership and Governance at Muckamore Abbey Hospital is being commissioned to address any leadership and governance issues that may have contributed to safeguarding deficits in the hospital.

A timeline for completion of the review will be agreed at the first meeting with the review team and HSCB/PHA lead officers.

Methodology

The Review team seek to establish lines of communications with all the organisations that are impacted by this review. The Belfast HSC Trust will be the main focus of the review, but other organisations may include the RQIA, other Trusts, as well as families and carers. The DoH will also be approached to ascertain what policies were in operation during that time period that would be relevant to the issues of leadership and governance. The HSCB/PHA will inform these parties of the mandate of the Review Team.

The Review team will seek to gather information for 2012 – 2017 from these relevant sectors that will help address the issues of how leadership and governance were exercised during this period. This will be carried out through interviews with individuals identified by the team and scrutiny of the relevant documentation. Documentation may include, Minutes of Board, Senior Management Team, and Hospital Management meetings; as well as risk registers; operational and strategic plans; service improvement plans; and financial strategies. Other documentation may include incident reporting, complaints, and organisational structures (this list is not exhaustive). The team will meet families and carers to ascertain their observations of matters of leadership and governance.

The Review team will identify good practice in the HSC/NHS and the public sector that can provide benchmarks to evaluate how leadership and governance was exercised within the Belfast Trust. The team will always act fairly and transparently, and with courtesy.

Purpose of the Review

This review is being commissioned by the Health & Social Care Board & Public Health Agency (HSCB/PHA) at the request of the Department of Health. The purpose of this review is to critically examine the effectiveness of Belfast Health & Social Care Trust's leadership, management, and governance arrangements in relation to Muckamore Abbey Hospital for the five-year period preceding the adult safeguarding allegations that came to light in late August 2017.

The review should take cognizance of any relevant governance issues highlighted by other agencies such as RQIA and PSNI since 2017. Ultimately, the review seeks to establish if good leadership and governance arrangements were in place and failed and if so, how/why ; or were effective systems not in place.

Terms of Reference

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to quality, safety and user experience. Drawing upon families, carers, and staff's experience, conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

Strategic leadership

- Shared principles, values, and objectives across the Trust services for people with a learning disability
- The role of Belfast HSC Trust Board and Senior Management Team in providing leadership and oversight
- The role of Belfast HSC Trust Board and Senior Management Team in ensuring clarity of purpose for MAH

Operational Management

- Clarity of line-management arrangements
- Clarity of lines of accountability from ward staff through to Trust Board
- Clarity of roles and responsibilities of and between operational, governance, and professional leadership and management at the hospital
- Clarity of roles and responsibilities between staff in the hospital and community based clinical and key worker staff.
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour.
- Operational aspects of adult safeguarding arrangements.
- Operational systems for raising and addressing concerns about quality and safety of patient care.
- Operational aspects of service improvement arrangements.

Professional / Clinical leadership

- Professional adult safeguarding arrangements
- Clinical leadership within multidisciplinary teams
- Professional supervision (across all disciplines working in the hospital)
- Professional aspects of systems and supports for raising and addressing concerns about quality and safety of patient care (including those available to students from all disciplines on placement in the hospital).
- Continuous professional development arrangements for all levels of staff
- Process for introducing and monitoring the implementation of new evidence based professional practice and clinical updates
- Professional aspects of service improvement arrangements
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour

Governance

- Incident reporting and reviewing arrangements and how these informed patient care (to include restrictive practices)
- Clinical and practice audit
- Dealing with complaints
- Whistleblowing
- Inspection reports
- Health & Safety
- Risk assessment and management
- Arrangements for learning and improvement from the above.
- Monitoring and accountability arrangements for physical interventions
- Monitoring and accountability arrangements for seclusion.
- Multidisciplinary staff availability, working, and skill mix
- Delivery of evidence-based therapeutic interventions in line with NICE and other relevant clinical practice guidelines

Accountability

- Meaningful engagement with families of patients/carers
- Meaningful engagement with people who use the hospital's services
- Reporting and accountability arrangements
- Working arrangements with community-based services
- Openness to visitors and scrutiny

Hospital Culture and Informal Leadership

- Hospital culture across all staff in all professions/roles in all settings within the hospital.
- The extent of compassionate values based and human rights-focused practice in the hospital.
- The nature of the management approach to staff including the extent of formal and informal supports.
- Ward dynamics and relationships amongst staff teams including positions of power/influence in staff teams. This analysis should include any available information from the safeguarding investigation about the numbers, roles, grading, experience, training, length of service and shift patterns of staff alleged to have been directly involved in abuse and those alleged to have witnessed it but did not act on it.

Support to Families and Carers

- The DOH will engage PCC to provide independent support for families and carers who become involved in the review process.

Anticipated Outcome

Produce a set of recommendations for consideration and approval by the Muckamore Abbey Hospital Departmental Assurance Group in relation to the implementation of a governance and assurance framework for Muckamore Abbey Hospital & Belfast HSC

Trust; other HSC Trusts with Learning Disability Hospitals; and wider mental health and learning disability services.

Appendix 2

Curriculum Vitae of Independent Review Team Members

David Bingham

Before retirement from the NHS in March 2016 David was Chief Executive of the Business Services Organisation for Health and Social Care in Northern Ireland. He had spent most of his career in the public sector, with a background of General Management, Human Resources or Management and Organisational Development. In addition to his health service experience he had spent eight years in the senior civil service.

Maura Devlin

Maura is a registered nurse and currently the Northern Ireland council member of the Nursing and Midwifery Council. She was Director of Nursing and Midwifery Education in the Clinical Education Centre and previously worked in a range of assistant director roles in the health and social care sector in Northern Ireland. Since retiring, she has served as an independent chair for Fitness to Practice proceedings at the Northern Ireland Social Care Council. She currently works as a professional advisor to the Northern Ireland GP Federations.

Marion Reynolds MBE, BSc, Dip Soc Work, CQSW, Cert Adv Soc Work

Marion worked from 1975 to 2009 at practitioner, management, inspection, policy development, and commissioning levels in Family and Child Care services in Northern Ireland. She commissioned the full range of statutory family and child care services for the population of the Eastern Health and Social Services Board from 2006 to 2009. In addition she chaired the Board's Area Child Protection Committee. Previously she

worked as a Social Services Inspector, at the DHSSPS (1992 to 2005). Marion contributed to the development of professional standards for children's services.

Since 2010 Marion has worked as an Independent Social Worker providing independent social work analysis and reports for a range of social services providers in both Northern Ireland and the Republic of Ireland.

Marion is currently involved as a: member of the Exceptional Circumstances Body of the Department of Education (2010 to present), member of the Northern Ireland Advisory Group of Homestart (UK) (2005 to present); Board Member Alpha Housing Association (2012 to present). Previously she was a Commissioner with the Northern Ireland Human Rights Commission (2009 to September 2017).

Katrina McMahon

Katrina is a former acting Head and Business Manager of the HSC Leadership Centre. She worked in the Health and Social Care sector for 37 years in various management roles within HSC Trusts and the Management Development Unit. Her particular areas of interest are in business systems and managing complex health care based projects.

Appendix 3

List of documentation received by the Review Team

File Number	Origin	Date Received	Comment
1	Belfast Trust	21/2/20	Policies and Procedures
2	Belfast Trust	21/2/20	Policies and Procedures
3	Belfast Trust	4/3/20	Policies procedures and reports
4	Belfast Trust	6/3/20	SAIs' and Incident reports
5 (File 1)	Belfast Trust	6/3/20	CORE minutes Modernisation Minutes
6 (File 2)	Belfast Trust	6/3/20	Professional Senior Nurse Minutes
7 (File 3)	Belfast Trust	6/3/20	Nurse Management Structure Re-settlement Information Audit Lead Minutes Governance Minutes
8 (File 4)	Belfast Trust	6/3/20	Learning & Children's Senior Managers Minutes
9	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits

10	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits
11	Belfast Trust	1/6/20	Assurance Standards Trust Board Updates + MAH Senior meetings
12	Belfast Trust	1/6/20	Ennis Investigation
13	Belfast Trust	1/6/20	Information relating to Ennis Report
14	Review Team		CCTV file
15	Belfast Trust	8/6/20	Nurse Training Plan Nurse Governance Structures KPIs' Nurse Governance Quality Reports
16	Belfast Trust	8/6/20	Nurse Management Plans Nursing & Midwifery Workforce Steering Group Assurance Framework
17	Belfast Trust	16/6/20	Trust Board Sessions, Exec Team minutes Statutory Function Reports Risk Registers
18	Belfast Trust	16/6/20	Quality improvement/Quality & Safety

			Improvement Plans
19	Belfast Trust	16/6/20	Adult Protection Policy Adult Safeguarding Policy Nursing KPIs'
20	Belfast Trust	26/6/20	Risk Registers Records of Leadership Walkrounds Nursing Governance Nursing Workforce Minutes
21	Belfast Trust	26/6/20	Minutes of Social & Primary Care Directorate Team meetings LD Senior Management Team Meetings

File Number	Origin	Date Received	Comment
22	RQIA	7/2/20	Documents A-G
23	DOH	28/2/20	Ennis documentation Early alerts received by DoH re Muckamore Whistleblowing Complaints Adult Safeguarding Restraint & Seclusion Statistics on Workforce Assaults

24	HSCB/PHA		Early Alert Position Report – Brown Complaint
25	Review Team		Ennis Investigation
26	Review Team		Additional ad-hoc documents
27	Belfast Trust		Documents from Chief Executives office
28	Departmental Professional Nursing Officer		Best Practice Documentation

Appendix 4

Meetings held with key personnel

Date	Job title
4/2/20	Chief Executive, Regulation &Quality Improvement Authority
13/2/20	Chief Executive, Belfast HSC Trust
18/2/20	Director of Primary Care, DoH
18/2/20	Social Services Officer, DOH
18/2/20	Nurse and Specialist Learning Diasability Manager, seconded to MAH
20/2/20	Officials , DoH
20/2/20	Social Services Officer, DOH
21/2/20	Director of Neurosciences, Radiology and MAH
21/2/20	Permanent Secretary, DoH
25/2/20	Programme Manager, Mental Health & Learning Disability, PHA
27/2/20	Medical Director and Director of Improvement Regulation & Quality Improvement Authority
27/2/20	Director of Nursing & Allied Health Professions – PHA
27/2/20	Social Care Lead Mental Health & Learning Disability, PHA
2/3/20	Manager Independent Advocacy Service,Bryson House
2/3/20	Health Minister
3/3/20	Chief Nursing Officer, DoH
5/3/20	Complaint Support Manager, PCC

5/3/20	Director, Mencap
6/3/20	Former Director of Adult, Social and Primary Care
13/3/20	Director of Social Work/Children's Community Services
16/3/20	Deputy Director and DRO, HSCB
21/5/20	MP
21/5/20	Chair of Parents & Friends of Muckamore Abbey Hospital
22/5/20	Director, Northern HSC Trust
26/5/20	Parent and Aunt
28/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
28/5/20	Hospital Service Manager/Assoc Director of Learning Disability Nursing, MAH
29/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
2/6/20	Hospital Service Manager/ Assoc Director of Learning Disability Nursing, MAH
4/6/20	Executive Director of Nursing and User Experience
4/6/20	Parent
5/6/20	Senior Manager for Service Improvement and Governance, Belfast HSC Trust
12/6/20	Ennis Investigation Officer
15/6/20	Former Director of Adult Social & Primary Care
18/6/20	Chief Executive, Belfast HSC Trust
20/6/20	Chairman, Belfast HSC Trust
22/6/20	PSNI
23/6/20	Non-Executive Director, Belfast HSC Trust

23/6/20	Nursing Lead for Transformation, DoH
23/6/20	Clinical and Therapeutic Services Manager, MAH
25/6/20	Trust Adult Safeguarding Specialist
25/6/20	Social Services Officer, DOH
25/6/20	Executive Director of Nursing and User Experience, Belfast HSC Trust
30/6/20	Former Director of Social Work, RQIA
3//7/20	Former Director of Social Work, Family and Childcare
16/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Clinical Lead, former Clinical Director

Appendix 5

TIMELINE OF RELEVANT INCIDENTS: MUCKAMORE ABBEY HOSPITAL 2012 - 2020

November 2012 – Complaints made of physical and emotional abuse of patients in Ennis Ward. PSNI informed. Review took place under the Trust's Safeguarding Vulnerable Adults Policy.

October 2013 - Date of Ennis Safeguarding Vulnerable Adults Report.

August 2017 - Complaint by a parent of a non-verbal male patient that his son was being abused at the Intensive Care ward at Muckamore Abbey.

August 2017 - Information that video recording may be available in relation to the allegations of patients being ill-treated by hospital staff. PSNI and the Trust began investigating the allegations and reviewing the video recordings.

November 2017 - Four staff members had been suspended and the BBC reported that the allegations "centred on the care of at least two patients".

January 2018 - The Trust established an Independent Expert Group to examine safeguarding at the hospital between 2012 and 2017. The report's authors included Dr Margaret Flynn, who oversaw the review into the 2012 Winterbourne View hospital scandal in England which saw six care workers jailed.

July 2018 - The Irish News reported details of CCTV footage allegedly showing ill treatment of patients. The Trust apologised "unreservedly" to patients and their families. It further stated: "As part of the ongoing investigation and a review of archived CCTV footage, a further

number of past incidents have been brought to our attention. It confirmed that a further nine members of staff had been suspended at MAH.

August 2018 - The BBC reported that between 2014 and 2017, five vulnerable patients were assaulted by staff at Muckamore Abbey Hospital. In response to a Freedom of Information (FoI) request the Trust confirmed that in hospital between 2014 and 2017 there had been more than 50 reported assaults on patients by staff, with five investigated and substantiated.

November 2018 - The Independent Expert Group established by the Trust to enquire into the allegations of August 2017 completed its report, *A Way to Go*

December 2018 - The *A Way to Go* Report which enquired into allegations of abuse and neglect at Muckamore Abbey was leaked to the media. By this stage, 13 members of the nursing staff were suspended and two senior nursing managers were on long-term sick leave.

December 2018 - A mother of a severely disabled Muckamore patient gave her first broadcast interview to BBC News NI. She described the seclusion room her son was placed in as "a dark dungeon". CCTV footage from the Psychiatric Intensive Care Unit (PICU) showed her son being punched in the stomach by a nurse. The footage, taken over a three-month period, also showed patients being pulled, hit, punched, flicked and verbally abused by nursing staff. The Belfast Trust confirmed that the seclusion room use was being reviewed though it was still used in emergencies.

