Exhibit 69

Report on Professional Nursing Assurance

Muckamore Abbey Hospital

Findings, Recommendations and Action Plan

Francis Rice

Professional Nurse Advisor

February 2020

Background

1. An adult safeguarding investigation was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the Police Service of Northern Ireland (PSNI) and Belfast Health and Social Care Trust (the 'Trust').

2. During January 2018, the Trust set out Terms of Reference for a level 3 review of safeguarding activities at the Hospital under the Health and Social Care Board (2016) Procedure for the Reporting and Follow up of Serious Adverse Incidents, Version 1.1. The Trust asked the Review Team to identify the principal factors responsible for historic and recent safeguarding incidents at the Hospital. The review team appointed was independent of the Hospital.

3. A Review of Safeguarding at Muckamore Abbey Hospital 'A Way to Go' was published in November 2018

4. This review made a number of recommendations relating to the need for reform within the Hospital and the development of robust community based Health and Social Care services so that individuals with a learning disability are enabled to have full lives in their families and communities.

5. The Chief Executive of the Trust wrote to the Permanent Secretary on 8 March 2019 indicating that it fully accepted the complexity and gravity of the situation, and requested the Department's help and support in order to achieve the best possible outcome for patients at Muckamore Abbey Hospital.

6. The Department agreed to facilitate monthly update meetings with the Trust and Health and Social Care Board (HSCB) in relation to Muckamore Abbey Hospital. These meetings were set up at the request of the Trust to help support them in relation to improving services at Muckamore Abbey Hospital. Three meetings have taken place to date (10 April, 8 May and 5 June 2019). The Trust repeatedly highlighted recruitment and retention of nursing staff as an ongoing and significant risk at these meetings.

7. The Regulation and Quality Improvement Authority (RQIA) carried out two unannounced inspections in Muckamore Abbey Hospital in 26–28 February 2019 and 15-17April 2019. The RQIA subsequently wrote to the Chief Medical Officer (CMO) on the 30th April 2019 advising of their 'serious concerns relating to care treatment and services as currently provided for patients in Muckamore Abbey Hospital' - the RQIA specifically highlighted their concerns in relation to availability and planning of nursing staff to meet assessed patient need; a 'disconnect between site managers and ward staff'; and expressed their concern for health and wellbeing of staff, particularly nursing staff, in the hospital. The RQIA recommended that the Department of Health implement a special measure and establish two taskforces.

8. The Department called a meeting in relation to the RQIA letter to CMO, which was held on 14th May 2019. This meeting was convened in response to the 30th April 2019 RQIA Article 4 letter to the CMO.

9. The DOH agreed to establish the new Muckamore Departmental Assurance Group (MDAG) following the second RQIA unannounced inspections in April 2019 and the associated Article 4 letter to the Department. The objective of the group, to be jointly chaired the Chief Social Services Office/Chief Nursing Office was to provide the Permanent Secretary (and any incoming Minister) with assurance that the Permanent Secretary's commitments on resettlement and also the recommendations in the SAI report were being robustly and effectively addressed.

10. The Belfast Trust advised the DOH that as of 20 June 2019 there were 44 WTE Registered Nurse vacancies at the hospital currently being backfilled by use of agency and Bank Nursing staff. The number of staff suspensions to date is 48 (22 registered nurses and 26 healthcare assistants), though there remains the potential for this number to increase should further concerns emerge from the viewing of historical CCTV footage which is ongoing.

11. In light of this, and due to the fundamental role that nursing plays in care delivery on a day to basis to patients in the hospital, the Belfast Trust have commenced a

contingency planning process to prepare options in the event of further deterioration in staffing levels at Muckamore.

Professional Assurance

12. The Chief Nursing Officer sent a letter to Executive Director of Nursing, Belfast Health and Social Care Trust on 31 May 2019 seeking assurances regarding patient care and treatment and professional nursing in Muckamore Abbey Hospital. The Executive Director of Nursing, Belfast Health and Social Care Trust responded to this on 20 June 2019. There remained some issues of assurance that needed to be taken forward and therefore, I as professional advisor, was asked to take these forward in conjunction with Senior Nursing and Management Staff in Belfast Health and Social Care Trust..

Professional Nursing Advisor

13. I was asked, having been, a former HSC Executive/Director of Nursing and Interim Chief Executive, to work as professional Nursing advisor alongside clinicians and management in the Belfast Trust to assist with stabilising the nursing workforce, providing expert advice, professional assurances and if appropriate, make recommendations to The Chief Nursing Officer and Department of Health regarding current services, care and treatment within Muckamore Abbey Hospital. This work commenced on 18 September 2019.

Terms of Reference for Professional Nursing Advisor

14.

- To work alongside clinicians and management in BHSCT with responsibility for services provided at Muckamore Abbey Hospital.
- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing care for individuals with a learning disability.
- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing governance, training and

development for nurses and healthcare support workers working in Muckamore Abbey Hospital.

- To ensure that there is a clear and effective clinical, professional, and operational structures in place for all registrants and health care support workers and that staff are aware of these.
- To ensure that all registrants and health care support workers are aware of how to escalate or raise concerns and feel confident and supported in doing so.
- To establish if current nursing practice and care in Muckamore Abbey Hospital is safe, effective and compassionate.
- To review the quality and effectiveness of nursing care and practice currently being delivered in conjunction with ward sisters and ensure that it is in keeping with NICE and other relevant evidence based clinical guidelines and that progress is being monitored and evaluated.
- To identify and where appropriate introduce appropriate routine outcome measures to nursing care as delivered in Muckamore Abbey Hospital.
- To report on the above to CNO via the Muckamore Departmental Assurance Group and other mechanisms as appropriate.

Methodology

15. I officially commenced this work on the 18th September 2019 and prior to this date in preparation for starting, read the following reports:

- "A Way to Go" A review of Safeguarding at Muckamore Abbey Hospital – November 2018.
- Final Report of Independence Assurance Team – Muckamore Abbey Hospital – 19 September 2018.
- Belfast Trust ASPC Directorate, Muckamore Abbey Hospital summary of staff exit interviews 16 August 2018
- CNO Professional Letter to Miss Brenda Creaney, Executive Director of Nursing and User Experience, Belfast Health and Social Care Trust – 31 May 2019

- Response to CNO Professional Letter from Miss Brenda Creaney, Director of Nursing, Belfast Health and Social Care Trust – 20 June 2019
- The Draft HSC Action Plan in relation to the review "A Way to Go"
- From 18th September 2019 I requested information in relation to Nursing Workforce, Professional Governance, Patient Safety, Performance against resettlement targets, Regulation and Quality Improvement Notices (RQIA) and communication mechanisms with Muckamore Abbey Hospital Staff, users, carers and advocates in Muckamore.
- I visited all the wards in Muckamore Abbey Hospital and spoke to the multi-disciplinary teams to include Nursing staff (registered and non registered)
- I met with Nursing students, Medical, Social Work, Psychology, Patient Client Support Services and Allied Health Professional staff.
- I met with Service Users, carers and advocates.
- I attended Charge Nurses meetings and purposeful Inpatient Admission (PIPA) Meetings
- I spoke to and attended Senior Management Meetings (Belfast Health and Social Care Trust)
- I met with the Deputy Chief Executive/Medical Director, Director of Nursing and User Experience, Director of Adult and Social Primary Care and Director of Human Resources, Belfast Health and Social Care Trust.
- I met with the Nurse Development Lead for the Hospital, Day Services Staff, and Clinical Governance staff.
- I met with the Resettlement Lead for Muckamore Abbey Hospital.
- I met with staff from the Muckamore Abbey Review Team (DOH), The Chief and Deputy Chief Nursing Officers, The Nursing Advisor for Mental Health and Learning Disability, Chief Social Services Officer and staff from the Directorate of Mental Health, Disability and other people (DOH).
- I met with the leads responsible for taking forward the recommendations of the HSC Action Plan in response to the Review of Safeguarding "A Way to Go"
- I met with the Director of Nursing (PHA) and Director of Social Care (HSCB)
- I carried out a number of visits to wards observing Leadership and Professional Practice, to get a better understanding of challenges and

determine the level and nature of assurance I would be able to provide to DOH.

- I attend the Muckamore Departmental Assurance Group (DOH)

Through this I believe I was able to gain a fuller understanding of the Professional Nursing issues and determine how the Trust was taking actions forward and addressing future professional issues in Muckamore Abbey Hospital. This in turn enabled me to ascertain the level of assurance I could provide for the Department of Health Chief Nursing Officer and make recommendations for improvement.

Preliminary Findings

16. I found all the staff, service users, carers and advocates in the Hospital to be very receptive to me being there to provide professional nursing advice and support. Through spending time individually with staff, with teams, service users, carers and advocates I was able to ascertain a significant level of commitment to ensure the complex needs of patients were met and that patients received the best care possible under very difficult circumstances, mainly negative media attention and significant workforce challenges.

    Staff were extremely honest and forthcoming in identifying and communicating issues, what help they need and how the Belfast Trust could help and support them further. The staff were exhausted.

Workforce

17. There are a significant number of vacancies in the nursing workforce in Muckamore Abbey Hospital, which presents a daily challenge to the provision of safe staffing on wards with a disproportionate reliance on bank and agency staff. This is of significant concern in terms of the safe and effective care of patients and the future sustainability of the Hospital. The uncertainty of the future of the Hospital is exacerbating recruitment and retention issues.

- There are 111.51 WTE vacancies in the Hospital of registered and non-registered nurses as a result of vacancies, sick leave and maternity leave being covered by bank and agency staff (68.34 WTE).
- A significant number of staff resignations 15 WTE (8 Band 5, 2 Band 6 and 5 Band 3) 6 WTE Retirements (Band 5) (December 2019)
- Agency and bank staff (registered) are not taking charge of work shifts in spite of some of them having been "block booked" for 18 months.
- There are on average 84 WTE nursing staff (non-registered) involved in the special observation of patients each week
- There are no Ward Support Officers in post in the Hospital.
- The Nurse Development Lead is working his resignation.
- Staff are exhausted.
- Behaviour Support training needs to be extended to include registered and non-registered staff and fully integrated into MDT Treatment Plans to achieve NICE Guidance NG11.
- An interim workforce plan is required to ensure safe staffing levels on each ward (RQIA Improvement Notice) (February 2019)

Governance and Safety

18.

a. Hospital Risk Register requires reviewing specifically in relation to nursing workforce
b. Observation and Seclusion policies require reviewing
c. Policy development process require reviewing
d. Weekly Ward safety report is required to keep staff abreast of patient safety issues and required action and improvement
e. Induction, MAPA and mandatory training is not 100% complete for all staff.
f. Staff care planning and "PARIS" Training requires updating
g. Charge Nurse/Senior Nurse meetings require reinstating
h. Patient inpatient admission (PIPA) meetings require to be implemented in all wards
i. Increased focus required on the implementation of NICE Guidelines/DOH Circulars/Professional Letters.

j. Due to the significant challenges in relation to Workforce there requires to be renewed focus on:
   - Staff appraisal and supervision
   - Reflective practice
   - The development of Key Performance Indicators for nursing
   - The development of a professional nursing forum
   - The development of Nursing Practice
   - The implementation of research and development to inform Clinical Practice
   - Professional training and development Plans require updating.

Communication

19.

a. Communication lines have become complicated and staff do not understand the professional or operational structures or lines of accountability within the Hospital.
b. There is a feeling expressed by staff that they are not adequately communicated with or listened to in relation to the ongoing workforce and professional issues and the PSNI Investigation and hear most of the information on the news.
c. Staff report a “disconnect” between them and site managers.

Leadership

20.

a. Because of ongoing staff changes and the ongoing investigation in Muckamore Abbey Hospital, there is not clear evidence of effective leadership at ward or directorate level.
b. Clinical Leadership (all disciplines) is not as strong as it should or could be and staff feel vulnerable and disempowered due to recent events.
c. There is no divisional nurse in the current structure and professional governance lines of accountability are unclear.

Summary

21. In the course of my observation visits, most of which were unannounced, I found the care to be compassionate and effective and staffing levels were being monitored on a shift basis to ensure patient safety in spite of the issues I have outlined in my findings to date. I could not see evidence of true multi-disciplinary working on the hospital site which is a significant issue of concern as the nursing staff are carrying the larger share of the workload.

    In the absence of a regional alternative, the hospital is still receiving admissions, which is adding further pressure on the nursing staff.

The staff are fully aware that a number of professional and governance issues require revision, updating and renewed focus, however until the workforce is stabilised this will prove to be extremely difficult.

The staff's main concern is having sufficient nurses to look after the needs of patients and ensuring there is a truly multidisciplinary approach to the effective needs assessment, care planning and resettlement of patients. They were also very unnerved by the continued reading of the CCTV footage and feel that they could be in danger of being disciplined in spite of not, in their view, having done anything wrong

I spoke to and met Dr Cathy Jack, Deputy Chief Executive, Miss Brenda Creaney, Director of Nursing and User Experience and the Director of Human Resources, Belfast Health and Social Care Trust on 23 September 2019 as the Chief Executive was on annual leave relayed my concerns and highlighted preliminary findings and recommendations.

On 8 October 2019 a new operational and professional nursing structure was put in place by the Belfast Health and Social Care Trust to include a Director, Co-Director, Divisional Nurse, Interim Senior Manager, Senior Nurses based on hospital wards and revised arrangements for overseeing the Safeguarding and Financial agendas. A

diagrammatic version of the new professional and management structure was sent to all wards and departments in the Hospital.

I am included in the work of the Senior Management Team, Senior Nursing and ward teams and members of the Multi-Disciplinary Team. I am working with them to take forward actions in relation to, Professional Governance and Nursing issues based on my findings and can report progress to date against an action plan and my findings I have devised to address the issues of concern and my findings. The implementation of this action plan will go a some way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of a competent, confident and supported workforce and ultimately the safe and effective care to patients enhanced by effective Clinical and Social Care Governance and Communication Mechanisms.

The Regulation and Quality Improvement Authority carried out a further inspection on the 10 – 12 December 2019 of all wards and services in Muckamore Abbey Hospital and were extremely complimentary of the progress made to date in relation to the areas of Governance, Staffing, Financial Governance, Physical Healthcare, Seclusion, Restrictive Practice and Safeguarding. The Improvement Notices around staffing have been lifted in full, Financial Governance lifted in full except for the requirement for “internal audit” to conduct their audit, which is due on February 2020.

With regard to the Safeguarding Improvement Notice, RQIA have stated when the Trust provides further evidence, in the form of audits, currently being carried out that the new policies and procedures being implemented are effective, the improvement notice will be lifted in full.

RQIA report a totally different ‘feel’ about the site, the staff are more open, honest, feel totally supported and the patients receive safe and effective care.

The challenges with the Nursing Workforce remain and RQIA recognise the need for the Trust to continue to receive help from the wider HSC to ensure patients continue to receive safe and effective care and that the care being delivered can be sustained.

Action Plan

I have devised an action plan to address the professional nursing and governance issues I have identified to date which the Senior Staff in Muckamore Abbey Hospital have seen and are in accordance with. The implementation of the action plan will go some way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of safe and effective care and a competent, confident and fully supported workforce, enhanced by effective clinical, social care governance and communication mechanisms. However a number of challenges remain that the Trust need to address in conjunction with the Public Health Agency (PHA) Regional Health and Social Care Board (RHSCB) and the Department of Health (DOH).

Issues for Future Consideration

There are a number of issues that I have identified during my work that are not included as recommendations in the action plan as they are beyond my remit. These recommendations require to be addressed by the Trust as they will have a direct impact on the present and future sustainability of Muckamore Abbey Hospital in its current form, and indeed the efficiency and effectiveness of Trust Learning Disability Services and professional practice in the future. The Trust will be required to work in collaboration with other Health and Social Care Trusts, the Regional Health and Social Care Board/Public Health Agency and Department Of Health to address these issues, which, in my view are;

A. A plan to permanently recruit and retain a nursing workforce required to ensure the safe and effective nursing care of the current and future Learning Disability patient population.
B. The development of a Comprehensive needs assessment of our Learning Disability population in Northern Ireland, to inform the development of a regional strategic approach to an integrated hospital and community service model, clinical practice, standards of service provision and future accommodation needs.
C. An increased focus on quality improvement, user, carer and advocacy involvement in co-production, design and delivery of services.

D. The provision of suitable accommodation to facilitate the complete resettlement of the complex patients who are currently cared for in the Muckamore Abbey Hospital and the need for consideration of a regional approach to this.
E. The development of an agreed modern care pathway and fully integrated multi-disciplinary model of Acute Hospital Care Service provision for Learning Disability patients.
F. The establishment of a modern multi-disciplinary Community Learning Disability Care and treatment model for Learning Disability patients to include forensic, home treatment, crisis response, assertive in and out reach multi-disciplinary teams with clear lines of Professional Accountability.
G. The provision of a comprehensive and fully integrated training and development multi-disciplinary programme to equip staff with the skills, knowledge, and expertise to assess, care and treat all Learning Disability patients.
H. The lack of development of Clinical and Social Care 'Leaders' in the field of Learning Disability and the need to develop a programme to nurture and enhance Leadership in this field.
I. Behaviour Support training needs to be extended to include registered and non-registered staff and fully integrated into MDT Treatment Plans to achieve NICE Guidance NG11.
J. Increased focus required on the implementation of NICE Guidelines/DOH Circulars/Professional Letters.
K. The further development and review of the model of Multi-Disciplinary Assessment and Care Planning in Muckamore Abbey Hospital to ensure the holistic needs of patients are being identified and appropriate therapeutic interventions are being carried out to ensure an optimum level of patient functioning and independence and address any patient trauma issues identified as a result of the alleged abuse.