January 2019 - The chair of Northern Ireland's biggest review into mental health services, Prof Roy McClelland, told BBC News NI that the allegations emerging from Muckamore could be "the tip of the iceberg."

February 2019 - The Chief Executive of the Belfast Health Trust, Martin Dillon, tells the BBC "the buck rests with me" in his first interview on the Muckamore abuse allegations. "Some of the care failings in Muckamore are a source of shame, but my primary focus is on putting things right," he said.

August 2019 - The police officer leading the investigation said that CCTV footage revealed 1,500 crimes on one ward alone. The incidents happened in the psychiatric intensive care unit over the course of six months in 2017-18. The police revealed the existence of more than 300,000 hours of video footage.

August 2019 - Northern Ireland's health regulator, RQIA, took action against the Belfast Trust over standards of care at Muckamore. Three enforcement notices were issued by the Regulation and Quality Improvement Authority (RQIA) over staffing and nurse provision, adult safeguarding, and patient finances. In a statement to the BBC, the Trust said it was trying to develop a model of care "receptive to the changing needs of patients".

September 2019 - Northern Ireland Secretary, Julian Smith, apologises for the pain caused to families by the situation at Muckamore Abbey Hospital, during a meeting with the father of one of the patients.

October 2019 - Dr Margaret Flynn, co-author of the *A Way to Go* Report into safeguarding at Muckamore tells BBC News NI that the hospital "needs to close". Her November 2018 report found that patients' lives had been compromised. She revealed that some patients had been manhandled and slapped on some occasions. She said that she was disappointed that the facility was still open.

October 2019 - Police investigating abuse allegations make their first arrest in the Muckamore investigation. A 30-year-old man was arrested by officers in Antrim on 14th October but he was later released on police bail.

October 2019 - Belfast Health Trust reported that it has spent £4m on agency staff in order to cover vacancies at Muckamore, because so many members of staff have been suspended during the abuse probe. The current tally of suspensions on 18th October 2019 stands at 36. Agency nurses are being drafted in from England and further afield to care for patients. It is reported that they are being paid up to £40 an hour.

November 2019 - A 33-year-old man becomes the second person to be arrested in the Muckamore abuse investigation. He was detained in Antrim on 11th November but was later released on police bail.

December 2019 - Police make more arrests in the Muckamore abuse investigation. A 33-year-old man was arrested in the Antrim area on the morning of 2nd December. The following day, officers said the man had been released on bail pending further inquiries. In the same week, the Irish News reports four more suspensions, bringing the total number of Muckamore staff suspended by health authorities to 40. The Belfast Health Trust confirms that all 40 employees have been "placed on precautionary suspension while investigations continue". On 16th December, a 36-year-old woman became the fourth person to be arrested and questioned about ill-treatment of patients. She was released on police bail the following day.

December 2019 - BBC News NI reveals that 39 patients who should have been discharged will have to stay at Muckamore Abbey Hospital because there are no suitable places for them in the community. The same day, RQIA announces the results of a three-day unannounced inspection of Muckamore, including an overnight visit. The RQIA inspection finds there have been "significant improvements" but it

still has concerns about financial governance and safeguarding arrangements.

January 2020 - Muckamore patients' families meet the new Health Minister, Robin Swann, following the restoration of Northern Ireland's devolved government. A spokesman for the campaign group Action for Muckamore, says that he was disappointed that Mr Swann could not give them assurances that a full public inquiry would take place. The meeting followed a fifth arrest in the abuse investigation. A 34-year-old man was questioned before being released on police bail the following day, pending further inquiries.

January 2020 - Terms of Reference for a review of leadership and governance at Muckamore Abbey Hospital and at Belfast Trust were agreed by the HSCB and PHA which had been requested by the DoH to conduct such a review.

January 2020 - Man arrested as part of MAH investigation. The 5th arrest.

February 2020 - Male nurse who was suspended was arrested by the police; the 6th arrest.

February 2020 - Muckamore Abbey Hospital Review Team commence the review into leadership and governance.

March 2020 - A 28 year-old woman who was arrested in the police investigation of patient abuse at Muckamore Abbey, in Co Antrim has been released. This was the 7th arrest.

March 2020 - MAH Review Team temporarily stood down due to the Coronavirus Pandemic. Timescale for delivery of interim findings and final reports necessarily amended.

April 2020 - The Public Prosecution Service writes to families for the first time confirming that it has received an initial file from the PSNI in respect of seven staff members which it is now reviewing.

Appendix 6

Overview of Ennis Report Appendix 1 of that Report

Source	Incident Number(s) (inclusive)	Comments
[redacted]	1 – 15	**1, 3, 5, 7, 8** relate to staff alleged inappropriate or rough handling of 3 patients [redacted] & [redacted]. Others appear practice issues
[redacted]	16 – 18, 52 - 53	Incident **16** relates to rough handling of [redacted] Practice issues: incident **17** similar to incident **50**; incident **18** similar to **37**, **51** and **59**. **Part of 52** may be the same incident as **49** expanded. **53** may be incident **17**.
[redacted]	19 – 23, 59 - 63	**59 – 63** are repeats of **22, 20, 19 & 44** one is similar to **37**
[redacted]	24 – 25	Describes 2 incidents relating to [redacted] unclear what the allegations are
[redacted]	26, 45 - 48	**26** rough handling of [redacted] when redressing her. Not repeated in [redacted] statement to HR in 2014. **45 – 48** comments in respect of [redacted] stripping and belt issues. Should cross-reference with [redacted] HR statement in May 2014
[redacted]	27 – 28	In the statement to HR [redacted] stated incident **27** was not a concern and it was an Erne member of staff, not Ennis, who provided an explanation. In relation to **28** said staff knew patients well & '*I could not praise the staff enough for the work they do.*'
[redacted]	29 – 31, 54 - 58	**29** in the interview with HR this comment was refuted: 'denied that staff had taken [redacted] hand out of [redacted] **30 – 31** practice issues.
[redacted]	32 – 39	32 rough handling (? Of [redacted] Incident **34** similar to that described at **24**, form of restrictive practice as described. Incident **35** practice issue. Incident **36** similar to incident **48.** Incident **37** similar to **59.** Incident **38** practice issue.
Patient's	40	Rough handling allegation

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brother		
Multiple Private Provider staff	41 – 44	Incidents relate to lack of induction, lack of engagement with patients, lack of adequate staffing, culture on the ward. Should cross-reference with [redacted] and [redacted] statements to HR in May 2014
[redacted]	49 – 51	Incident **49** repeat of **59** and other allegations in relation to rough handling of [redacted] and fitting belt too tightly. In statement to HR states witnessed this on one occasion only. Following practice issues: incident **50** repeat of **17**; incident **51** similar to incidents **18**, **37** and **59**.

Appendix 7

Strategy Discussions/Case Conferences and Case Records– Information Base for Review Team's Analysis in respect of Ennis

Strategy Discussions/Case Conferences

1. In keeping with the Trust's adult safeguarding policy, the investigation was conducted on a multidisciplinary basis and jointly with the PSNI given the criminal nature of a number of the allegations. Strategy meetings and case conferences were convened under the Joint Protocol for Investigation 2009 arrangements and the Regional Adult Protection Policy & Procedural guidance (Safeguarding Vulnerable Adults) 2006 on the following dates:

   - 9th November 2012 Vulnerable Adult Strategy discussion;
   - 15th November 2012 second Vulnerable Strategy Meeting;
   - 12th December 2012 strategy discussion;
   - 20th December 2012 strategy discussion;
   - 9th January 2013 strategy discussion;
   - 29th March 2013 strategy discussion;
   - a meeting scheduled for the 14th May 2013 was cancelled as the investigation was not completed;
   - 5th July 2013 Adult Safeguarding Case Conference;
   - 28th October 2013 Adult Safeguarding Case Conference.

2. The Safeguarding Vulnerable Adult policy requires that where there is confirmed or substantial risk of abuse a case discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify

risks and the actions necessary to manage those risks.[104] The purpose of the case discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan.[105] Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the Core Group who will work together to implement and review the Care and Protection Plan.[106]

3. The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.[107] The Care and Protection Plan will identify the person who is responsible for monitoring its operation. It should be reviewed within 10 working days of its implementation and should be reviewed at a 3 monthly interval at minimum.[108]

4. The initial meeting was held within the required timeframe and comprehensively considered the allegations received by the Trust on the 8th November 2012. No patient or family member was invited to attend the meeting; no explanation was provided although from the discussion it was apparent this was in the patients' best interests. A Protection Plan was agreed, each task was not assigned to a named attendee.

5. At the second discussion convened on the 15th November 2012 MAH staff were excluded to 'facilitate a more independent investigation.' The meeting agreed that the Designated Officer would be the main link to hospital staff. The meeting noted that there were 'some further concerns about possible physical abuse had emerged, also poor care practice and a general concern about an uncaring

[104] Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance, 2006, Para. 14.10, Page 36
[105] Ibid par. 15.1, Page 38
[106] ibid par. 15.7, Page 40
[107] ibid par. 15.13, Page 42
[108] ibid par. 16.3 – 16.4, Page 43

culture in the ward.' The meeting considered the complaints made against individual staff and reached conclusions about whether or not a staff member could be reinstated or placed on precautionary suspension. Much of the discussion at this meeting surrounded perspectives on professional practice at Ennis. The meeting did not commence with feedback on how aspects of the Protection Plan had operated since the initial strategy discussion. A revised Protection Plan was agreed the staffing component of this was to be addressed by the Designated Officer with senior Trust managers. The Review Team considered that preliminary discussion with MAH managers and delegating the staffing issue to them to pursue with senior managers would have been a more inclusive working arrangement.

6. The third strategy meeting convened on the 12th December 2012 highlighted information still awaited from MAH medical staff. An update on progress with interviews was provided. As of that date the PSNI had not interviewed any staff employed by the Private Provider. The meeting was informed that a Co-Director of Nursing (Education and Learning) had been identified to lead and co-ordinate monitoring arrangements at Ennis. The Designated Officer confirmed that after checking she was now in a position to confirm that since the last meeting monitoring staff 'were in place 24 hours a day and that they were supernumerary.' There was considerable discussion about staffing levels at Ennis. It was noted that 2 of the 5 patients named might be able to provide some information at interview. The agreed Protection Plan remained 24 hour monitoring with the precautionary suspension of 3 staff members continuing The Review Team considered that greater focus was required on the alleged incidents in an effort to bring the safeguarding investigation to an early conclusion.

7. The fourth strategy meeting convened on the 20th December 2012 had in attendance a member of the Trust's HR Department and the Co-Director of

Nursing (Education and Learning). The MAH Service Manager also attended this meeting. During this meeting the police representative noted that it would only interview patients or staff in respect of criminal allegations not professional practice matters. The police confirmed that the Private Provider's staff have now all been interviewed and statements taken. The police noted that these staff had not raised similar concerns about other wards on which they had worked. The Designated Officer noted that this was positive she remarked that 'there were clear differences being reported between it [Ennis] and other wards.

8. Three staff were identified by the Private Provider's staff whose identify could not be confirmed as their names were unknown. There was a discussion about whether a patient being held constituted a safeguarding concern. In this respect the police confirmed that this matter would not be investigated as a criminal matter. It was decided that 'social services would continue to interview them in relation to the allegations.' The police asked the Trust not to proceed with disciplinary measures before the police interviews. HR asked for a police timescale as it was important for the Trust to move ahead with its processes, It was agreed that HR interviews would be completed independently of safeguarding interviews. Fourteen action points were agreed at the end of this meeting the majority of which were assigned to named members of the strategy team.

9. This meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run in parallel. It also highlighted that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considers it essential that at the outset each allegation is assessed on the basis of the existing information and categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

10. The fifth strategy meeting was held on the 9th January 2013. Both of the Designated Officer's line managers attended this meeting [a Co-Director for Learning Disability Services and a Service Manager for Community Learning Disability Services]. The Co-Director raised his concern about the list of allegations presented by the Designated Officer some of which were specific while others were negative comments. He stressed the need to obtain evidence and facts, which was difficult in relation to negative comments. The Review Team considers that had the initial allegation been disaggregated (see Para 8.29) that the safeguarding investigation would have been able to focus its energies on abusive issues. The RQIA representative sought clarity on MAH staff now attending the Co-Director stated that the Trust's senior management had 'concluded that it was important she was in attendance to clarify any issues specific to nursing practice on the wards in MAH…'

11. This meeting commenced with a consideration of progress against the actions established at the previous meeting. The Review Team considers such an approach commendable as it serves to focus attention on any matters which remain outstanding. Concerns raised by a patient's sister during contact were discussed and it was agreed to recommend that these be progressed through the Trust's complaints procedures. This meeting agreed an alteration to the 24/7 monitoring arrangement such that it could now be undertaken by newly appointed staff at Ennis at Band 5 and above. Fifteen action points were agreed. Each was assigned to a named individual; such practice is commendable. The next meeting was scheduled to be held on the 1st February 2013.

12. The next meeting was held on the 29th March 2013 nearly two months later than initially scheduled. Neither the Co-Director of Nursing nor the MAH staff member was in attendance. Consideration had been given to deferring the meeting due to their non-availability but as the police wished to provide feedback it had been decided to proceed. The focus was therefore an update from the PSNI and on

further investigation planning. The Co-Director observed that 'while recognizing that the investigation is incomplete, he emphasised that we are 5/6 months into this investigation and there is no evidence of institutional abuse.' He further noted that neither the Co-Director of Nursing nor the MAH staff member feel there is indication of institutional abuse at this stage. These are the first references to institutional abuse in the records of these meetings. All staff in the Ennis ward are to be interviewed by two community based learning disability social workers using an 'agreed script with a semi structured interview questionnaire.' The meeting also considered progress against the actions agreed at the previous meeting. At this stage neither patients nor all staff working at Ennis had been interviewed by Trust staff; more than five months after the receipt of the allegations. The Review Team considers this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

13. The penultimate meeting was held on the 5th July 2013 at which copies of the draft final report was circulated. The Public Prosecution Service had still to assign a public prosecutor to the case. The Co-Director, Learning and Disability Services, asked that pressure is kept on the process as public money is being spent with staff members remaining on suspension. He asked if the disciplinary process could commence pending an outcome of the police investigations. He asked that a meeting take place with the Trust's HR Department to discuss proceeding with disciplinary proceedings. As the draft report had been circulated at the commencement of the meeting there was not time to consider it, although the DO 'advised that the focus of the rest of the meeting would be the conclusions and recommendations section of the report. It was agreed to defer until after the meeting as there had not been enough time to go through the report prior to it. One of the patient interviews remains outstanding as there is no Speech and Language therapist during July.