I am aware that some of these issues are being taken forward in the Muckamore Abbey Hospital HSC Action Plan, which is reported at the Department of Health Muckamore Departmental Assurance Group (MDAG). The Trust in conjunction with the appropriate stakeholders may wish to consider taking forward those issues that are not currently in the MDAG or the action plan in this report.

ACTION PLAN

ACTION PLAN Nursing Workforce			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Agency nursing staff are fully integrated into ward teams and registered nursing staff are competent to take charge of shifts on wards in MAH.	Divisional Nurse Senior Nurses	To develop and implement a competency framework for registered agency nursing staff to assess and sign off competency to take charge of ward shifts. 75% complete	
To ensure all vacant Band 6 and 7 registered nursing staff posts are appointed to every ward in the hospital.	Divisional Nurse	No band 7 vacancies remain. All band 6 vacancies in process of recruitment.	
To ensure vacant Ward Sister Support Officer posts are recruited to hospital wards.	Divisional Nurse	To advertise, shortlist, interview and appoint Ward Sister Support Officer to hospital wards. No suitable applicants from Agency Workers.	
To appoint 30 WTE registered nurse from 5 HSC Trusts to work for a period of 3 months initially in MAH to stabilise the nursing workforce and ensure the delivery of safe staffing levels in MAH.	DOH Chief Nursing Officer Director of Nursing BHSCT Director	DOH to issue a letter to Trust to reflect that each Trust identify 6 WTE registered nurses who would benefit from a 15% increase in pay, terms and conditions.	
		To work with each of the 5 HSC Trusts to identify 6 WTE registered (RNMH/RMN) nurses to work in MAH. 5 Registered Nurses appointed to date.	
To develop an interim workforce plan for each ward to ensure safe staffing levels in all wards in MAH and communicate to staff that the hospital is not closing.	Divisional Nurse	To develop a nursing workforce plan on a spreadsheet with guidance for nursing staff to ensure adequate levels of registered and non-registered sisters staff on a daily basis ensure the safety and effective care of patients in MAH.	

		To work with Finance to build an appropriate budget to take forward the implementation of the workforce plan and identify cost pressures. To review the night co-ordinator role to include twilight hours and weekends.	
To develop an agreed job description for the appointment of a Regional Bed Manager for Adult Learning Disability.	Co-Director	To advertise, shortlist, interview and appoint a Regional Bed Manager for Adult Learning Disability. In the process of recruiting. Interview second week in February 2020.	
To participate fully with the PHA in the development of the future nursing workforce plan (delivering care) for Adult Learning Disability Service.	Divisional Nurse	To identify senior nurses to join the regional (PHA) and 5 HSC Trust workforce planning group for Adult Learning Disability Service.	
To develop and make available a staff counselling service to be available for MAH staff. To review the effectiveness of this service in supporting staff.	Co-Director	To appoint a counsellor to be available on site for staff who wish to avail of confidential counselling service. Counsellor appointed three days per week and communicate to staff on the MAH site.	
To work closely with Trade Union colleagues to keep them abreast of issues on MAH site and ensure there are appropriate arrangements for them to support staff.	Divisional Nurse/Co-Director	Trade union colleagues to attend charge nurse meetings with senior nurses and meetings with staff on MAH site as appropriate.	

ACTION PLAN Governance, Safety and Professional Nursing			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To review the policy on special observation of patients in MAH.	Divisional Nurse	To collate data which clearly identifies the number of patients on special observation, reason for, type of, and mechanisms for multi-disciplinary review of special observations.	
		To review the policy in line with findings in connection with members of the multi-disciplinary forum.	
To review the risk register in MAH to ensure all risks have been identified and escalated as appropriate.	Co-Director	Senior leadership and clinical team to review risk reports in line with Trust policy and current event in MAH.	
To work with senior and governance team to ensure the policy development process is reviewed and that there is a plan to review all hospital policies.	Co-Director	Governance lead with senior management and senior clinical team to review the policy development process to ensure it is in line with the Trust policy review process.	
		To develop a plan to review all existing hospital policies.	
		To draft and implement a restrictive practice policy.	
To work with clinical and governance teams to ensure that each ward receives information pertaining to patient safety and actions to address areas of concern and implement NICE guidelines as appropriate.	Co-Director	Governance lead to collate all information in relation to safety reported by each ward and prepare a safety report for each ward, which also feeds into the Trust Safety reports to Trust board.	
		MAH site safety brief to be circulated every morning at 7am	

		MAH site safety brief to be circulated every night at 8pm with senior nursing staff.	
		Weekly Live Governance to be implemented on the hospital site.	
		Weekly MAH Safety Reports are now provided for each ward on the hospital site.	
To ensure all staff including agency staff attend induction	Divisional Nurse	Senior Nurses, Ward Sisters and Charge Nurses to ensure that staff attend induction.	
All elements of Mandatory training will be up to date and recorded for all staff on MAH site.		WSSOs to assist Ward Sisters/Charge Nurses with organising and recording of training when appointed.	
To ensure care planning and 'PARIS' training is up to date for all staff on MAH site.	Divisional Nurse	Senior Nurse managers to work with Human Resources and charge nurses to identify training needs of staff and ensure all training and records are up to date. Care Planning 90%/Paris 100% (Registered Staff)	
To develop a training needs analysis and training matrix for all staff by ward.	Divisional Nurse	Senior nurses, charge nurses, and care support officers to work together to identify training needs of staff, a training matrix and work with the education provider (CEC) to provide same.	
To introduce multi-disciplinary Patient Inpatient Admission (PIPA) review meetings on each ward.	Divisional Nurse	Senior nurse manager to work with charge nurse and ward MDT teams to develop and implement PIPA meetings by November 2019 and review effectiveness.	
To appoint a Nurse Development Lead in MAH.	Divisional Nurse	To devise job description, advertise, shortlist, interview and appoint to these positions.	

		The NDL post will focus on: - The development of key performance indicators for hospital learning (i.e. circular observation, seclusion, rapid tranquilisation). - The development of professional nurse forum. - The development and implementation of appraisal, clinical supervision and reflective practice for all nursing staff. - The development and implementation of professional standards and practices in all wards in MAH. - The promotion of Research and Development in the nursing workforce to guide clinical practice. - To provide assurance to the Trust in relation to the implementation of NICE Guidelines/DOH Circulars/Professional Letters. Nurse Development Lead Post appointed December 2019 (waiting on pre-employment checks)	
		Service Improvement Coordinator appointed November 2019. Learning Disability Governance Manager appointed December 2019.	

ACTION PLAN Communication			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Senior Management to establish meetings with all staff in the hospital, users, carers and advocates to listen to and communicate with them. To keep them abreast of all issues in the hospital and take their issues on board and ensure they are addressed. Senior Management to evaluate the effectiveness of communication mechanisms and ensure staff fully understand the operational and professional lines of accountability in Muckamore Abbey Hospital.	Director	To establish two weekly senior management forum meeting during which strategic, operational, clinical, finance, and Human Resource issues are tabled and discussed.	
	Co-Director/Divisional Nurse	To establish bi-monthly meetings with users and carers and advocacy workers on site to promote open communication. To establish weekly meetings between senior nurses and charge nurses on site to discuss operational issues. Charge nurses to have monthly update meetings in their respective wards for all staff minuted and sent to all staff.	

ACTION PLAN Leadership			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To put in place an effective leadership team to ensure that the operational, strategic and professional issues are taken forward on the MAH site and in particular those issues raised in the Adult Safeguarding investigation and subsequent report 'A way to go'. To appoint a Divisional Nurse who if not from a Learning Disability background has access to a Senior Learning Disability Nurse for professional and operational guidance in Muckamore Abbey Hospital with a clear professional line of accountability to the Director of Nursing and User Experience.	Director	To appoint an interim leadership team to include divisional nurse to ensure the efficient and effective management and leadership of the MAH site.	
		Put in place plans to appoint a permanent Leadership team to include a Divisional Nurse and communicate the same to staff, users, carers and advocates.	
		To consider the commissioning of a leadership programme for senior clinical and social care staff at MAH through the "HSC Leadership Centre".	
		To implement Patient Inpatient Admission (PIPA) meetings at clinical level with senior nursing leadership.	
		To implement multi-disciplinary clinical improvement meeting on each ward monthly.	
		To implement Leadership "walk about" on a weekly basis.	
		Trust to appoint a service improvement co-ordinator MH and LD services. Post appointed January 2020.	
		To Review the model of Multi-Disciplinary working on the Muckamore Abbey Hospital site to include staff working in Community Services.	

ACTION PLAN Regulation Quality and Improvement Authority			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To address the recommendations raised by RQIA in their improvement notices – to finance, staffing, -- and safeguarding.	Co-Director	To review patient finances in MAH, develop guidance for nursing and finance staff. Work with "Department of Communities" to ascertain the accuracy of benefits currently received by patients to ensure appropriate financial systems and processes are in place to protect patients and staff and refer to the "Office of Care and Protection" where appropriate.	
		To conduct unannounced inspections of the revised finance procedures.	
		To review the Trust seclusion policy and provide training to staff as appropriate	
		To work with the RHSCB to access the Trust compliance with safeguarding policies and procedures on the MAH site, review and train staff as appropriate.	
	Divisional Nurse	To develop an interactive interim workforce plan for each ward to ensure the safe and effective care and staffing levels until the regional 'Delivering Care' workforce plan is complete and train staff in its use.	

ACTION PLAN Resettlement			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To resettle the Adult Learning Disability population (52 of MAH patients into suitable community facilities with appropriate support and input from facilities staff and Health and Social Care teams.	Director	All care and treatment plans to be fully updated by the multidisciplinary team for all patients in each HSC Trust to ascertain the level of need for each patient, where their need can best be met alongside assessing the level and nature of unmet needs (52 patients remaining)	
		To inform the commissioner and DOH of current and future needs of the Muckamore Abbey Hospital patient population to ensure adequate commissioning and provision of safe and effective care now and in the future.	
		To work with the commissioner and HSC Trusts to review the “admission policy” and current agreement for Muckamore Abbey Hospital to continue to receive admissions from other Trusts with a view to finding alternative arrangements within the region in order to expedite the resettlement process.	

RAG Rating	
Completed	
Work in progress	
Progress required/Risk of not meeting target	

Exhibit 70

MAHI - STM - 300 - 1809

STANDARDS FOR NURSING ASSISTANTS

EMPLOYED BY HSC TRUSTS IN NORTHERN IRELAND

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

FOREWORD

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. Mandating these Standards across the HSC will serve to recognise and support the valued contribution made by this cohort of staff.

The Department of Health commissioned these Standards for Nursing Assistants employed by Health and Social Care Trusts in Northern Ireland, and wishes to acknowledge the role of the Northern Ireland Practice and Education Council and the Working Group established to lead the development of these Nursing Assistant Standards and associated resources in partnership with the HSC.

Charlotte McArdle Chief Nursing Officer

Andrew Dawson Director of Workforce Policy (Acting)

Introduction

These Standards are for all Nursing Assistants employed in Health and Social Care (HSC) Trusts across Northern Ireland. A Nursing Assistant is someone who undertakes delegated aspects of nursing care and is supervised by a Registered Nurse. The Department of Health (DoH) and HSC Trusts have a duty and a responsibility to protect and improve the health and wellbeing of people who use our services. Nursing Assistants will be supported by their employers to adhere to these Standards in order to deliver person-centred, safe, effective and compassionate care, across all healthcare settings.

Nursing Assistants make a valuable and important contribution to the delivery of high quality, person-centred healthcare. They have a responsibility and a duty of care to ensure their conduct does not fall below these Standards and that no act or omission, within the sphere of their role, harms the safety and wellbeing of people who use our services.

Department of Health Mandate

The DoH fully endorses the Standards for Nursing Assistants and requires that they be implemented and enforced across all HSC Trusts. HSC Trusts must monitor the implementation of the Standards and take action where concerns have been raised. The Department will monitor and seek assurances from Trusts regarding implementation. The Standards are consistent with and complement the overarching Code of Conduct for HSC Employees (DoH, 2016).

Purpose

This document presents the Standards of care, conduct and behaviours required of Nursing Assistants and informs employers, colleagues, people who use our services and the public about these. The Standards form part of employers' existing policies and procedures which Nursing Assistants must adhere to.

Scope

The Standards apply to all Nursing Assistants employed to support Registered Nurses in HSC Trusts, providing care and services for people who use our services. The Standards will also be referenced in Nursing Assistant job descriptions relevant to the Agenda for Change band and in the Knowledge and Skills Framework (KSF) post outline.

Employers' Responsibilities

Employers of Nursing Assistants are required to have systems and processes in place, including the provision of relevant training and ongoing development, which enables and supports these employees to achieve the Standards.

The key principles for employers are as follows. Employers will:

- ensure that individuals recruited and employed as Nursing Assistants have the necessary attributes for the role;
- provide training on these Standards so that Nursing Assistants understand their role, accountabilities and responsibilities;
- have systems, processes and procedures in place, including KSF post outlines and personal development plans, appraisal and ongoing support/ supervision, to enable Nursing Assistants to meet the requirements of the Standards;
- provide access for Nursing Assistants to education, training and development activities to develop and enhance their knowledge, skills and behaviours relevant to their role;
- support Nursing Assistants with opportunities for career development and ensure that adherence to the Standards is integrated into day-to-day practice within the organisation.

What the Standards will mean for Nursing Assistants

The Standards for Nursing Assistants are informed by the Nursing and Midwifery Council's guidance for Registered Nurses regarding the act of delegation (NMC, 2015[1]). It is important to note that a Registered Nurse is accountable for the decision to delegate care and should only delegate care to a Nursing Assistant who has had appropriate training and whom they deem competent to perform a delegated activity. The Nursing Assistant should also understand their role, which includes the nature of the activity, what is expected of them, their limitations and, if circumstances change, when to seek advice. The Nursing Assistant is then accountable for their actions and decisions when undertaking a delegated activity, although the registered practitioner remains accountable for the overall management of the person in their care.

By following these Standards, Nursing Assistants can be assured that they are working to the standard agreed by the DoH, which is essential to protect the people who use our services and others. This document sets clear Standards for Nursing Assistants to:

- help them fulfil the requirements of the role;
- identify the learning and development to be undertaken to develop their knowledge, skills and behaviours;
- enable them to do the right thing at all times.

[1] Nursing and Midwifery Council (2015) The Code: Professional Standards for Practice and Behaviour for Nurses and Midwives. London: NMC

What the Standards will mean for people who use our services

The Standards have been developed on the principle of protecting the public. They assist people who use our services to understand the standards expected of Nursing Assistants and their employers.

What the Standards will mean for Registered Nurses and Managers

The Standards will help Registered Nurses, employers and managers understand the standards expected of Nursing Assistants. Line managers will, as part of annual KSF and Personal Development Review/appraisal meetings and ongoing support/ supervision, agree areas for the Nursing Assistant's personal development. This will be achieved by reviewing the individual's knowledge, skills and attributes in line with the Standards, the individual's job description and KSF post outline.

The Standards for Nursing Assistants

As a Nursing Assistant you must adhere to these four Standards:

1

Support the delivery of safe, person-centred and compassionate care to people who use our services.

2

Communicate openly and honestly to promote the health and wellbeing of people who use our services.

3

Maintain your knowledge, skills and experience to enable you to do your job properly, in order to improve the quality of care to people who use our services.

4

Respect and protect at all times the right to confidentiality, privacy and dignity for people who use our services.

Standards and Guidance Statements

Each of the four Standards has associated guidance statements which will help you to enhance your knowledge, skills and behaviours to continuously improve your performance and the care you provide for people who use our services. It is essential that you familiarise yourself with these Standards and adhere to them whilst working within your organisation's policies and procedures.

Standard 1:

Support the delivery of safe, person-centred and compassionate care to people who use our services.

1. Care for people who use our services safely and compassionately at all times, to enhance person-centred care.
2. Be accountable by making sure you can always answer for your actions and omissions, in relation to caring for people who use our services.
3. Be honest with yourself and others and only carry out those activities within your remit and delegated to you, for which you have undertaken relevant training and education and have been deemed competent by a Registered Nurse.
4. Do not misuse your privileged position to neglect, harm, abuse or exploit people who use our services.
5. Work collaboratively with colleagues across all disciplines to support person-centred care.

Standard 2:

Communicate openly and honestly to promote the health and wellbeing of people who use our services.