14. The Co- Director, Learning and Disability Services, noted that the investigation had dealt with 'a broad range of issues which were not part of the original allegations but arose during interviews with Private Provider staff. He asked for the outcome of the investigation in relation to these matters as 'the report refers at various points to 'no conclusion drawn'.' The DO replied that no evidence had been found to substantiate the allegations but 'the investigating team felt the [Private Provider staff] were credible.' The DO agreed to make a distinction between Ennis prior to the allegations and after the Improvement Plan.

15. There was a discussion about whether there was evidence of a culture of bad practice. The DO replied 'that the conclusions reached by the investigation team was there was enough to warrant considerable level of suspicion ... although [the Private Provider staff] also identified good practice which would suggest that any poor practice was not totally widespread.' The meeting concluded by a review of the protection plan and agreeing a series of changes.

16. The final case conference meeting [for which minutes are available on case records] was held on the 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation in Ennis ward. The purpose of the meeting was to:

- discuss the conclusions and recommendations following the safeguarding investigation;
- discussion of updates to families/relatives of service users named in the report; and
- an update on the police investigation.

The DO noted that amendments had been made to the draft report tabled at the previous meeting and had been emailed to participants. No feedback/issues were received in respect of the amended report.

17. The PSNI advised that it could be several months before the charges against the two staff came to trial. It was recommended by investigation team that the disciplinary action commence. MAH Service Manager confirmed that this action had commenced but was at an early stage. The Co-Director Learning Disability Services recommended advice be sought from Human Resources 'before staff were spoken to'.

18. The DO noted the difficulty the investigation team experienced in weighing the 'very different evidence provided by the two staff teams [MAH and Private Provider staff]. It was not possible to identify all the staff allegedly involved in poor practice. There was not enough evidence to warrant disciplinary action against some staff due to lack of corroboration and their own differing accounts. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the Private Provider's staff's report as evidence. Uncorroborated reports being viewed as evidence was discussed. 'There was considerable discussion in relation to having sufficient evidence to support the allegations made.' It was also noted that there were discrepancies in the reports received from the Private Provider's staff in relation to induction.

19. The staffing situation at Ennis prior to the events of November 2012 was discussed as was the arrangements now in place to 'check daily staffing numbers on a daily basis throughout the hospital.' Hospital management also accepted the recommendation that 'the hospital needs to review for any practice on Ennis ward that could be deemed restrictive.' A successful bid has been made for psychology support in resettlement wards to help with meeting patients' needs. Other professional services had also commenced in Ennis Ward.

20. The impact of the investigation on Ennis staff was recognised and consideration was afforded to meeting their need for information about the investigation and its

outcome. The PSNI noted that in respect of the charges it was pursuing this could not be shared with staff but more general feedback was possible. The Co-Director, Learning and Disability Services noted that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' RQIA supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked 'to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue.

21. A further meeting was arranged for the 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

Case Records

22. There is evidence on the files examined that the MAH Service Manager was at times reporting to the Operations Manager and safeguarding lead. An example was in as email of the 16th November 2012 when confirmation was provided that a number of actions had been taken in line with the findings at the Strategy Meeting held on the 15th November regarding the absence of supporting evidence in respect of a student nurse and a member of staff which would enable her return to duties. The Operations Manager was asked to 'confirm the following: 'the band 6 or above is required to be supernumerary; the monitor will be on shift 24 hours per day; that they will have no substantive role in Ennis in the past 3 months, 6 months, or year can you give a time frame; will the independent monitors be in place for the 24 hour period when you make the arrangements.'

23. The Review Team had some concern that the safeguarding investigation was extending its role into managing the situation at Ennis. The purpose of a case conference is to evaluate the available evidence and to determine an outcome based on balance of probability. In complex situations a strategy discussion is convened which comprises key people who meet to decide the process to be followed after considering the initial available facts. These meetings may conclude by making recommendations to the constituent agencies involved in a specific case. The membership of these meetings is independent of the management in each of the constituent organisations. Accountability rests with individual agencies for progressing recommendations. Failure to comply with recommendations can be brought by the safeguarding lead to the attention of individual agencies for it to take remedial action, where required.

24. The Review Team noted on the 5th March 2013 that the Operation Manager emailed her line managers and the MAH Service Manager noting that while 'many of the reports [monitoring reports] continue to be very positive' she wished to meet to discuss 'the greater number of quality concerns reported' since the withdrawal of supernumerary monitors. On the 6th March the MAH Service Manager's responded stating: 'in continuing to review the monitoring forms I feel the concerns noted are similar in nature to the previous monitors, I am reassured by the open and transparent reporting the monitors are providing... A weekly support meeting is in place to discuss concerns. We have a number of action plans in place to address [a range of identified issues].'

25. The Operation Manager's response of the same date while noting her continued preference for a meeting asked as an alternative for copies of the action plans and for details in respect of the weekly support meetings. She also noted that from the monitoring reports she could not identify whether or not staffing levels are appropriate. It is the opinion of the Review Team that the role of the DO in this respect was not appropriate. It carried the potential to undermine the

managerial system at MAH. In the view of the Review Team reporting on compliance with recommendations was the proper way to seek to monitor compliance levels. In situations where there concerns were identified the appropriate response would have been to seek further assurances either from the MAH Service Manager or the Director of Nursing or her nominee rather than assuming what appears to have been a quasi-oversight function. There was also evidence on file of the Operations Manager being kept informed of therapeutic input in respect of individual patients.

26. The Review Team also found in the community services Ennis files a series of emails about matters such as ward keys for Ennis which did not appear germane to the safeguarding investigation. The chain of emails was copied to the Operations Manager to inform her that 'keys for Ennis have now requisitioned and arrived'. Confirmation of capital funding approval was also provided along with a detailed internal inspection schedule of the ward. The degree of apparent oversight of the Ennis ward was higher than the Review Team would have expected. The safeguarding investigation took from the 8th November 2012 until the 23rd October 2013 which is longer than one would have expected, especially given the nature of the complaints. Given the significant amount of work carried by the DO the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation.

27. The Trust arranged for its Co-Director of Nursing (Education and Learning) to engage with managers at MAH in relation to safeguarding patients in Ennis. This staff member was independent of MAH. She undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;

- consideration of progress against draft improvement plans; and
- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

A comprehensive report was produced at the conclusion of the second visit made on the 9th January 2013 which is available on the safeguarding files. This staff member was also a member of the multidisciplinary safeguarding team. As the Service Manager from MAH was not, for a period, a member of that team this staff member acted as a communications link between the safeguarding team and MAH thereby ensuring that matters identified were communicated and taken forward within both processes.

Appendix 8

Timeline in respect of Mr. B's Complaint

Date	Information
12.08.17	Member of staff (healthcare support worker) assaulted Mr. B's son (AB) a patient in PICU. The incident was witnessed by a staff nurse who reported it to the Nurse in Charge. Neither of the staff completed an Adult Safeguarding Form (ASP1). The Nurse in Charge emailed the Deputy Charge Nurse (DCN) with a request to meet to discuss 'a concern'. This meeting occurred on 17th August. The DCN considered the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN emailed the staff nurse for more details. The incident was not escalated at that time.
20.08.17	The DCN received an allegation that another patient on PICU had allegedly been verbally abused by the healthcare support worker involved in the AB incident. The DCN emailed the Charge Nurse (CN) for advice. The CN was not on duty that day.
21.08.17	The CN returned of annual leave for a late shift. The CN immediately escalated the concerns to Senior Management and requested ASP1 forms be completed on the ward. The CN reminded staff of their responsibilities under adult safeguarding arrangements. The Acting Head of Service was contacted and action discussed. The precautionary suspension of the staff member was agreed. The Adult Safeguarding Officer was notified and an interim protection plan was put in place. The PSNI and the Community Designated Officer as well as patients' next-of-kin were notified about events in respect of the incidents. A single-agency, PSNI led investigation was confirmed. The police officer stated that interviews would be scheduled following his return from annual leave 11th September 2017.
22.08.17	At 7.30 am the healthcare support worker at the start of his shift was

	placed on precautionary suspension by the Service Manager and the Senior Nurse Manager. Associate Director of Social Work, as safeguarding lead, was notified of the incident by the Service Manager.
25.08.17	On the way to a scheduled meeting at MAH to discuss the assault on his son, Mr. B contacted RQIA about the situation. RQIA contacted the Senior Nurse Manager for confirmation that the safeguarding processes had commenced. Mr. B met with the Senior Nurse Manager and the adult safeguarding officer. The timing of the meeting was to facilitate Mr. B securing support from a Carer Advocate. Mr. B was provided with details of the Community Designated Officer in case he requires any further information. Mr. B at this meeting asked if there was CCTV footage of the incident. He was told that CCTV was not operational. He did not accept this response. Mr. B made a formal complaint in respect of events concerning his son. He was telephoned on 29th August 'to confirm we have now received the email he tried to send on 25th August' (email sent to wrong address). The Senior Nurse Manager and the Service Manager held a conference call with the PSNI to clarify an approach to investigation. The police-allocated case officer gave permission for the safeguarding officer to speak to the witness of the alleged incident of 12th August 2017 on that staff member's return from annual leave on 29th August 2017.
28.08.17	Mr. B met with his MP about his concerns about the treatment of his son. The MP immediately contacted the Chief Social Services Officer at the Department.
29.08.17	Mr. B emailed seeking a response to his complaint of 25th August 2017. It sent this email to the HSC Board. Within a half an hour of receipt of this

	email, an email was sent to the Belfast Trust stating that the HSC Board had called asking had it received the complaint and asking that someone contact Mr. B by phone. His mobile number was provided.
29.08.17	Mr. B's complaint of 25th August 2017 was received by the Trust as there had been an error in the email addressed used on 25.08.17. The safeguarding lead spoke to the witness who confirmed that he had seen a shove or possibly a hit to stomach area of Mr. B's son. This was not a formal interview as instructed by the police due to the ongoing PSNI investigation. Incident of alleged verbal abuse of a patient by a healthcare worker was being managed by the designated community social worker.
29.08.17	The Directorate of Legal Services (DLS) was contacted for a legal view on accessing CCTV footage. This was subsequently followed up in writing, possibly on 4th September 2017. At some point the possibility that the incident of 12th August had been captured on CCTV was discussed by senior managers at MAH. The Review Team has not been able to identify when this possibility was initially raised, nor when the footage was first checked. It would appear however, that by 29th August 2017 there was awareness that there was CCTV footage available and the question arose of what, if any, use could be made of it. There was a belief among the staff interviewed by the Review Team that the CCTV would become operational on 11th September 2017.
29.08.17	Trust Complaint Department representative forwarded Mr. B's complaint to the Co-Director of Learning and Disability Services, noting that the Governance Lead had already advised that it would be 'investigated under safeguarding in the first instance … When the safeguarding investigation is complete, we will respond to the complaint.'

29.08.17	The Co-Director of Learning and Disability Services emailed the Governance Lead at MAH in respect of Mr. B's complaint stating: 'Not a complaint. Being investigated under safeguarding by PSNI.' The Co-Director of Learning and Disability Services also emailed the Trust's Complaints Department in response to an email from it noting that 'when the safeguarding investigation is complete we will respond to the complaint'. The Co-Director of Learning and Disability Services stated in her response: 'Complaints need to write and tell [Mr. B] it is being investigated under safeguarding.
30.08.17	The Governance Lead at MAH emailed the Trust's Complaints Department stating: 'this is being investigated under safeguarding so is not a complaint.' In keeping with the email advice she had received from the Co-Director of Learning and Disability Services.
30.08.17	The Trust's Complaints Manager replied to Mr. B acknowledging receipt of his complaint. She advised that once the safeguarding investigation had completed that 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009)'. The letter also advised Mr. B that 'a member of the Adult Safeguarding team will be in contact with you shortly.' This letter was shared in draft with MAH Governance Lead and approved by same.
30.08.17	RQIA contacted the Trust's Director of Social Work seeking assurance about safeguarding training for staff.
30.08.17	Mr. B's MP met with the Departmental Director of Mental Health, Disability and Older People to discuss Mr. B's concerns about his son's care.
31.08.17	The Trust's Complaint's Department emailed the Co-Director of Learning and Disability Services advising that, 'complaints have written out to Mr. B [on 30th August 2017] and closed down as a complaint.' The letter to Mr. B stated however, that the complaint had been set aside pending the completion of a safeguarding review.

31.08.17	A representative of the Department and the HSC Board emailed the Co-Director of Learning and Disability Services following contact from Mr. B.
01.09.17	The Service Manager prepared an SAI form in respect of the incident regarding Mr. B's son. This was returned to her by MAH's Governance Department stating that it did not meet the criteria for an SAI.
06.09.17	The DLS responded stating that as the matter was of a safeguarding nature, the Trust was at liberty to access the CCTV footage.
07.09.17	Request to Service Manager from the Co-Director of Learning and Disability Services for an Early Alert following contact with the Department. There is no reference to CCTV footage in the Early Alert. Director of Nursing and CNO advised by Service Manager of the Early Alert by the Service Manager.
08.09.17	Director of Mental Health, Disability, and Older People at Department provided Mr. B's MP with preliminary information provided by the Trust.
17.09.17	Service Manager contacted the investigating officer upon his return from annual leave. She advised him of the possibility of CCTV footage.
18.09.17	Information on staff roster forwarded to PSNI as requested.
19.09.17	Service and Improvement Manager viewed CCTV footage to check if the incident of 12th August 2017 was available.
20.09.17	Service Manager and Service and Improvement Manager viewed the footage. The matter was then escalated to the Directors of Nursing, Social Work, and Medicine. This is the first evidence of information being brought to the attention of the Executive Team and Trust Board members. Hand written notes taken by the Director of Medicine confirm the date as 20th September 2017.
20.09.17	Departmental Director of Mental Health, Disability, and Older People provided Mr. B's MP with an update based on the Trust's Early Alert and advice from Belfast Trust
21.09.17	CCTV download completed. Viewing arranged to identify patients/staff.

	Present at the viewing were the: Clinical Director, Service and Improvement Manager, Senior Nurse Manager, the Ward Consultant, the safeguarding officer and the Assistant Medical Director.
22.09.17	Meeting held to discuss concerns and their management. Chaired by the Director of Adult, Social and Primary Care, attended by Service Manager, the Co-Director Mental Health Services, and the Assistant Service Manager, Learning Disability
24.09.17	The Co-Director Mental Health Services made an unannounced visit to PICU.
25.09.17	The RQIA lead inspector for MAH updated by the Service Manager and the Clinical Director.