1. Communicate in an open, honest, accurate and timely way with people who use our services and with colleagues to support the delivery of person-centred care.
2. Document and maintain clear and accurate records relevant to the care you have given to a person using our services in line with your organisation's policy.
3. Report any changes in or concerns about the condition of a person who uses our services immediately to the Registered Nurse, who is responsible for the overall management of the person's care.
4. Always take complaints or concerns seriously and raise issues that you are concerned about with your line manager, in line with your organisation's policies.
5. When communicating with people who use our services and with colleagues, recognise the limitations of your role, knowledge and competence.

Standard 3:

Maintain your knowledge, skills and experience to enable you to do your job properly, in order to improve the quality of care to people who use our services.

1. Participate in training and personal development required by your employer and take responsibility for the achievement of the competence essential for your role, in line with KSF and organisational requirements.
2. In agreement with your line manager, ensure you comply with all statutory and mandatory training required for your role.
3. Maintain an up to date record of your own training and development.
4. Contribute to the learning and development of others where appropriate.

Standard 4:

Respect and protect at all times the right to confidentiality, privacy and dignity for people who use our services.

1. Do not discuss or share personal information about people and their treatment inappropriately or with anyone other than relevant colleagues in the team.
2. Uphold and promote the principles of equality, diversity and inclusion for people who use our services and your colleagues, as everyone is entitled to be treated fairly and without bias.
3. Establish and maintain clear and appropriate boundaries in your relationships with people who use our services and with colleagues at all times. Always behave in a professional manner.
4. Refuse to accept any offers of loans, gifts, benefits or hospitality from anyone in your care, or anyone close to them, which may be seen to compromise your position.
5. Do not use social media to share information about the environment you work in or the people for whom you care.

Department of Health,
Castle Buildings, Stormont, Belfast,
Northern Ireland, BT4 3SQ.

www.health-ni.gov.uk

February 2018

Exhibit 71

Maintaining High Professional Standards in the Modern HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

Department of Health, Social Services & Public Safety
November 2005

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

CONTENTS *Page*

INTRODUCTION

1. This document introduces the new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

2. Throughout this framework where the term "performance" is used, it should be interpreted as referring to all aspects of a practitioner's work, including conduct, health and clinical performance. Where the term "clinical performance" is used, it should be interpreted as referring only to those aspects of a practitioner's work that require the exercise of clinical judgement or skill.

3. Under the Directions on Disciplinary Procedures 2005, HPSS organisations must notify the Department of the action they have taken to comply with the framework by 31 January 2006.

4. The framework is in six sections and covers:

   I. Action when a concern first arises

   II. Restriction of practice and exclusion from work

   III. Conduct hearings and disciplinary procedures

   IV. Procedures for dealing with issues of clinical performance

   V. Handling concerns about a practitioner's health

   VI. Formal procedures – general principles

5. Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist.

Background

6. There has been some concern in the past about the way in which complaints about doctors and dentists have been handled. Developing new arrangements for dealing with medical and dental staff performance has become increasingly important in order to address these concerns and to reflect the new systems for quality assurance, quality improvement and patient safety being introduced in the HPSS.

7. The National Clinical Assessment Authority (NCAA) was established to improve arrangements for dealing with poor clinical performance of doctors. The Department entered into a service level agreement with the NCAA in October 2004 to provide advice and guidance to the HPSS. Since April 2005,

the NCAA has become a division of the National Patient Safety Agency, and is now known as the National Clinical Assessment Service (NCAS).

8. The new approach set out in the framework builds on four key elements:

- appraisal[1] and revalidation – processes which require practitioners to maintain the skills and knowledge needed for their work through Continuing Professional Development (CPD);
- the advisory and assessment services of the NCAS – aimed at enabling HSS Bodies[2] to handle cases quickly and fairly - reducing the need to use disciplinary procedures to resolve problems;
- tackling the blame culture – recognising that most failures in standards of care are caused by systems' weaknesses, not individuals per se;
- new arrangements for handling exclusion from work as set out in Sections I and II of this framework.

9. To work effectively these need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists maintaining their competence; and which support an open approach to reporting and addressing concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through disciplinary action. However, it is not intended to weaken accountability or avoid disciplinary action where the situation warrants this approach.

The new framework

10. At the heart of the new arrangements is a co-ordinated process for handling concerns about the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS. Whatever the source of this information the response must be the same –

- to ascertain quickly what has happened and establish the facts;
- to determine whether there is a continuing risk;
- to decide whether immediate action is needed to manage the risk to ensure the protection of patients;
- to put in place action to address any underlying problem.

[1] Appraisal is a structured process which gives doctors an opportunity to reflect on their practice and discuss, with a suitably trained and qualified appraiser, any issues arising from their work, and their development needs.

[2] In the Direction and Framework "HSS bodies" means: HSS Trusts, HSS Boards and Special Agencies

Under these new mechanisms, exclusion from work must be used only in the most exceptional circumstances.

11. All HSS bodies must have procedures for handling concerns about an individual's performance. These procedures must reflect the framework in this document and allow for informal resolution of problems where deemed appropriate. Concerns about the performance of doctors and dentists in training should be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset. The onus still rests with the employer for the conduct of the investigation and any necessary action.

SECTION I. ACTION WHEN A CONCERN FIRST ARISES

INTRODUCTION

1. The management of performance is a continuous process to ensure both quality of service and to protect clinicians. Numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures.

2. Concerns about a doctor or dentist's performance can come to light in a wide variety of ways, for example:

   - concerns expressed by other HPSS staff;
   - review of performance against job plans and annual appraisal;
   - monitoring of data on clinical performance and quality of care;
   - clinical governance, clinical audit and other quality improvement activities;
   - complaints about care by patients or relatives of patients;
   - information from the regulatory bodies;
   - litigation following allegations of negligence;
   - information from the police or coroner;
   - court judgements; or
   - following the report of one or more critical clinical incidents or near misses.

3. All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to establish the facts and the substance of any allegations. Unfounded or malicious allegations can cause lasting damage to a doctor's reputation and career. Where allegations raised by a fellow HPSS employee are shown to be malicious, that employee should be subject to the relevant disciplinary procedures.

SUMMARY OF KEY ACTIONS NEEDED

4. The key actions needed at the outset can be summarised as follows:

   - clarify what has happened and the nature of the problem or concern;
   - consider discussing case with NCAS on the way forward;
   - consider if urgent action needs to be taken to protect the patient/s;
   - consider whether restriction of practice or exclusion is required;

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member* "should be involved to any significant degree in the management of individual cases.

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
   - immediate telephone advice, available 24 hours;
   - advice, then detailed supported local case management;
   - advice, then detailed NCAS performance assessment;
   - support with implementation of recommendations arising from assessment.

10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.

11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.

14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.

17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.

19. An immediate time limited exclusion may be necessary

- to protect the interests of patients or other staff;
- where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

20. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.

21. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

22. The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting

23. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

24. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

26. At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body should be notified. Guidance on the process for issuing alert letters can be found in circular HSS (TC8) (6)/98. This framework also sets out additional circumstances when the issue of an alert letter may be considered.

27. Section II of this framework sets out the procedures to be followed should a formal investigation indicate that a longer period of formal exclusion is required.

FORMAL APPROACH

28. Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CE must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.

29. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action.

30. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

The Case Investigator's role

31. The Case Investigator:

- must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff[3] with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;
- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

[3] Where no other suitable senior doctor or dentist is employed by the HSS body a senior doctor or dentist from another HSS body should be involved.

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
- must assist the designated Board member in reviewing the progress of the case.

32. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.

33. The Case Investigator has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

The Case Manager's role

34. The Case Manager is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority

35. The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.

36. If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another HSS body or elsewhere be invited to assist.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

SECTION II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

INTRODUCTION

1. This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.

2. In this part of the framework, the phrase “exclusion from work” has been used to replace the word “suspension” which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

3. The Directions require that HSS bodies must ensure that:

   - exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
   - where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
   - all extensions of exclusion are reviewed and a brief report provided to the CE and the board;
   - a detailed report is provided when requested to the designated Board member who will be responsible for monitoring the situation until the exclusion has been lifted.

MANAGING THE RISK TO PATIENTS

4. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.

5. The purpose of exclusion is:

   - to protect the interests of patients or other staff; and/or
   - to assist the investigative process when there is a clear risk that the practitioner’s presence would impede the gathering of evidence.

6. It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

7. **Under the Directions, an HSS body cannot require the exclusion of a practitioner for more than four weeks at a time.** The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key aspects of exclusion from work

8. Key aspects include:

- an initial “immediate” exclusion of no more than four weeks if warranted as set out in Section I;
- notification of the NCAS before immediate and formal exclusion;
- formal exclusion (if necessary) for periods up to four weeks;
- ongoing advice on the case management plan from the NCAS;
- appointment of a designated Board member to monitor the exclusion and subsequent action;
- referral to NCAS for formal assessment, if part of case management plan;
- active review by clinical and case managers to decide renewal or cessation of exclusion;
- a right to return to work if review not carried out;
- performance reporting on the management of the case;
- programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
- a right for the doctor to make representation to the designated Board member

9. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director.

Exclusion other than immediate exclusion

10. A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether there is reasonable and proper cause to exclude. **The NCAS must be consulted where formal exclusion is being considered.** If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.

11. The report should provide sufficient information for a decision to be made as to whether:

    (i) the allegation appears unfounded; or

    (ii) there is a misconduct issue; or

    (iii) there is a concern about the practitioner's clinical performance; or

    (iv) the complexity of the case warrants further detailed investigation before advice can be given.

12. Formal exclusion of one or more clinicians must only be used where:

    a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of:

    - allegations of misconduct;
    - concerns around the functioning of a clinical team which are likely to adversely affect patients;
    - concerns about poor clinical performance; or

    b. the presence of the practitioner in the workplace is likely to hinder the investigation.

13. Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

14. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion

(paragraph 30 of Section I defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

15. The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 19, and the need to remain available for work paragraph 20) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

16. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

17. If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.

18. If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

Exclusion from premises

19. Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff

Keeping in contact and availability for work

20. Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HPSS employer. This caveat does not refer to time for which they are not being paid by the HPSS employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

21. The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

Informing other organisations

22. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HPSS and non-HPSS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer[4].

23. Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HPSS, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.

24. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called ‘gardening leave’ have been

[4] HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointments.

commonly used in the recent past. **No HSS body may use "gardening leave" as a means of resolving a problem covered by this framework.**

Existing suspensions & transitional arrangements

25. On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

26. The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the Department (Director of Human Resources).
- receive an assurance from the CE and designated board member that the agreed mechanisms are being followed. Details of individual exclusions should not be discussed at Board level.

Regular review

27. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[5]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

28. The HSS body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

[5] It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to CE and Medical Director. • Each review is a formal matter and must be documented as such. • The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: • A report must be made by the Medical Director to the CE: - outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed - a timetable for completion of the investigation. • The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. • The case must be formally referred back to the NCAS explaining: - why continued exclusion is thought to be appropriate; - what steps are being taken to complete the investigation at the earliest opportunity. • The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, • A further position report must be made by the CE to

	the Department indicating: - the reason for continuing the exclusion; - anticipated time scale for completing the process; - actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

29. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

The role of the Department in monitoring exclusions

30. When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.

31. When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

RETURN TO WORK

32. If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there is a case of misconduct that must be put to a conduct panel (paragraph 38 of section 1). Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.

2. It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraph 5 of Section IV refers).

3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation. [6]

4. Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.

5. HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

CODES OF CONDUCT

6. Every HPSS employer will have a Code of Conduct or staff rules, which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:

   - a refusal to comply with the requirements of the employer where these are shown to be reasonable;
   - an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of

[6] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee

doctors and dentists by their regulatory body[7];

- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

7. The employer's Code of Conduct should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Similarly the Labour Relations Agency (LRA) Code of Practice provides a non-exhaustive list of examples. Acts of misconduct may be simple and readily recognised or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.

8. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.

9. It is for the employer to decide upon the most appropriate way forward, including the need to consult the NCAS and their own sources of expertise on employment law. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively, or in addition, he or she may make representations to the designated Board member.

10. In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC.

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

11. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters

[7] In case of doctors, *Good Medical Practice.* In the case of dentists, *Maintaining Standards.*

would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

Cases where criminal charges are brought not connected with an investigation by an HPSS employer

12. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made. Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

13. If the practitioner is acquitted following legal proceedings, but the employer feels there is enough evidence to suggest a potential danger to patients, the Trust has a public duty to take action to ensure that the practitioner does not pose a risk to patient safety. Where the charges are dropped or the court case is withdrawn, there may be grounds to consider allegations which if proved would constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned.

SECTION IV. PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

INTRODUCTION & GENERAL PRINCIPLES

1. There will be occasions following an adequate investigation where an employer considers that there has been a clear failure by an individual to deliver an acceptable standard of care, or standard of clinical management, through lack of knowledge, ability or consistently poor performance. These are described as clinical performance issues.

2. Concerns about the clinical performance of a doctor or dentist may arise as outlined in Section I. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through local informal processes set out in Section I (paragraphs 15 – 17) **the matter must be referred to the NCAS before consideration by a performance panel** (unless the practitioner refuses to have his or her case referred).

3. Matters which may fall under the perfomance procedures include:

   - out moded clinical practice;
   - inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
   - incompetent clinical practice;
   - inappropriate delegation of clinical responsibility;
   - inadequate supervision of delegated clinical tasks;
   - ineffective clinical team working skills.

   Wherever possible such issues should be dealt with informally, seeking support and advice from the NCAS where appropriate. The vast majority of cases should be adequately dealt with through a plan of action agreed between the practitioner and the employer.

4. Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in Section V of this framework.

How to proceed where conduct and clinical performance issues are involved

5. It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If a

case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[8].

7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

8. If the practitioner does not agree to the case being referred to NCAS, a panel hearing will normally be necessary.

HEARING PROCEDURE

The pre-hearing process

9. The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;
- all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date

[8] see paragraphs 5 and 6 in section 6I on arrangements for small organisations

should be set for the hearing;

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;
- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;
- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.[9] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

11. Arrangements must be made for the panel to be advised by:

- a senior member of staff from Human Resources;
- an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HPSS employer;

[9] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee.

- a representative of a university if provided for in any protocol agreed between the employer and the university.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS/NHS employer, in the same grade as the practitioner in question, should be asked to provide advice. In the case of doctors in training the postgraduate dean's advice should be sought.

12. It is for the employer to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The employer should review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The employer must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

Representation at clinical performance hearings

13. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.

14. The practitioner may be represented in the process by a companion who may be another employee of the HSS body: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the clinical performance hearing

15. The hearing should be conducted as follows:

- the panel and its advisers, the practitioner, his or her representative and the Case Manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- the Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
- the procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;
- the side calling the witness can question the witness;
- the other side can then question the witness;
- the panel may question the witness;
- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

- the Case Manager presents the management case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification;
- the practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification;
- the Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- the Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation;
- the panel shall then retire to consider its decision.

Decisions

16. The panel will have the power to make a range of decisions including the following:

<u>Possible decisions made by the clinical performance panel</u>

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;
- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

- the clinical performance problem(s) identified;
- the improvement that is required;
- the timescale for achieving this improvement;
- a review date;
- measures of support the employer will provide; and
- the consequences of the practitioner not meeting these requirements.

In addition, dependent on the extent or severity of the problem, the panel may:

- issue a written warning or final written warning that there must be an improvement in clinical performance within a specified time scale together with the duration that these warnings will be considered for disciplinary purposes (up to a maximum of two years depending on severity);
- decide on termination of contract.

In all cases where there is a finding of unsatisfactory clinical performance, consideration must be given to referral to the GMC/GDC.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. The panel may wish to comment on the systems and procedures operated by the employer.

17. A record of all findings, decisions and written warnings should be kept on the practitioner's personnel file. Written warnings should be disregarded for disciplinary purposes following the specified period.

18. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Given the possible complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

19. The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

Introduction

20. Given the significance of the decision of a clinical performance panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process.

21. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel, in arriving at their decision, acted fairly and reasonably based on:

- a fair and thorough investigation of the issue;
- sufficient evidence arising from the investigation or assessment on which to base the decision;
- whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 24 below).

22. A dismissed practitioner will, in all cases, be potentially able to take their case to an Industrial Tribunal where the fairness of the Trust's actions will be tested.

The appeal process

23. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.

24. Where the appeal is against dismissal, the practitioner should not be paid, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

The appeal panel

25. The panel should consist of three members. The members of the appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the designated board member. These members will be:

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool.[10] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[11] who must also have the appropriate training for hearing an appeal.

In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university

26. The panel should call on others to provide specialist advice. This should normally include:

- a consultant from the same specialty or subspecialty as the appellant, but from another HPSS/NHS employer [12];
- a senior Human Resources specialist.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS employer in the same grade as the practitioner in question should be asked to provide advice. Where the case involves a doctor in training, the postgraduate dean should be consulted.

27. The Trust should convene the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 29. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant's objections should be noted carefully. Trusts are reminded of the need to act reasonably at all stages of the process.

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[10] See Annex A.

[11] Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.