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 2 September 2020

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Brenda Creaney	Belfast Trust
Charlotte McArdle	DoH (Joint Chair)	Gillian Traub	Belfast Trust
Maire Redmond	DoH	Bernie Owens	Belfast Trust
Mark Lee	DoH	NI British Psychological Society representative	
Ian McMaster	DoH		
Aine Morrison	DoH		
Siobhan Rogan	DoH		
Sean Scullion	DoH (Note)		
Marie Roulston	HSCB		
Briege Quinn	PHA		
Rodney Morton	PHA		
Dawn Jones	Family representative		
Brigene McNeilly	Family representative		
Aidan McCarry	Family representative		
Margaret O'Kane	South Eastern Trust		
Tracy Kennedy	Belfast Trust		
Patricia McKinney	Belfast Trust		
Karen O'Brien	Western Trust		
Petra Corr	Northern Trust		
Barney McNeaney	Southern Trust		
Stephen Matthews	Cedar		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
Tony Stevens	RQIA (observer)		
Lynn Long	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees and noted apologies received. He advised members that the meeting was again being held by video-conference in light of

the continuing Government guidance on social distancing, and this arrangement would be kept under review for future meetings.

2. He advised members that Margaret Kelly had left the Group to take up a new post, and extended his appreciation to her for her contribution to the work of MDAG. A replacement for her on MDAG would be identified as soon as possible.

3. He also advised the Group that David Bingham, the Chair of the independent panel who carried out the Leadership and Governance review into the hospital would join the meeting to brief members on the Review's findings.

Agenda Item 2 - Minutes of Previous Meeting

4. The minutes of the previous meeting held on 24 June were agreed by members, subject to amendment of the wording on two specific points highlighted by members.

5. Sean Holland noted that the summary of the key points from the 24 June meeting which had been circulated to members following the meeting had subsequently been reported on in the media. As there is a risk that some of the information contained in MDAG minutes may have the potential to enable the identification of individual hospital in-patients with attendant implications for their confidentiality, he proposed that in future full MDAG minutes should be produced immediately following meetings and published on the Department's website once agreed by MDAG members. The Group indicated their agreement to this.

Agenda Item 3 – Update on Action Points.

6. Sean Holland provided an update on the open action points arising from previous meetings. He advised that the Belfast Trust will provide an update on their engagement with the East London Foundation Trust at the next scheduled MDAG meeting. He noted that the Department had arranged a meeting with the HSCB to agree the way forward for the resettlement programme, and advised

that members would be provided with an update on this at the next MDAG meeting.

7. He noted the report on the evidence for the effectiveness of CCTV in care homes had been circulated to members and updated members on the Belfast Trust's contact with the relatives of patients involved in the Ennis report. He asked that the Belfast Trust update the group of the listening event planned for families following publication of the Leadership and Governance Review be brought to the next MDAG meeting. He further asked that an update as to progress of the Regional Contingency Plan also be brought to the next meeting.

Agenda Item 5 - Implementation of Leadership and Governance Review recommendations

8. Seán Holland provided a summary of the recommendations from the Review report and members agreed that these are monitored through MDAG by adding to the current HSC action plan.

Agenda Item 6 – Update on MAH staffing position

9. The Chair asked for an update on this agenda item pending David Bingham joining the meeting. Patricia McKinney advised that as of 31st August 2020 there are 30.82 whole time equivalent registered Learning Disability nurses (Band 5-7 inclusive) and 100.08 whole time equivalent Nursing assistant (Band 3) substantive staff in MAH (inclusive of Maternity leave and Sick leave).

10. The Trust have secured a 12 month commitment from the agency who provides the largest number of registrants on site for 50 whole time equivalent registrants, and have worked with the Belfast Trust nurse bank to secure this commitment which will help to maintain and sustain services over the Winter and into next year.

11. Recruitment is continuing with eight band 5 registrant posts offered in recent recruitment exercises. Four staff have started and a further one will start in early September.

12. Patricia also updated members on arrangements instigated by the Nursing and Midwifery Council (NMC) to support the pandemic response which allowed nursing students to opt in to join the workforce in a paid capacity for their final 6 months, whilst still retaining their student status. The Department of Health issued guidance to employers that students who opted in to the paid arrangements should be remunerated at Band 4 (AfC). They were also supported in their learning during this time. The feedback from the students was very positive. It was also clear from feedback from the teams that these students were very valued by them. There were 7 transition students in MAH. Four of the students were subsequently offered posts in the hospital and are included in the numbers above.

Agenda Item 4 – Leadership and Governance Review briefing

13. David Bingham joined the meeting to provide members with a briefing on the report of the Leadership and Governance review. He summarised the methodology the panel used in their review and also the key findings, which were that vulnerable patients and their families were failed by the hospital which operated as a place apart out of the line of sight of the Trust, the Muckamore hospital management team was dysfunctional, the Ennis report was a missed opportunity to identify institutional abuse, Trust governance arrangements were ineffective and advocacy arrangements lacked independence.

14. Sean Holland welcomed the briefing and invited members to raise any questions.

15. Family representatives indicated they had found reading the report to be very distressing and expressed concern that senior Trust staff were not being held to account for the failings identified. They considered that the findings were further evidence that people with learning disabilities were not regarded as a priority by health and social care services. One of the family representatives asked Group members for their views on the report's findings.

16. Sean Holland advised he was ashamed to be associated with what had happened at the hospital, and stressed the need for real changes to address these issues. He noted in particular the findings in relation to shortcomings in adult safeguarding arrangements and also referenced similar findings emerging from reports on Dunmurry Manor.

17. Charlotte McArdle acknowledged the report made difficult reading, and felt the same feelings of shame, devastation and anger described by Sean Holland. Charlotte commented that with hindsight of course things could have been different and committed to learning the lessons and making necessary changes. Charlotte said as a mother and sister it was by luck that she was not standing in the relatives' shoes of people in Muckamore Abbey Hospital. She also stressed the importance of addressing perceptions that people with learning disabilities were viewed as a lower priority for HSC services.

18. Another family representative expressed frustration with difficulties in making contact with senior Trust staff which contributed to a breakdown in trust between families and hospital staff. Concerns were also expressed that incidents were continuing to occur at the hospital, and that families were not being involved in planning for the future direction of the hospital.

19. Sean Holland noted the concerns raised, and indicated he would be willing to discuss these further with family representatives in a separate meeting.

AP1: Meeting to be arranged between Sean Holland, HSCB and MDAG family representatives (Action: DoH).

20. Marie Roulston on behalf of the Health and Social Care Board expressed empathy with families on the content of the report, and advised she had shared with Trust Directors of Social Work to ensure the lessons it contained on working with vulnerable adults were disseminated across all services. She reiterated the commitment of the HSCB to work with the Department and Trusts to ensure all necessary changes were implemented.

21. Rodney Morton acknowledged the report was painful for families and that it indicated nurses had let patients down, and extended an apology for that. He

stressed the importance of independence in delivering effective advocacy, and asked whether the panel had identified any measures which might strengthen this.

22. David Bingham advised that the panel had found that advocacy arrangements in place at the hospital had been directed primarily towards facilitating resettlement, and suggested contracts between the Trust and advocacy organisations be reviewed to ensure conflicts of interest are avoided.

23. Family representatives indicated they had raised this issue repeatedly with the Trust and the HSCB without success, and suggested that each patient should have an independent advocate.

24. Tracy Kennedy advised that the report's content had been shared with all staff on site through a number of briefing sessions, and that all staff had been directed to the full report published on the Department's website. A summary had also been circulated to staff who were not at work. She expressed an apology for past failings at the hospital, and advised that the Trust were working to ensure there would be no recurrence of these across the Trust's Learning Disability services.

25. Sean Holland advised members that the Minister was considering the review's findings, and had signalled his intention to meet again with patient's families. Arrangements for this were being made.

26. The family representatives asked whether a decision had been made on a public inquiry, and Sean Holland advised that the Minister wished to consult further with families on the appropriate form of inquiry.

27. The family representatives asked about arrangements for family and carer involvement in planning decisions and advised that many families and carers had become disillusioned with arrangements to engage with them, pointing to limited family involvement on the Trust Carer's Forum as evidence of this.

28. Vivian McConvey acknowledged the difficulties, and suggested that a one-to-one approach tailored to individual's wishes might help to deliver improved

levels of engagement. She advised she would dedicate a member of the Patient Client Council staff to this work with the aim of working with families to develop a plan for effective advocacy arrangements at the hospital. The family representatives indicated they would be willing to support this approach, and Vivian advised she would implement this through contact with the MDAG family representatives initially.

AP2: Contact MDAG family representatives to agree implementation of plan to improve advocacy arrangements at the hospital (PCC)

29. Tracy Kennedy advised the hospital team on site were willing to engage with families and carers in whichever forum was preferred by families and carers.

30. Marie Roulston stressed the importance of effective engagement arrangements being in place across all Learning Disability services, including services for children with disabilities, and Siobhan Rogan made the point that any such arrangements must also make provision to facilitate input from patients.

31. David Bingham advised that the panel had queried whether the current ownership of Muckamore Abbey Hospital by the Belfast Trust was the optimal arrangement, and also whether the predominantly medical model of services in place at the hospital was the appropriate one in the future.

32. Sean Holland thanked David Bingham for his briefing and for the work carried out by the independent panel. He indicated that the remaining items on the meeting agenda would be carried forward for consideration at the next MDAG meeting, which will be held on 28th October.

Summary of Action Points

Ref.	Action	Respon -sible	Update	Open/ closed
2/09/AP1	Meeting to be arranged between Sean Holland,	DoH		

	HSCB and MDAG family representatives			
2/09/AP2	Contact MDAG family representatives to agree implementation of plan to improve advocacy arrangements at the hospital	PCC		

HSCB / PHA Quality, Safety and Experience Group Meeting
Wednesday 3 February 2021 at 2.00pm

Via Video/Tele Conference dial - 9028 9536 1551 –
Meeting space number: 3362152# or via
pexip: 3362152@hscni.net

AGENDA

Apologies: Louise McMahon

1.	**Matters Arising from Action Log:** Any actions from action log will be under agenda item 8.	Refer to item 8 below
2.	**Improvement Plan for SAI Process –** *Denise Boulter / Anne Kane*	**Paper to follow**
3.	**Normal Standing Items brief updates:** a. Update on the Regional Falls Group – AM Phillips b. Update on Regional Pressure Ulcer Prevention Group – *AM Phillips* c. QIP Report – AM Phillips d. Update on 10,000 voices – L Craig • You and Your Experience of Mental Health Services During COVID-19 Pandemic" **(attached)** • Your experience of Mental Health Services – Regional report **(attached)** e. Update on Quality 2020 • Draft 2020/21 Quality Report f. Child Death Notification Process Report – J McClean / H Reid g. HSCQI Update	*Verbal Updates*
4.	**New Items from SAI Review Sub-Group / Professional Groups** a. Request received from RQIA Inspector in relation to two Acute level 1 SAIs (HSCB ID 18947 and 18836) – D Boulter b. Trust's Response Re Level of Review - Trust Ref: 127058 / HSCB Ref: S18999 – B Quinn c. RQIA input to SAI process – A Kane/B Quinn d. Trust Response to DRO Queries - Trust Ref: SET42.20 HSCB Ref: SE18157 – D Boulter e. Recommendation for the HSCB/PHA from the Review of Leadership & Governance at Muckamore Abbey Hospital – B Quinn f. Request for indemnity for independent review panel members	**Attached** **Attached** **Attached** **Attached** **Attached** **Attached**
5.	**New Items from Regional Complaints Sub-Group:**	

	a. HSC Complaints Update for QSE	**Attached**
6.	**New Items from SQAT** a. AoB - Okenden Report 10th Dec 2020 into Maternity Care - Shewsbury and Telford - *AM Phillips* b. New Assurance Process for SQAs – 3 month pilot – *D Boulter*	 **Attached** **Verbal update**
7.	**Report for Nomination of Leads and Oversight Groups to oversee Implementation of Report Recommendations:** a. RQIA Review of Nice Clinical Guideline 174, Intravenous (IV) Fluid Therapy in adults in hospitals in Northern Ireland b. MBRRACE-UK perinatal mortality surveillance report: UK perinatal deaths for births from January to December 2018	 **Attached –** Lead and oversight group to be assigned

8. Review of Action Log

Item No	Title	Date Item first referred to QSE	Most recent action agreed at QSE	Person/s Responsible	Action Log Page Number	Attachment or Update
a.	**Updates to SAI Procedure**	**04.07.18**	**Update 1 July 2020** – An update was included in packs noting that following a level 3 SAI review it was identified that a review of the SAI procedure document (not the process) was required to simplify the document to make it easier to read and also to improve the patient/family aspects of it. This was commenced however due to work on IHRD and RQIA on reviewing SAI's this was put on hold until these reviews were complete. It was noted that as part of learning from the Covid-19 pandemic it is felt that the process in itself may need to be reviewed and simplified including such aspects as: • Level of review • DRO input to include ability to insist on change of level • Family engagement • Statement of patient rights • Mechanism for escalation of capacity issues and identification of the mitigation Following discussion, members agreed this should be formulated into a new SAI Operational Framework which would be taken forward at a workshop to be held in place of the September QSE meeting and would be reviewed at the October QSE meeting. **Update 03.02.21** – Propose closure of this item on the action as this is incorporated within the Improvement Plan.	**Anne Kane / Denise Boulter**	3	

Item No	Title	Date Item first referred to QSE	Most recent action agreed at QSE	Person/s Responsible	Action Log Page Number	Attachment or Update
b.	**Capacity Issues Reported as SAIs/EAs**	**04.09.19**	**Update 1 July 2020 –** An update was included in packs noting it had been identified that a number of SAI notifications related to capacity/commissioning. It was further noted a Thematic review of "waiting list issues" reported through the SAI process had been prepared by Mary Hinds however was currently in draft due to other work commitments related to covid-19. Following discussion it was agreed: • Denise to discuss with Mary Hinds and Lisa McWilliams with a view to issuing of the final report. • Margaret to link with Mary to obtain listing of SAIs included as part of the report to be linked back to the Datix records. • New SAI Operational Framework to incorporate Mechanism for escalation of capacity issues and identification of the mitigation	**D Boulter**	4	For discussion
C.	**Review of Terms of Reference**		**Update 5 August 2020**: The workshop will now take place on Wednesday 7 October 2020. Lagan Valley Island Conference Centre is the proposed venue – Denise Boulter to confirm. Invitation to the workshop will be widened to include members from all relevant HSCB and PHA Safety and Quality related groups. Members approved the template Grainne Cushley had prepared and it was agreed the template will be issued to the following groups./areas for completion • SQAT • SAI Review Group	**Grainne Cushley**	5	

Item No	Title	Date Item first referred to QSE	Most recent action agreed at QSE	Person/s Responsible	Action Log Page Number	Attachment or Update
			• Professional Groups. • Complaints Group • 10,000 voices • QIP, Pressure Ulcer and Falls Groups • Q2020 • HSCQI • Child Death Notification – Sinead/Heather/Joanne • Safeguarding Process – Joyce McKee **Update 07.10.20 -** Due to the increasing number of Covid cases it was agreed to put the proposed workshop on hold until further notice. **Update 03.02.21** – Propose closure of this item on the action as this is incorporated within the Improvement Plan.			
d.	**Update on SAI process**	**01.07.2020**	**Update 5 August 2020:** The Chief Executive letters highlighting the outstanding reports as at June 2020 have been issued to Trusts. An overview was included in member's packs. The letters also included the following: • Outstanding Terms of Reference for level 2/3 SAIs. • Request for submission of an action plan to address current backlog • BHSCT were asked to include names of membership of review panels for level 2 and 3 SAIs Anne advised a mechanism whereby the new Incident Review Group might be involved in regional coding on DATIX	**D Boulter** **A Kane**	6	

Item No	Title	Date Item first referred to QSE	Most recent action agreed at QSE	Person/s Responsible	Action Log Page Number	Attachment or Update
			will be discussed at the next weekly incident review meeting. **Update 03.02.21** – Propose closure of this item on the action as this is incorporated within the Improvement Plan.			
e.	**Initial Scope of Enteral Feeding Incidents – Possible Thematic Review**	**01.07.2020**	Due to time constraints this item was not discussed and will be relisted for the October meeting due to number of items pending for the August agenda and the dedicated workshop in place of the September QSE meeting.	**D Boulter**	7	For discussion
f.	**Possible Campaign - Patients responsibility to check on test results and appointments especially if outstanding for a long period of time**	**01.07.2020**	Due to time constraints this item was not discussed and will be relisted for the October meeting due to number of items pending for the August agenda and the dedicated workshop in place of the September QSE meeting.	**D Boulter**	7	For discussion
g.	**AoB – Security of Wards at Night**	**01.07.2020**	Due to time constraints this item was not discussed and will be relisted for the October meeting due to number of items pending for the August agenda and the dedicated workshop in place of the September QSE meeting.	**D Boulter**	7	For discussion
h.	**Independent Review S10617 - SHSCT SAI 69712** –	07.10.20	Briege Quinn in referring to the paper included in packs provided a briefing on this incident. Following discussion, it was agreed (1) QSE would relist this as a substantive item to have oversight of progress on the independent review report action plan; (2) Newly appointed PHA and HSCB Chief Executives to be briefed on the SAI.	**B Quinn**	7	**Attached** – email from J Burns Briege Quinn to attend the meeting for this item

Item No	Title	Date Item first referred to QSE	Most recent action agreed at QSE	Person/s Responsible	Action Log Page Number	Attachment or Update
i.	**Briefing Paper - Introduction of Domestic Homicide Reviews In Northern Ireland**	07.10.20	– Joyce McKee in referring to the paper included in packs briefed members on the Introduction of the Domestic Homicide Reviews which is due to come into force within Northern Ireland . It was noted the Department of Justice is currently finalising detailed multi-agency guidance for the conduct of DHRs in Northern Ireland. The purpose of the paper is to brief SMT/AMT on key elements of that guidance, the interfaces between DHRs and existing review and learning processes, and to highlight where some adjustments to those processes may be required. It was noted the introduction of Domestic Homicide Reviews in Northern Ireland fulfils both a statutory requirement under section 9 of the Domestic Violence, Crime and Victims Act (2004) and meets a key commitment of the Stopping Domestic and Sexual Violence and Abuse Strategy (2016). The learning that can be identified through these Reviews will provide significant opportunities to prevent further deaths or serious injury and to improve services designed to support victims of domestic abuse or violence. The HSCB/PHA will be expected to contribute fully to this process. Following discussion, it was agreed to add this to the list of pending issues to be taken into consideration when reviewing the SAI procedure. Joyce agreed to discuss with Anne Kane best way to take forward and if SMT should be requested to expedite the approval of the DHR pending the review of the SAI procedure.	**J McKee**	8	For discussion

Item No	Title	Date Item first referred to QSE	Most recent action agreed at QSE	Person/s Responsible	Action Log Page Number	Attachment or Update
j.	**Proposed new HSCB/PHA Safety Strategy**	07.10.20	It was noted a meeting had been held with the DoH on Monday 5 October. It is the view of the PHA Director of Nursing that all strands of safety and quality need to be looked at and not just SAIs to form a HSCB/PHA safety strategy. Following discussion, Grainne Cushley agreed to commence developing a first draft of the strategy in consultation with Margaret McNally.	**D Boulter**	8	Verbal Update

9. Any Other Business

10. Date, Time and Venue of next meeting: To be discussed.

Agenda

Meeting re SAI Improvement Plan between HSCB/PHA & BHSCT

Monday, 22nd March 2021 @ 12noon

Zoom Link:

https://hscni-net.zoom.us/j/82754598583?pwd=RlR4aXdTZ2hxNmE4R28xQzFsaG04Zz09

1. Overview of Data / Outstanding Information:

    a) Outstanding SAI reports (attached)
    b) Outstanding TOR (attached)
    c) Outstanding assurances on Safety and Quality Alerts (attached)
    d) Outstanding Response to queries / requests for information (attached)
    e) Production of a Trust SAI/Assurance improvement plan
    f) Monthly SAI/Assurance Performance Meetings – nominations required

2. HSCB recurring issues:

    a) Early alerts to be reported as SAIs
    b) Level of SAI review to be changed
    c) Amendments to ToR / Reports
    d) Regional Recommendations / Actions included in review reports without prior agreement with relevant organisations
    e) Capacity issues being reported as SAIs

3. Engagement with service users, families/carers and victims throughout SAI Reviews (attached)

4. Process for informing Trust Board on SAI/Early Alert issues

5. Covid19 Outbreak SAIs (attached)

6. Recommendation of training for staff in relation to the importance of record keeping in the context of SAIs

7. Trust Issues to be raised with HSCB/PHA

8. AOB

MUCKAMORE ABBEY HOSPITAL HSC ACTION PLAN

October 2021

INTRODUCTION

The independent Serious Adverse Incident (SAI) review report into safeguarding at Muckamore made for stark reading. It exposed not only significant failings in the care we provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities. In short, it told us that, while we have achieved much through Bamford, there is much more we need to do.

This is our response, and sets out exactly what we now must do. It recognises that the events at Muckamore have caused much distress for the patients receiving treatment in the hospital and their families and carers, and has also damaged wider public confidence in how the HSC system provides care, treatment and support to people with a learning disability and their families. The measures set out in this document are intended to address the issues that the SAI report highlighted, but also to provide wider assurance to society that the HSC system is working together in a co-ordinated way to make life better for people with a learning disability.

As the Permanent Secretary made clear when he met with all HSC Chief Executives in January this year, we must effect lasting change, with reference to every single recommendation in the SAI report. It is right that this report acts as our barometer, and the success of our efforts should be measured against it.

This document therefore sets out what we are doing and plan to do in response to its call to action. Specifically, it reiterates the overarching recommendation of the report endorsed by the Permanent Secretary that Muckamore must return to being a hospital not a residential facility. This will require a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs.

This timeline will be monitored closely by the Muckamore Departmental Assurance Group, which will include representation from the HSCB, PHA, RQIA, the 5 Trusts, professional representatives, specialist accommodation providers, appropriate academic expertise and importantly the families of patients, which will also ensure the team in Muckamore and the wider community services have the necessary support and resources in place to achieve these goals. A first but critical step will be to develop and deliver enhanced services in the community to source, support and sustain people in the places where they live. This will be the key role of the Regional Learning Disability Operational Delivery Group led by the Health and Social Care Board.

However, this document also recognises that more actions will follow as we progress the co-production of a new service model for learning disability as part of our transformation agenda. When developed, this will bring with it a new set of actions to consult on and implement.

We are also conscious that the police investigation into the unacceptable events at Muckamore Abbey Hospital is still ongoing. We await the outcome of that investigation and will be ready to take any additional actions to ensure that lessons are learned and put into practice across the full spectrum of learning disability services in Northern Ireland.

In this context this plan should be considered a live document which will be subject to ongoing review and development to drive further and emerging improvements to current practice.

INDEX

RAG Rating	
Completed	
Work in progress	
Progress required	

SECTION A

COMPLETED ACTIONS

Permanent Secretary commitments						
PS1		**HSCB / PHA**	**A3**	By **March 2021**, complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes.	**Acute Care Review**	
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**DOH**	**A4**	By 31 **August 2019**, establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming Minister) that the	**Governance**	

				resettlements commitments and recommendations of the SAI report are met (see full governance structures associated with this plan at **Annex A**).		
PS1		**DoH/DoJ**	**A9**	By **31 December 2019,** provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.	**Governance**	
PS1		**HSCB/HSC Trusts**	**A10**	By **30 December 2020**, review current forensic LD services, identify and address service development needs to support people in community settings.	**Service Model**	
SAI Independent Review Panel recommendations						
R1.	Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which	**HSCB/PHA**	**A11**	By **December 2020,** deliver a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time, in the right place; along with a costed	**Service Model**	

R.2	understand that ordinary lives require extraordinary supports – which will change over the life course. An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle			implementation plan, which will provide the framework for a regionally consistent, whole system approach. This should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on implementation. **Postscript-October 2021** The 'We Matter' final draft Learning Disability Service Model was formally presented to the DoH on 5 October for consideration.		

	cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.					
	Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community	**HSCB/HSC Trusts**	**A15**	By **30 June 2020** review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex needs.	**Accommodation**	

	services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.					
		HSCTS	**A16**	By **31 December 2019** address security of tenure of people with a learning disability living in supported housing.	**Accommodation**	
		HSCTs	**A17**	By **31 March 2020** complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD.	**Accommodation**	
SAI Patients families recommendations						

R3	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	**Belfast Trust**	**A18**	Appoint a carers consultant and co-produce a communications strategy with parents and carers. **Completed**		
R4.	Families and advocates should be allowed open access to wards and living areas.	**Belfast, Southern and Western Trusts.**	**A19**	Co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey).	**Service Model (Assessment & Treatment)**	
R5.	There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	**Belfast, Southern and Western Trusts.**	**A20**	By **30 June 2020,** carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.	**Service Model (Assessment & Treatment)**	
R6.	The use of seclusion ceases.	**Belfast, Southern and**	**A21**	By **31 January 2021,** complete an urgent review of seclusion policy and practice in MAH (and	**Service Model (Assessment &**	

		Western Trusts.		Lakeview and Dorsey), to inform wider consideration of regional policy, and share outcomes with families.	**Treatment)**	
R6.	The use of seclusion ceases.	**DOH**	**A22**	By **March 2021,** develop a co-produced and publish regional seclusion and restraint policy/guidance**.**	**Governance** **(Mental Health Action Plan)**	
R8.	People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.	**Belfast Trust**	**A24**	By **31 December 2019,** review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are fully involved, taking account of lessons emerging from Independent Review into Dunmurry Manor.	**Service Model**	
R9.	The Hospital's CCTV recordings are retained for at least 12 months.	**Belfast Trust**	**A25**	By **31 October 2019,** liaise with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation.	**Governance**	

R11.	Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	**Belfast Trust**	**A27**	By **31 October 2019,** provide an information booklet to families on the complaints process.	**Governance**	
R12.	Families receive regular progress updates about what is happening as a result of the review.	**Belfast Trust**	**A28**	By **31 October 2019,** a schedule of Trust meetings with families will be produced and circulated to families.	**Governance**	
SAI Senior Trust staff recommendations						
R16.	A shared narrative is set out.	**HSCB/ PHA/HSC Trusts**	**A33**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set out the road map for regional adult learning disability services in the future.	**Service Model**	
R17.	Commissioners specify what "collective commissioning" means.	**HSCB**	**A34**	By **March 2021,** HSCB to write to BHSCT outlining the current position and status of commissioning for HSC	**Governance**	

				Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor.		
R18.	The transformation required in learning disability services must be values driven and well led.	**HSCB/ PHA/HSC Trusts**	**A35**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with people with learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.	**Service Model**	
R19.	The purpose of all our services is clear.	**HSCB/ PHA/HSC Trusts**	**A36**	By **December 2020,** the LD Service Model Transformation project will inform the development of a regionally consistent model for community and acute services and will provide clarity around purpose.	**Service Model**	
R23.	Trusts and Commissioners must be knowledgeable about the	**HSCB/ PHA/HSC Trusts**	**A42**	By **December 2020** the LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning	**Service Model**	

	"user experience" and that of their families.			disability, carers, and families. The future model for LD services will be designed around their aspirations, and will ensure effective structures are in place on an ongoing basis to fully operationalise this commitment.		
R24.	Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.	**DoH/HSCB/ PHA/HSC Trusts**	**A43**	By **December 2020,** all parts of the HSC will have been involved in the development of the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent, whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.	**Service Model**	
LG4	The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought	**HSCB/PHA**	**A47**	This was taken to HSCB/PHA Quality, Safety and Experience meeting on 3/2/21.QSE were asked to discuss potential mechanism to seek Trust assurances. It was agreed that this will be listed for discussion at the quality, safety and		

	to the attention of the Trust Board.			experience meeting with Trusts.		
LG5	Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.	**HSCB/PHA**	**A48**	This work has been actioned by HSCB and is progressing and is being led by the Governance Lead in HSCB.		

SECTION B

RESETTLEMENT

Permanent Secretary commitments						
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**HSC Trusts**	**A1**	By **30 November 2019** carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing contingency plans for their patients, including updated discharge plans for each individual assessed as medically fit for discharge, with a target date for the individuals' discharge, a timeline to deliver appropriate high quality placements matching each individual's assessed needs and identifying any barriers to discharge. **October 2021 Update** No change. Monthly community integration meeting hosted by HSCB continues to meet to progress discharge planning	**Resettlement**	

				and to identify discharge dates.		
PS1		**HSCB/HSC Trusts**	**A2**	By **30 November 2019** develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge. **Linked to A1.** **October 2021 update** Resettlement plans continue to be monitored as per the Community Integration Programme (CIP) meetings, Delegated Statutory Function - DSF Review meetings and updates at the Regional Learning Disability Operational Delivery Group (RLDODG). No change re August position. Each Trust has provided detailed plans via the DSF process.	**Resettlement**	
PS1		**DoH/HSCB/HSC Trusts**	**A7**	By **30 September 2020,** in conjunction with DfC/DoF and housing providers, identify	**Resettlement**	

				barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability. **October 2021 update** HSCB continues to work with the HSCTs and NIHE to remove barriers to accommodation and develop bespoke solutions. Regional procurement meeting lead by HSCB and Social Care Procurement Unit (SCPU) have developed a draft communication strategy re bespoke accommodation options.		