[12] Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

28. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original performance hearing. The following timetable should apply in all cases:

- appeal by written statement to be submitted to the designated appeal point (normally the Director of HR) within 25 working days of the date of the written confirmation of the original decision;
- hearing to take place within 25 working days of date of lodging appeal;
- decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

29. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

Powers of the appeal panel

30. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.

31. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

32. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

Conduct of appeal hearing

33. All parties should have all documents, including witness statements, from the previous performance hearing together with any new evidence.

34. The practitioner may be represented in the process by a companion who may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative

will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

35. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.

36. The panel, after receiving the views of both parties, shall consider and make its decision in private.

Decision

37. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's Case Manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

Action following hearing

38. Records must be kept, including a report detailing the performance issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the clinical performance procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Industrial Tribunal.

Annex A

APPEAL PANELS IN CLINICAL PERFORMANCE CASES

Introduction

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.

2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held Northern Ireland wide list rather than through local selection. The benefits include:

   - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
   - the ability to monitor performance and assure the quality of panellists.

3. The following provides an outline of how it is envisaged the process will work.

Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with the Department, who will be responsible for administration of the list

5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the BMA, BDA, defence organisations, and the NCAS. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.

6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

7. Panel members will be subject to appraisal against the core competencies and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.

8. The level of fees payable to panel members will be set by the Department and paid locally by the employer responsible for establishing the panel.

9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competencies and /or seminars designed to provide background on the specific context of HPSS disciplinary procedures.

SECTION V. HANDLING CONCERNS ABOUT PERFORMANCE ARISING FROM A PRACTITIONER'S HEALTH

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there are concerns about the practitioner's health that should be considered by the HSS body's Occupational Health Service (OHS) and the findings reported to the employer.

2. In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.

3. The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HPSS.

HANDLING HEALTH ISSUES

4. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)[13]. The practitioner may be accompanied to these meetings (as defined in Section I, para 30). Confidentiality must be maintained by all parties at all times.

5. The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.

6. In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures (as outlined in Section IV), or misconduct procedures (as outlined in Section III) would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to

[13] In the absence of a Medical Director organisations should put in place appropriate measures as part of agreed arrangements for small organisations to ensure the appropriate level of input to the process. See section vi.

resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

7. A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

8. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of actions a Trust might take in these circumstances, in consultation with OHS and having taken advice from NCAS and/or NIMDTA if appropriate.

Examples of action to take

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- remove the practitioner from certain duties;
- make adjustments to the practitioner's working environment;
- reassign them to a different area of work;
- arrange re-training for the practitioner;
- consider whether the Disability Discrimination Act (DDA) applies (see below), and, if so, what other reasonable adjustments might be made to their working environment.

DISABILITY DISCRIMINATION ACT (DDA)

9. Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.

10. Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non-disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

Examples of reasonable adjustment

- make adjustments to the premises;
- re-allocate some of the disabled person's duties to another;
- transfer employee to an existing vacancy;
- alter employee's working hours or pattern of work;
- assign employee to a different workplace;
- allow absence for rehabilitation, assessment or treatment;
- provide additional training or retraining;
- acquire/modify equipment;
- modifying procedures for testing or assessment;
- provide a reader or interpreter;
- establish mentoring arrangements.

11. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and HPSS Superannuation Branch**.**

Note. Special Professional Panels (generally referred to as the "three wise men") were set up under circular TC8 1/84. This part of the framework replaces those arrangements and any existing panels should be disbanded.

SECTION VI. FORMAL PROCEDURES – GENERAL PRINCIPLES

TRAINING

1. Employers must ensure that managers and Case Investigators receive appropriate training in the operation of formal performance procedures. Those undertaking investigations or sitting on disciplinary or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members have completed before they can take a part in these proceedings.

HANDLING OF ILLNESS ARISING DURING FORMAL PROCEEDINGS

2. If an excluded employee or an employee facing formal proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside formal procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

3. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner should have the opportunity to provide written submissions and/or have a representative attend in his absence.

4. Where a case involves allegations of abuse against a child or a vulnerable adult, the guidance issued to the HPSS in 2005, "Choosing to Protect – A Guide to Using the Protection of Children Northern Ireland (POCNI) Service", gives more detailed information.

PROCESS FOR SMALLER ORGANISATIONS

5. Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

6. Such organisations should consider working in collaboration with other local HPSS organisations (eg other Trusts) in order to provide sufficient personnel

to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HPSS organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

TERMINATION OF EMPLOYMENT WITH PROCEDURES UNFINISHED

7. Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

8. There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

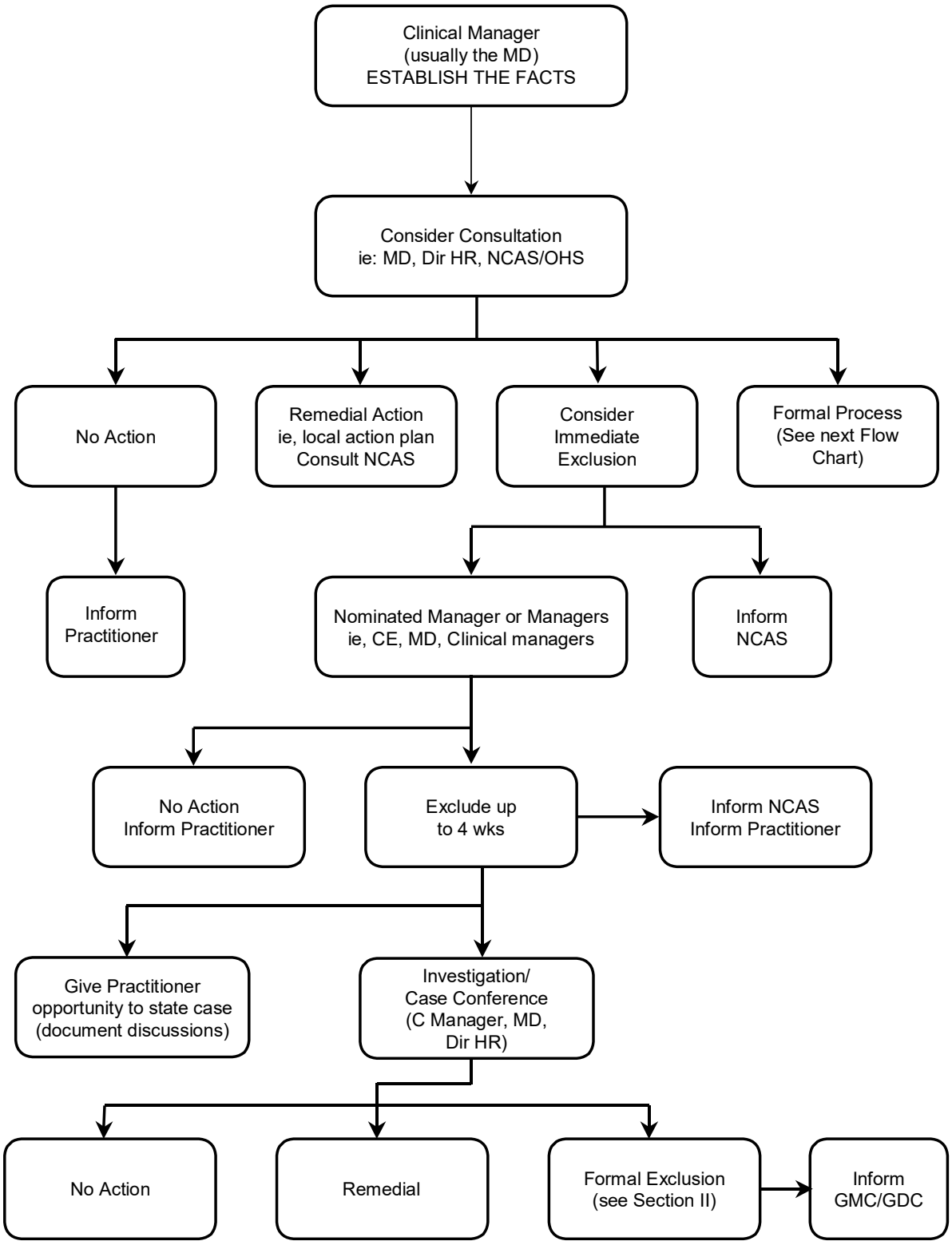
9. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning).