SECTION C

WORKFORCE

Permanent Secretary commitments						
PS1		**DOH/HSCB/HSC Trusts**	**A5**	By **30 September 2021,** develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care e.g. Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by June 2022 deliver training to an agreed cohort of staff. **October 2021 update** Once approved the Learning Disability Service Model (LDSM) alongside the Community Based Assessment and Treatment work will have a focus on developing and upskilling the workforce.	**Workforce**	Rating changed from Amber to Red – date for delivery passed.

				JDs for all posts via Delivering Care Funding at 8A and below have been agreed. HSCB are finalising 8B Nurse consultant post JD. The electronic recruitment process has commenced.		
SAI Hospital Staff Recommendations						
R13.	An enhanced role for specialist nursing staff is set out.	**Belfast Trust**	**A29**	By **30 June 2020,** develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work. **October 2021 update** JDs for all posts via Delivering Care Funding at 8A and below are being agreed. As per above HSCB are finalising 8B Nurse consultant post JD.	**Workforce**	
		DOH	**A30**	By **September 2021,** complete a review of Learning Disability Nursing. **October 2021 update** Despite best efforts to keep the review on track it has been impacted by the pandemic, as	**Workforce**	

				unfortunately engagement events with some key stakeholders had to be postponed due to competing pandemic related demands. The review team are currently completing final stakeholder engagement – this will be completed by mid-October 2021.		
R20.	All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing.	**DoH**	**A37**	By **September 2021,** develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services. **October 2021 update** Funding for 2021/22 has been identified and a Project Co-Ordinator has been appointed, taking up post on 18 October 2021, to take this work forward. The Terms of Reference will now be finalised and membership of the working	**Workforce**	Rating changed from Amber to Red as date for delivery now passed.

				group is being considered. Nominations will be sought from HSCB, Trusts, voluntary sector, carers etc It is likely the first meeting of the Group will take place in January 2022. Funding for further years will need to be agreed as part of the 2022/23 budget process.		

SECTION D

TRANSFORMATION: [SERVICE MODEL; ACUTE CARE REVIEW; ASSESSMENT & TREATMENT]

Permanent Secretary commitments						
PS1		**HSCB/PHA**	**A6**	By **31 March 2022,** commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent review of acute inpatient care. **October 2021 update** Investments to date have supported the development of appropriate services and the community based assessment work will provide the strategic direction for the future delivery of Community Services.	**Assessment & Treatment**	
PS1		**HSCB/HSC Trusts**	**A8**	By **March 2021,** in the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher tariff placements which specifies what	**Service Model**	

				staff and service requirements justify a higher tariff. **October 2021 update** Regional Physical Disability Leads have scoped the existing processes regarding the allocation of enhanced tariffs. Further work is required to ensure a regionally agreed framework.		
SAI Senior Trust staff recommendations						
		HSCB/ PHA/HSC Trusts	**A38**	By **March 2022,** deliver community and home treatment services and support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in the community where possible and only in hospital when indicated/necessary. **October 2021 update** The Community Based Assessment Rehabilitation and Treatment (CART) Task and	**Service Model** **(Assessment & Treatment)**	

				Finish Group is ongoing. This is exploring the range of assessment and treatment options in the community using a tiered/stepped model of care approach. No further update from Trusts in respect of above workstream. Each Trust progressing their assessment and treatment models.		
R21. **R22.**	The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop. Time limited and timely Assessment and Treatment become the norm.	**HSCB/PHA/ HSC Trusts**	**A39**	By **31 December 2019** support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for learning disability services **October 2021 update** When the permanent 8B MHLD Bed Manager Post is appointed this work will form part of that role. No development on bed manager protocol. MAH accepted 2 new detained admissions and have no further capacity for new admissions	**Service Model** **(Assessment & Treatment)**	

				across any ward including regional forensics without further discharges.		
		HSCB/HSC Trusts	**A40**	By **30 November 2019**, appoint a regional bed manager for all 3 current in-patient units. **October 2021 update** The permanent 8B MHLD Bed Manager Post Job Description has been updated to include the interface between MH & LD. It is anticipated this post will be advertised early/mid November.	**Service Model** **(Assessment & Treatment)**	
		HSCB/PHA/ HSC Trusts	**A41**	By **March 2022,** taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation. This should include community based assessment and treatment, clear thresholds	**Service Model** **(Assessment & Treatment)**	

				for hospital admission and timely, supported discharge from hospital. (See Permanent Secretary commitments). **October 2021 update** The Community Based Assessment Rehabilitation and Treatment (CART) Task and Finish Group is ongoing. This is exploring the range of assessment and treatment options in the community using a tiered/stepped model of care approach.		

SECTION E

CHILDREN AND YOUNG PEOPLE

SAI Hospital Staff Recommendations						
		HSCB/PHA/ HSC Trusts	**A12**	By **March 2021** develop a regionally consistent pathway for children transitioning from Children's to Adult services, including: • People with learning disability and complex health needs. • People with Leaning disability and social care needs. • People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours. **October 2021 update** The issue of transition has been agreed as one of the four priority themes in the Disability Framework developed by the HSCB with the 5 Trusts. This	**Children and Young People**	

				paper has been submitted to DoH.		
		HSCB/PHA/ HSC Trusts	**A13**	By **31 December 2020** finalise and develop a costed implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services required to support them into adulthood. **October 2021 update** Interviews for post to support implementation of EHWB Framework will take place in October.	**Children and Young People**	
		HSCB/PHA/ HSC Trusts	**A14**	By **31 December 2020** review the needs of children with learning disability that are currently being admitted to Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional	**Children and Young People**	

				review of children's residential services. **October 2021 update** Disability Framework has been submitted to DoH. Monthly meetings occur between Trusts/HSCB and Iveagh to focus on Operational Policy and delayed Discharges. Draft of new strengthened Operational Policy has been developed.		

SECTION F

GOVERNANCE

SAI Patients Families Recommendations						
R10.	Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	**Belfast Trust**	**A26**	By **30 November 2019** develop an information paper and share with families and staff. **October 2021 update** This work is continuing	**Governance**	

SECTION G

SAFEGUARDING

SAI Patients families recommendations						
R7. **R.14**	The perception that people with learning disabilities are unreliable witnesses has to change. Responses to safeguarding incidents and allegations are proportionate and timely.	**Belfast Trust**	**A23/A31**	By **30 June 2020,** complete a review of Adult Safeguarding culture and practices at MAH, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **October 2021 update (DoH ASG Team)** CPEA recommendations included a major adult protection change programme in N. Ireland and consideration of an Adult Protection Bill. This work is being led by the DoH with the introduction of a new Adult Protection structure in N. Ireland.	**Safeguarding**	

				The Adult Protection Transformation Board, chaired by the Chief Social Work Officer, has been established and BHSCT are represented on this Board. The Transformation Board meets monthly. An Interim Adult Protection Board (IAPB) was established in February 2021 and an IAPB update is now a standing item on the Transformation Board agenda. DoH undertook a public consultation to inform the development of the Adult Protection Bill. The purpose of the new legislation is to introduce additional protection to strengthen and underpin the adult protection process. The consultation was open for 16 weeks (17 December 2020 to 8 April 2021). An Analysis Report of responses, along with a policy paper outlining our final proposals for the way forward, have been published to the DoH website. The intention is to bring the draft		

				Bill forward early in the next mandate. The BHSCT will be guided by the Transformation Board and the IAPB regarding the priority actions to be taken forward. Trust have advised there is no further update.		
		HSCB	**A32**	By **December 2021,** carry out a review of regional Adult Safeguarding documentation, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **October 2021 update** Draft membership and work-plan of the Procedures (Joint Protocol) Sub-group now drawn up and work to commence.	**Safeguarding**	

SECTION H

Leadership And Governance Review Recommendations						
LG1	The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.	**DOH**	**A44**	By March 2022, complete a review of the accountability arrangements for DSF. The HSCB are developing an outcomes based reporting template which will be the first stage of this process. In preparation for the Social Care Directorate moving into the Department following the closure of the HSCB in 2022, a review of the accountability arrangements for DSF will be undertaken.		
LG2	The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and	**DOH**	**A45**	The Department has carried out a fundamental review of the 2003 Order and the existing regulatory framework and has developed a new draft regulatory policy that includes the principles of regulation, along with the broad scope of services to be regulated and the		

	inspecting all hospital provision.			proposal that the regulator should have wider powers of enforcement etc. This work has been the first phase of the process before moving on to phase 2, which will include the risk assessment of each provider type and consider the appropriate regulatory approach, including the range of enforcement and sanctions. Phase 2 will result in a clear regulatory framework and legislation and this framework will reflect Departmental Policy. After restoration of the Assembly in January 2020, the Minister approved on 2 July 2020 the Consultation on Phase 1 of the Review of 2003 Order and the current Regulatory Framework, which would involve the proposed policy being launched for public consultation for a period of 16 weeks to allow sufficient time to engage with		

				service users/providers/public during the current pandemic and its associated restrictions in terms of social distancing. As part of the Department's continued response to the pandemic the Departmental Top Management Group (TMG) decided to reactivate the Department's Business Continuity Plan in Autumn 2020. As a result the launch of the consultation was delayed. A review of regulation will be taken forward in due course. Unfortunately definitive timescales cannot be set. Whilst such a review remains a priority for the Department, there is a need for the parameters for such a review to be set and there will then be the need for engagement with the Health and Social Care Service to learn from and take into account experiences over the past 18 months.		

LG3	The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.	**DOH**	**A46**	By June 2021, develop in partnership with patients, relatives and carers a plan for the future configuration of services to be delivered on the Muckamore Abbey Hospital site, including appropriate management arrangements. **October 2021 update** Work is continuing on exploring the potential for on-site resettlement provision at MAH and a meeting between the DoH and BHSCT is due to be held on 21 October to discuss next steps. Engagement is also continuing with the HSCB and Trusts on actions to help enhance processes around resettlements.		
LG6	Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.	**HSCB/PHA**	**A49**	**October 2021 update** From a nursing perspective a Task and Finish was established and had discussed a number of options for KPIs. Due to COVID progress has been slower than anticipated. An external advisor is currently		

				being sought to support the development of the KPI and this work will be completed by March 2022. It is anticipated that the 5 Learning Disability Nurse Consultants will progress this work when appointed. The wider Care Sensitive indicators which will include MDTs will be set in the context of the wider service indicators included within the LDSM, the Community Based Assessment and Treatment Model and the new Restraint and Seclusion policy being developed by DoH.		
LG7	The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.	**Belfast Trust**	**A50**	By January 2021, complete disciplinary action in respect of first 7 individuals whose cases have been forwarded by PSNI to PPS. Action against a further 9 individuals will commence when PSNI confirm their cases have been forwarded to PPS. **October 2021 update** Disciplinary action is continuing in line with employment law regulations.		

LG8	The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.	**Belfast Trust**	**A51**	A Co-Director for Learning Disability services was appointed in June 2020. The dedicated Divisional Nurse post remains and a dedicated Service Manager and two permanent dedicated Assistant Service Managers for the hospital have been appointed. Substantive appointments at Band 7 and Band 6 Ward Manager and Deputy Ward Manager level are being progressed. The Interim Director for Learning Disability Services will review the existing managerial arrangements as part of the Chief Executive's overall review of Directorate and Divisional structures which will take place in 2021. **October 2021 update** The current divisional nurse has been successful in a promotional opportunity, and the LD divisional a nurse post is being advertised.		

LG9	Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.	**Belfast Trust**	**A52**	By March 2021, complete a review of advocacy services. The Trust is engaging with representatives of Families Involved Northern Ireland (FINI) to develop Terms of Reference for a review of its advocacy arrangements. **October 2021 update** Two reviewers have been sourced, a meeting has been arranged in October to commence this work.		
LG10	The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.	**Belfast Trust**	**A53**	The Trust have engaged with Mr B and written to him in an attempt to address his outstanding concerns. The resolution of these concerns is ongoing at this time and while every effort will be made to progress the investigation into the outstanding issues of concern, it is not at this stage possible to provide a definitive completion date. **October 2021 update**		

				No further update		
LG11	In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.	**Belfast Trust**	**A54**	CCTV is currently used to inform and amend staff practice. Contemporaneous CCTV footage is independently viewed and the accounts of this footage, which reflects good practice and highlights any areas for concern, are shared with staff. Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site. These questionnaires specifically asked for views on the proposed extension of the use of CCTV into areas such as training and practice development. Feedback from the questionnaires will inform next steps. **October 2021 update** No further update		

LG12	The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.	**Belfast Trust**	**A55**	The Trust Chief Executive is responsible for holding Trust Directors to account for achievement against their objectives, which are set on an annual basis and reviewed monthly (these are modified as issues arise). Directorate and Divisional management priorities, which are set, reviewed and reported on quarterly, are also in place as a framework for accountability. This is being supported by a developing quality management system (QMS) which will provide a comprehensive overview of the performance of the Directorates and Divisions across a range of agreed metrics. The transparency of performance articulated via the quality management system will facilitate the Trust Board to provide ongoing challenge throughout the year, rather than being responsive to issues		

				escalated to it.		

GLOSSARY OF TERMS

HSC – Health and Social Care

DoH – Department of Health

DfC – Department for Communities

DoF - Department of Finance

HSCB – Health and Social Care Board

PHA – Public Health Agency

RQIA – Regulation and Quality Improvement Authority

BHSCT – Belfast Health and Social care Trust

NHSCT – Northern Health and Social Care Trust

SEHSCT – South-Eastern Health and Social Care Trust

SHSCT – Southern Health and Social Care Trust

WHSCT – Western Health and Social Care Trust

MAH – Muckamore Abbey Hospital

SAI – Serious Adverse Incident

Bamford – the Bamford Review of Mental Health and Learning Disability in Northern Ireland

LD – Learning Disability

NIHE – Northern Ireland Housing Executive

PBS - Positive Behaviour Support

RAID - Risks, Assumptions, Issues and Dependencies

ASG – Adult Safeguarding

PiPA - Purposeful Inpatient Admissions *Model*

MAPA - Management of Actual or Potential Aggression

Date of Meeting: 4 July 2018

Attendees: Mary Hinds (Chair), Anne Kane, Margaret McNally, Christine Armstrong, Patricia Crossan, Grainne Cushley, Jackie McCall, Brenda Bradley, Claire Buchner, Lisa McWilliams
Apologies: Joe Brogan, Brid Farrell, Joyce McKee, Mark Roberts, Lisa McWilliams, Liz Fitzpatrick, Mary McElroy

Date	Action No	Action Agreed	Person Responsible	Status
04.07.18	**3.4**	**Updates to SAI Procedure** • **Homicide protocol** – protocol to be updated to allow Band 8c and above to chair a review panel as opposed to Assistant Director Level. **Update 03 October 2018** – the core panel has been reformed for the homicide SAI in the southern Trust (Ref S10617) Christine Armstrong will provide support to this panel as required. • **Supporting families of victims when involved in homicide (linked to SAI S10617)** It was noted a meeting is being arranged to be held with Briege Quinn, Tony Black, Christine Armstrong and Anne Kane to look at revisions required to the Homicide protocol and the SAI engagement guidance with regard to supporting family of victims involved in a homicide Mary also noted that she had been in discussion with the SHSCT Chief Executive and there may be a further independent review of this SAI. **Update 03 October 2018** – the core panel has been reformed for the homicide SAI in the southern Trust (Ref S10617) Christine Armstrong will provide support to this panel as required. **Update 7 November 2018:** A letter has been issued to all Trust Chief Executives recommending interim guidance for them to follow regarding engagement with families including families of victims in the event of an SAI review involving homicide. **Update 3 October 2018** –it was agreed communication should be issued to Trusts in relation to the above	**A Kane/ J McKee** **A Kane with B Quinn C Armstrong** **A Kane** **A Kane** **A Kane** **Anne Kane**	**See update 09.01.19**

Date	Action No	Action Agreed	Person Responsible	Status
		once the above actions are complete and include the following topics: o Homicide protocol Supporting families of victims when involved in homicide) o Locum doctors – six monthly returns to HSCB – (*all relevant actions completed- removed from log)* o Laypersons removed from the SAI process - (*all relevant actions completed – removed from log)* **Update 6 December 2018:** It was agreed Anne Kane would draft a letter detailing the amendments to the SAI procedure for consideration at the January QSE meeting. **Update 06 February 2019: I**t has been agreed the SAI procedure will be reviewed during 2019. The letter to the Trusts detailing current amendments will not be issued now. Correspondence will be issued when the procedure has been reviewed. **Update 10 April 2019:** Item was deferred to next meeting **Update 5 June 2019** – It was noted the review of the SAI procedure is currently work in progress. **Update 3 July 2019** – Anne Kane and Denise Boulter are taking the review forward and will link in with the hyponatremia SAI workstream. Mary advised the service users involved in a recent level 3 SAI have expressed an interest in contributing to the review of the SAI Procedure. Anne Kane/Denise Boulter to link with them when procedure is further developed. **Update 4 September 2019:** Mary Hinds and Anne Kane advised the Review is ongoing. It was agreed part one will be completed by end of September with input from a service user. It is also hoped the SAI procedure will be web based in the future.	**Anne Kane** **Anne Kane** **A Kane** **A Kane** **C Armstrong** **Anne Kane / Denise Boulter**	**See update 09.01.19** **See update 10.04.19** **See update 05.06.19** **See update 03.07.19** **See update 04.09.19**

Date	Action No	Action Agreed	Person Responsible	Status
		Update 06 November 2019: The review of the SAI Procedure remains ongoing and interim work has taken place on some areas such as the family engagement. Other areas of work running in parallel i.e. outputs from the IHRD workstreams / changes to how level 3 reviews will be conducted and the RQIA review will inform the review of the SAI Procedure. It was agreed until this work has been completed it would not be possible to complete the full review of the SAI procedure. **Update 05 February 2020**: Denise advised the group that a lot of work has been carried out on the Review of the SAI Procedure by Anne Kane and Christine Armstrong, before her departure. She advised that work is ongoing however they are conscious that there may be recommendations from the number of reviews / areas of work currently ongoing, such as the RQIA review or the DoH request to review the process for Level 3 reviews **Update 1 July 2020** – An update was included in packs noting that following a level 3 SAI review it was identified that a review of the SAI procedure document (not the process) was required to simplify the document to make it easier to read and also to improve the patient/family aspects of it. This was commenced however due to work on IHRD and RQIA on reviewing SAI's this was put on hold until these reviews were complete. It was noted that as part of learning from the Covid-19 pandemic it is felt that the process in itself may need to be reviewed and simplified including such aspects as: • Level of review • DRO input to include ability to insist on change of level • Family engagement • Statement of patient rights • Mechanism for escalation of capacity issues and identification of the mitigation Following discussion, members agreed this should be formulated into a new SAI Operational Framework which would be taken forward at a workshop to be held in place of the September QSE meeting and	**Anne Kane / Denise Boulter** **Anne Kane / Denise Boulter**	

Date	Action No	Action Agreed	Person Responsible	Status
		would be reviewed at the October QSE meeting. **Update 03.02.21** – Members agreed to close this on the action log as this will be incorporated within the Improvement Plan.		**Mark Closed**

Date of Meeting: 04 September 2019
Attendees: Mary Hinds (Chair), Anne Kane, Brid Farrell, Brenda Bradley, Liz Fitzpatrick, Anne-Marie Phillips, Mark Roberts, Elaine Hamilton
In attendance: Sinead Magill
Apologies: Denise Boulter, Patricia Crossan

Date	Action No	Action Agreed	Person Responsible	Status
04.09.19	**2b**	**Capacity Issues Reported as SAIs/EAs** Members referred to example SAIs/EAs contained in papers which highlighted some service management and capacity issues. It was agreed SAIs/EAs which referred to capacity issues should be forward to Lisa McWilliams (PMSI) for Lisa to raise at Performance Management meetings with Trusts. **Update 05 February 2020**: Denise advised that she has forwarded the SAIs/EAs which referred to capacity issues to Lisa McWilliams. Denise noted that consideration will be given to how this information will be captured going forward and a regular reporting arrangement with Lisa McWilliams. **Update 1 July 2020 –** An update was included in packs noting it had been identified that a number of SAI notifications related to capacity/commissioning. It was further noted a Thematic review of "waiting list issues" reported through the SAI process had been prepared by Mary Hinds however was currently in draft due to other work commitments related to covid-19. Following discussion it	**Lisa McWilliams** **Governance Team to raise at all professional Group**	**Review next meeting**

Date	Action No	Action Agreed	Person Responsible	Status
		was agreed: • Denise to discuss with Mary Hinds and Lisa McWilliams with a view to issuing of the final report. • Margaret to link with Mary to obtain listing of SAIs included as part of the report to be linked back to the Datix records. • New SAI Operational Framework to incorporate Mechanism for escalation of capacity issues and identification of the mitigation **Update 03.02.21** – It was noted a weekly meeting with Directors is to be held to discuss safety issues/risks. It was agreed Lisa McWilliams, Rodney Morton and Marie Rolston will discuss a process for dealing with SAIs and Early Alerts reported in relation to capacity issues at their weekly meeting and report back to next QSE meeting. This will also be raised at meetings with Trusts.	**D Boulter** **M McNally** **D Boulter/ A Kane** L McWilliams, R Morton and M Rolston	

Date of Meeting: 1 July 2020

Attendees: Rodney Morton (Chair), Patricia Crossan, Denise Boulter, Anne Kane, Lisa McWilliams, Brid Farrell, Anne-Marie Phillips, Margaret McNally, Grainne Cushley, Linda Craig,

Apologies: Mark Roberts, Liz Fitzpatrick, Marie Rolston, Joe Brogan, Hugo Van Worden,

Note: Joyce McKee and Brenda Bradley attempted to join the meeting but due to connection problems were unable to join the meeting

Date	Action No	Action Agreed	Person Responsible	Status
01.07.2020	**2b**	**Review of Terms of Reference** – A copy of the current ToR were included in members packs which it was noted was last reviewed in 2015. Following discussion it was agreed a workshop will be held on 2 September 2020 to agree on an integrated approach which will be held in place of the usual QSE meeting. The following actions are to be undertaken in advance of the workshop:	**Grainne Cushley / Margaret McNally**	**Mark Closed**

Date	Action No	Action Agreed	Person Responsible	Status
		• Position paper template to be developed and issued to leads **by Grainne Cushley**; • Leads to populate position paper templates for consideration at September workshop **– leads**; • External venue to be sourced for workshop; • Progress to be reviewed at August meeting. **Update 5 August 2020**: The workshop will now take place on Wednesday 7 October 2020. Lagan Valley Island Conference Centre is the proposed venue – Denise Boulter to confirm. Invitation to the workshop will be widened to include members from all relevant HSCB and PHA Safety and Quality related groups. Members approved the template Grainne Cushley had prepared and it was agreed the template will be issued to the following groups./areas for completion • SQAT • SAI Review Group • Professional Groups. • Complaints Group • 10,000 voices • QIP, Pressure Ulcer and Falls Groups • Q2020 • HSCQI • Child Death Notification – Sinead/Heather/Joanne • Safeguarding Process – Joyce McKee **Update 07.10.20 -** Due to the increasing number of Covid cases it was agreed to put the proposed workshop on hold until further notice. **Update 03.02.21** – Members agreed to close this on the action log as this will be incorporated within the Improvement Plan.		

Date	Action No	Action Agreed	Person Responsible	Status
01.07.2020	**2d**	**Update on SAI process** – Members considered the information circulated prior to the meeting on open SAIs as at 28 May 2020. Following discussion the actions below were agreed: • Trusts Chief Executives to receive letters detailing outstanding SAI Review reports and Level 2/3 Terms of Reference; • Trusts to be asked to submit an action plan for receipt of outstanding SAI Review reports and Level 2/3 Terms of Reference; • Denise Boulter to work with HSCB/PHA colleagues to agree on an action plan for the closure of open SAIs by March 2021; • A Kane to consider additional coding at professional groups to facilitate trend and pattern analysis; • Overarching trends and pattern analysis to be provided for future SMT meetings; • A Kane / D Boulter / B Farrell to meet to agree a coherent plan to address capacity issues for DROs. **Update 5 August 2020:** The Chief Executive letters highlighting the outstanding reports as at June 2020 have been issued to Trusts. An overview was included in member's packs. The letters also included the following: • Outstanding Terms of Reference for level 2/3 SAIs. • Request for submission of an action plan to address current backlog • BHSCT were asked to include names of membership of review panels for level 2 and 3 SAIs Anne advised a mechanism whereby the new Incident Review Group might be involved in regional coding on DATIX will be discussed at the next weekly incident review meeting. **Update 03.02.21** – Members agreed to close this on the action log as this will be incorporated within the Improvement Plan.	**D Boulter** **A Kane**	**Mark Closed**
01.07.2020	**10a**	**AoB - Initial Scope of Enteral Feeding Incidents – Possible Thematic Review** – Due to time constraints this item was not discussed and will be relisted for the October meeting due to number of items pending for the August agenda and the dedicated workshop in place of the September QSE meeting.	**D Boulter**	**Mark Closed**

Date	Action No	Action Agreed	Person Responsible	Status
		Update 03.02.21 – It was agreed to close this item from QSE and reopen if further incidents are reported as Denise Boulter noted there have been no further incidents since listing this for QSE in July 2020.		
01.07.2020	**10b**	**AoB - Possible Campaign - Patients responsibility to check on test results and appointments especially if outstanding for a long period of time** – Due to time constraints this item was not discussed and will be relisted for the October meeting due to number of items pending for the August agenda and the dedicated workshop in place of the September QSE meeting. **Update 03.02.21** – Due to the current situation with the third surge in Covid cases it was agreed to close this item from QSE and reopen if required.	**D Boulter**	**Mark Closed**
01.07.2020	**10c**	**AoB – Security of Wards at Night** – Due to time constraints this item was not discussed and will be relisted for the October meeting due to number of items pending for the August agenda and the dedicated workshop in place of the September QSE meeting. **Update 03.02.21** – It was noted this item had been listed following 2 SAIs, however due to the current situation with the third surge in Covid cases it was agreed to close this item from QSE. Denise Boulter will relist if required in 6 months.	**D Boulter**	**Mark Closed**

Date of Meeting: 7 October 2020

Attendees: Denise Boulter(Chair), Liz Fitzpatrick, Anne Kane, Anne-Marie Phillips, Grainne Cushley, Margaret McNally, Joyce McKee, Briege Quinn

Apologies: Rodney Morton, Mark Roberts, Marie Rolston, Joe Brogan, Hugo Van Worden, Patricia Crossan, Aideen Keaney, Brid Farrell, Linda Craig, Brenda Bradley

Date	Action No	Action Agreed	Person Responsible	Status

07.10.20	1	**Independent Review S10617 - SHSCT SAI 69712** – Briege Quinn in referring to the paper included in packs provided a briefing on this incident. Following discussion, it was agreed (1) QSE would relist this as a substantive item to have oversight of progress on the independent review report action plan; (2) Newly appointed PHA and HSCB Chief Executives to be briefed on the SAI. **Update from Interim QSE/SQAT Meeting on 14.12.20 - Issue from Mental Health and Learning Disability Directors Meeting held on 3.12.20 re Letter to HSCB CE 21.06.2018 linked to SAI S10617** – Briege Quinn joined the meeting for this item. It was noted the letter included in members packs had been issued from the SHSCT to the HSCB Chief Executive on 21 June 2018 via email in respect of the above SAI. However, as the wrong email address was used this had not been received by the HSCB CE which has just been established following a query from the SHSCT. Following discussion, it was agreed for a response to be prepared (pending discussion with Lorna Conn) for issue to the SHSCT confirming that the 3 recommendations detailed within the letter have been taken forward in the independent review report. Sharon Gallagher (HSCB CE) to be briefed on the case). In addition, Briege sought members' approval for Mary Hinds to review all recommendations contained within the Independent Review Report to ensure all recommendations are aligned to pieces of work. It was noted there is no conflict of interest and Mary would be available to commence this piece of work from mid-January 2021. Following discussion, it was agreed for Mary Hinds to take this piece of work forward on behalf of the HSCB/PHA subject to advice from legal services. **Update 03.02.21** – Briege Quinn attended the meeting for this item. Briege confirmed that all recommendations have been subsumed into the current action plan and are being met through the Independent Review. Following discussion, Briege Quinn agreed to update Sharon Gallagher (HSCB CE) to on the case	B Quinn	Review next meeting