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

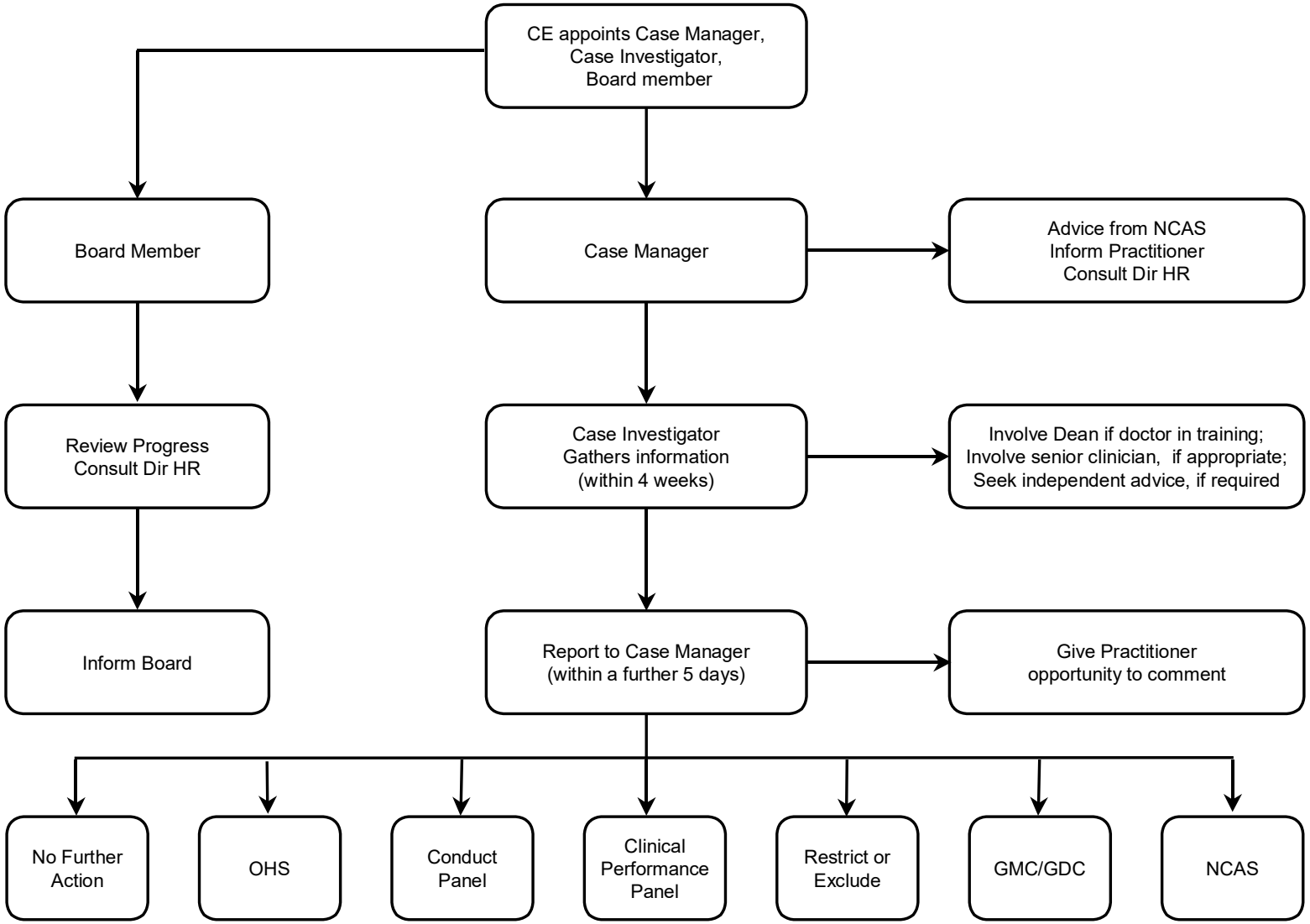
10. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

- settlement agreements must not be to the detriment of patient safety;
- it is not acceptable to agree any settlement that precludes involvement of either party in any further legitimate investigations or referral to the appropriate regulatory body.

INFORMAL PROCESS



FORMAL PROCESS



From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

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

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH439
HE1/20/437020

Date: 15 September 2020

Via email
Independent Providers
Directors of Adult Services HSC Trusts

Dear Colleagues

I am writing to you to highlight an issue which has been raised with me through my engagements with family representatives of current and past patients in Muckamore Abbey Hospital.

Concerns have been expressed to me that some providers have been engaged in attempts to put pressure on some resettled individuals and their families to consider moves from their current community placements to new supported living developments.

While I do not have access to the full case histories of the individuals involved, I would wish to re-emphasise the general principles underpinning the resettlement programme, and in particular that resettled individuals have a legitimate expectation that their community placement will be treated as their permanent home, with all the attendant rights and protections that are afforded to all citizens.

Any proposals to move individuals to other facilities should therefore only be pursued where there are irrefutable reasons for doing so, such as for example legitimate safety concerns which have the potential to cause the individual harm and which cannot be addressed, serious and substantial concerns about the viability of a provider or the closure of a facility. Such moves can be very traumatic for both patients and their families and must be avoided if at all possible.

In cases where a move becomes unavoidable, individuals and their families and carers should be made aware of the reasons for this at the earliest possible stage, and be fully involved in planning arrangements for an alternative placement.

I am asking you to ensure that all your staff involved in supporting learning disability patients in the community are clear about this communication to ensure that an accurate and consistent message is shared with patients, families and carers.

Yours sincerely

SEÁN HOLLAND
Chief Social Work Officer

From the Chief Social Work Officer
Sean Holland

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

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH438

Date: 15 September 2020

Via email:

Cathy Jack, Chief Executive, BHSCT
cathy.jack@belfasttrust.hscni.net

Dear Cathy

Regional Resettlement Process

You will be aware that one of the objectives of the Muckamore Departmental Assurance Group is to ensure that the Permanent Secretary's commitment to resettle patients from Muckamore is met.

At a recent meeting of the Group, members agreed that the Department and the Health and Social Care Board should jointly review the effectiveness of the current structures for progressing the regional re-settlement programme.

One of the issues being considered by the resettlement programme relates to the small number (less than ten) of very long stay patients currently living on the hospital site who are reluctant to relocate from what is effectively the only home they have known throughout their adult lives. In recognition of this, I am writing to request that the Belfast Trust develop a proposal for a model of on-site provision, separate from the assessment and treatment wards, which would be capable of meeting the particular needs of these individuals in a supported living setting located within the boundaries of the existing hospital site.

In relation to the resettlement of the wider hospital population, I understand the Belfast Trust is currently progressing with the NI Housing Executive business cases for new Supporting People facilities at Knockcairn/Rushey Hill and Lanthorne Mews intended to support the resettlement of Muckamore patients. I would be grateful for a progress update on these facilities, to include an indicative timescale for their completion.

I am copying this correspondence to Marie Roulston.

Yours sincerely

SEAN HOLLAND
Chief Social Work Officer/Deputy Secretary

cc: Mark Lee
Marie Roulston (HSCB)

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

WRITTEN STATEMENT TO THE ASSEMBLY BY HEALTH MINISTER ROBIN SWANN – THURSDAY 29 SEPTEMBER 2022 AT 11AM - PUBLICATION OF INDEPENDENT REVIEW OF THE LEARNING DISABILITY RESETTLEMENT PROGRAMME IN NORTHERN IRELAND

I wish to inform Members that the Department of Health has today published the final report of an independent review of the Learning Disability Resettlement Programme in Northern Ireland. The Report is available at Health Minister welcomes findings of resettlement review | Department of Health (health-ni.gov.uk)

The review was commissioned to examine and strengthen the oversight arrangements for resettling patients from Muckamore Abbey and other learning disability hospitals.

I want to thank the review panel for their thorough report and for their clear conclusions. I particularly welcome the panel's extensive engagement with patients and families in carrying out their review. Improving the well-being and quality of life for patients is front and centre of the resettlement work, and it is vital that all resettlement plans are person centred with the patient at the heart of all decision making process.

This report must act as a catalyst to radically improve the rate of progress on resettlement. Patients and families have already waited far too long in far too many instances.

I can confirm to the Assembly that I have accepted all the report's recommendations, and work is underway to implement these. As an important first step, I have agreed to the establishment of a Regional Resettlement Oversight Board, to be led by a regional senior leader and which will take responsibility for expediting the planned and safe resettlement of those patients whose discharge has been delayed.
I am pleased to announce that Dr Patricia Donnelly has agreed to chair the Regional Board. Patricia will work with senior Directors covering a number of policy and professional roles within my Department, and I look forward to her bringing her proven track record of delivery to this work. The Oversight Board will set a timetable for the resettlement of the remaining patients in Muckamore Abbey and the other regional learning disability hospitals, and regular updates on progress will be provided.'

As the resettlement programme at Muckamore Abbey progresses, the reducing number of in-patients at the hospital will raise questions about the future

configuration of services on the site. I can