07.10.20	3	**Briefing Paper - Introduction of Domestic Homicide Reviews In Northern Ireland –** Joyce McKee in referring to the paper included in packs briefed members on the Introduction of the Domestic Homicide Reviews which is due to come into force within Northern Ireland . It was noted the Department of Justice is currently finalising detailed multi-agency guidance for the conduct of DHRs in Northern Ireland. The purpose of the paper is to brief SMT/AMT on key elements of that guidance, the interfaces between DHRs and existing review and learning processes, and to highlight where some adjustments to those processes may be required. It was noted the introduction of Domestic Homicide Reviews in Northern Ireland fulfils both a statutory requirement under section 9 of the Domestic Violence, Crime and Victims Act (2004) and meets a key commitment of the Stopping Domestic and Sexual Violence and Abuse Strategy (2016). The learning that can be identified through these Reviews will provide significant opportunities to prevent further deaths or serious injury and to improve services designed to support victims of domestic abuse or violence. The HSCB/PHA will be expected to contribute fully to this process. Following discussion, it was agreed to add this to the list of pending issues to be taken into consideration when reviewing the SAI procedure. Joyce agreed to discuss with Anne Kane best way to take forward and if SMT should be requested to expedite the approval of the DHR pending the review of the SAI procedure. **Update 03.02.21** – As Joyce McKee was not present for the meeting it was agreed to relist for the next meeting.	J McKee A Kane	Review next meeting
07.10.20	5	**Proposed new HSCB/PHA Safety Strategy –** It was noted a meeting had been held with the DoH on Monday 5 October. It is the view of the PHA Director of Nursing that all strands of safety and quality need to be looked at and not just SAIs to form a HSCB/PHA safety strategy. Following discussion, Grainne Cushley agreed to commence developing a first draft of the strategy in consultation with Margaret McNally. **Update 03.02.21** – Denise Boulter reported she will be leading on this and work was ongoing.	D Boulter	Review next meeting

Date of Meeting: 3 February 2021
Attendees: Rodney Morton (Chair), Lisa McWilliams (Co-Chair), Denise Boulter, Anne Kane, Anne-Marie Phillips, Margaret McNally, Linda Craig, Joe Brogan, Brenda Bradley, Michael Cruikshanks Briege Quinn (for items 8h, 4b, 4c, 4e)
Apologies: Louise McMahon, Liz Fitzpatrick

Date	Action No	Action Agreed	Person Responsible	Status
03.02.21	2	**Improvement Plan for SAI Process –** It was noted a paper had went to SMT the previous day. The backlog of SAIs was being worked through both the professional groups and the Leadership centre. It was noted there are to be changes to the internal management of level 1 SAIs going forward with the introduction of two groups to replace the current separate professional DRO review groups. The changes are with patients in mind to ensure regional learning is disseminated expediently.	A Kane D Boulter	Review next meeting
03.02.21	3a	**Update on the Regional Falls Group -** A verbal update on the work of the Regional Falls Group was provided. No concerns were raised in respect of the work.	AM Phillips	Mark Closed – standing item
03.02.21	3b	**Update on Regional Pressure Ulcer Prevention Group -** A verbal update on the work of the Regional Pressure Ulcer Prevention Group was provided. No concerns were raised in respect of the work.	AM Phillips	Mark Closed – standing item
03.02.21	3c	**QIP Report -** A verbal update on the work of the Quality Improvement Project was provided. No concerns were raised in respect of the work.	AM Phillips	Mark Closed – standing item

03.02.21	3d	**Update on 10,000 voices** The following two reports were included in members packs: • You and Your Experience of Mental Health Services During COVID-19 Pandemic" • Your experience of Mental Health Services – Regional report A verbal update on the work of the 10,000 voices projects was provided. No concerns were raised in respect of the work of the projects. Following discussion, it was agreed Linda would link with Joe Brogan in respect of the data collected with a view to building in direct questions in respect of community pharmacy for future projects. Linda also agreed to link with Briege Quinn in respect of Mental Health Services.	L Craig	Mark Closed – standing item
03.02.21	3e	**Update on Quality 2020** – Capacity to undertake this work was currently had been raised with the DoH and discussions were on-going regarding this. A draft report for 2019/20 has been prepared and is due to be considered by SMT at next weeks meeting with a view to publication by 31 March 2021.	D Boulter	Mark Closed – standing item
03.02.21	3f	**Child Death Notification Process Report** - Due to staff redeployment this work has been put on hold.	S Magill with H Reid/ J McClean	Mark Closed – relist in 6 months
03.02.21	3g	**HSCQI Update** – An update was not available as there was no lead present from HSCQI.		Mark Closed – standing item
03.02.21	4a	**Request received from RQIA Inspector in relation to two Acute level 1 SAIs (HSCB ID 18947 and 18836) –** Members views were sought if Denise Boulter can share information with RQIA as the two SAIs in question are Trust Acute related SAIs. Following discussion, it was agreed Anne Kane would seek advice from Ken Moore.	A Kane	Review next meeting

03.02.21	4b	**Level of Review - Trust Ref: 127058 /HSCB Ref: S18999** – Members were briefed on this SAI by Denise Boulter. This is a SAI Level 1 Review. HSCB/PHA professional officers had requested SHSCT to review this incident as a Level 2 SAI given the seriousness of the incident. SHSCT have advised the review will be undertaken as a Level 1 with the caveat that if the review chair thinks it necessary they will reconsider. This has been escalated to QSE by the Chair of the Mental Health and Learning Disability group due to the Trust not making the change as requested via the DRO. Following discussion it was agreed to confirm the expectation for Trusts in relation to this with Governance Leads at the meeting scheduled for the following week. Anne Kane to provide a formal minute of the meeting to Briege Quinn following the Regional Governance Leads meeting. **Postscript – 05.03.21 - It was confirmed by Anne Kane this item is being raised at Performance meetings with Trusts and not at Governance Leads meeting.**	A Kane D Boulter	Mark Closed refer to Trust Performance Management meetings
03.02.21	4c	**RQIA input to SAI process –** Briege Quinn attended for this item. It was noted this item had previously been discussed at QSE. In providing background it was noted that RQIA had written to the PHA in September 2019 suspending commentary on SAIs. However due to recent confusion in relation to the role of RQIA and SAIs a meeting has been scheduled with RQIA for 11 February 2021 and PHA and HSCB officers to clarify this.	B Quinn R Morton	Review next meeting
03.02.21	4d	**Trust Response to DRO Queries - Trust Ref: SET42.20 - HSCB Ref: SE18157** – Members considered the briefing paper included in packs. It was noted the case was considered at the Paediatric Group at meetings held on 17 December 2020 & 11 January 2021. The case references a review of referrals (9698). An update on the outcome of the review was requested however the Trust in question has advised on 18 January 2021 this review has not commenced due to COVID 19 and staff redeployment. Following discussion, Lisa McWilliams agreed to discuss with David McCormick to seek opinion if this is acceptable and report back to Denise Boulter at the next meeting.	L McWilliams	Review next meeting

03.02.21	4e	**Recommendation for the HSCB/PHA from the Review of Leadership & Governance at Muckamore Abbey Hospital –** Briege Quinn attended for this item. The following recommendation from the Muckamore Abbey Hospital Leadership and Governance Review was brought to members attention: ***'The HSCB/PHA should ensure that any breach of requirements brought to its attention has, in the first instance, been brought to the attention of the Trust Board.'*** It was noted this recommendation should apply to any level 3 SAI and Early Alert that would fall into this category. Following discussion, it was agreed to confirm the expectation for Trusts in relation to this recommendation at the individual meetings with Trusts which are to be arranged as a result of a letter from Sharon Gallagher (HSCB Chief Executive) to Trust Chief Executives. There will be a formal minute of the meeting with each Trust which will be available following the meeting. Anne Kane to provide a formal minute of the meeting to Briege Quinn following the meeting. Item to be re-opened if required.	A Kane D Boulter	Mark Closed - A Kane to provide feedback to B Quinn following meeting

03.02.21	4f	**Request for indemnity for independent review panel members** – Members considered the briefing paper included in packs. It was noted a Level 3 Covid-19 related SAI was reported by the SHSCT on 10 September 2020 (HSCB ID 18475). Following the notification an independent review was commissioned by both PHA and the SHSCT. The Terms of Reference for the SAI were agreed by the DRO on 8 December 2020. However the Governance lead in SHSCT has recently contacted the HSCB advising the independent panel members would like indemnity provided given the potential of defamation or risk relating to recommendations from the final report. SHSCT have discussed this issue with DLS and given the independent nature of the review and the importance of SHSCT not developing a conflict of interest, DLS were of the opinion it would be best that this is facilitated by a body outside of the Trust. Following this request, A Kane contacted DLS who confirmed, given the high profile of this particular case it would be advisable that the indemnity, for independent panel members, is facilitated by a body outside of both SHSCT and PHA (commissioners of the review). DLS suggested HSCB provide the indemnity. DLS also queried the independence of review panel given a PHA staff member is a member of the review team. It was noted the request for the HSCB to provide indemnity for independent panel members of SAI reviews has not been raised previously with the HSCB for previous SAI reviews. QSE members were asked to consider the request for HSCB to provide indemnity for independent panel members for this specific SAI review. The collective view of the group was that indemnity should be sought from the organisations who are commissioning the review and it was agreed Anne Kane would seek further clarification from DLS on this issue.	A Kane	Review next meeting

03.02.21	5	**HSC Complaints Update for QSE –** Members considered the briefing paper included in packs. It was noted 3 quarterly Complaints Reports will be submitted to SMT covering the periods of January – March 2020; April – June 2020 and July – September 2020. The 3 reports were included in members packs for information. In addition 3 complaints articles were included in members packs; one of which was provided by a Trust, via the re-introduction of the HSC Learning Template, and the others were compiled by the RCSG Professionals. All 3 articles will appear in Edition 18 of Learning Matters. It was noted the majority of recommendations arising from the Audit on Complaints Management have been implemented; those which remain outstanding are due to the ongoing response to COVID-19. HSC Trusts will submit to the Board a composite complaints return in February 2021, covering complaints closed during October – December 2020. It was noted the NIAS complaints return for September 2020 which was due November 2020 remains outstanding, and this has been escalated to the Director of Quality in NIAS, who has provided an assurance that the information will be provided by return.		Mark Closed – standing item
03.02.21	6a	**Okenden Report 10th Dec 2020 into Maternity Care - Shewsbury and** Telford - A briefing on the report was included in members packs. **Postscript:** It was confirmed follow the meeting via email from Allison Little that the Ockenden report was raised at the HSC QI Maternity Collaborative meeting on the 28th January 2021. It was decided to develop a regional sub group to provide a response and take forward the recommendations of the report. Trusts were requested to share nominations for representation for a sub-group to PHA asap. It was also suggested that this be tabled at the next Maternity Strategy Implementation Group (February 26th 2021) to ensure strategic oversight and support for any commissioning implications, along with linking with Neonatal Network to adopt a system wide response.	AM Phillips	Mark Closed
03.02.21	6b	**Assurance Process for SQAs – 3 month pilot** – Denise Boulter reported that SQAT members had agreed for a three month pilot to take place whereby open alerts would be reviewed by leads and closed off via the SQA Programme Manager outside of SQAT meetings. Assurances will only be reviewed at SQAT by exception if escalated by the professional lead.		Mark closed

03.02.21	6c	**Performance against 72 hours notification of SAIs** – Anne Kane informed members of a request received from the BHSCT Governance Lead seeking information on the Trusts stats on their performance for reporting of SAIs within the 72 hour target. It was agreed report could be shared if other orgs were anonymised. Anne's team to prepare report and share with PHA colleagues prior to issue.	A Kane with R Morton	Mark Closed
03.02.21	7a	**RQIA Review of Nice Clinical Guideline 174, Intravenous (IV) Fluid Therapy in adults in hospitals in Northern Ireland** - Paul Cavanagh is leading on this with support from Anne Marie Phillips and Jackie McCall.	P Cavanagh with A-M Phillips and J McCall	Mark Closed from action log Alerts Team to include in 6 monthly report on progress to Governance Committee
03.02.21	7b	**MBRRACE-UK perinatal mortality surveillance report: UK perinatal deaths for births from January to December 2018 –** Heather Reid and Alison Little were identified as leads to report progress on implementation of the report recommendations. It was agreed Margaret McNally would link with the leads to confirm arrangements for providing updates to the six monthly progress report for inclusion within the overview report to Governance Committee.	Heather Reid and Alison Little	Mark Closed from action log Alerts Team to add to Alerts module on Datix and remain open for progress reporting

03.02.21	7c	**Balancing the Pressures: A review of the quality of care provided to children and young people aged 0-24 years who were receiving long-term ventilation** – Eilidh McGregor and Joanne McClean were identified as leads to report progress on implementation of the report recommendations. It was agreed Margaret McNally would link with the leads to confirm arrangements for providing updates to the six monthly progress report for inclusion within the overview report to Governance Committee. **Postscript** – Email sent to Rodney Morton and Lisa McWilliams following the QSE meeting highlighting the action for HSCB and PHA detailed within the cover letter from the CMO, which states the HSCB and PHA should: *Together with HSC Trusts, map out the aspects of the report which relate to the commissioning of services for the groups of patients who were the focus of this report.* Based on the above action confirmation is awaited from the Chair of QSE if Paul Cavanagh should be the lead working with Eilidh McGregor and Joanne McClean.		Review next meeting for confirmation

AGENDA

SPPG/PHA and xxx S&Q Performance Meeting

xx-xx-2024 MS TEAMS

Apologies:

Item No	To be discussed
1.	**Overview Summary Report** - *with attachments*: *a.* Outstanding SAI Review Reports / Outstanding ToRs / Deferred SAIs - *update to be provided* *b.* DRO queries / OS Escalation issues - *update to be provided* *c.* Outstanding Assurances on Safety and Quality Alerts – *no outstanding assurances* *d.* Outstanding Complaints - *update to be provided – paper to follow*
2.	**Request for Trust update on progress**: *a. Recommendations not being agreed and accepted by other organisations before they are included in a report* *b. Specific update on progress with finalising the TOR & TM* *c. Discussion on ILR* *d. Specific update on progress*
3.	**Outstanding SAI Review Reports** *a.* Deputy Secretary Letter - Performance Targets Set *b.* Early Regional Learning from SAI reviews underway but not completed *c.* Risks in relation to Outstanding SAI reports have been escalated within internal governance arrangements including to their Trust Board
4.	Any Other Business
5.	Date of next meeting: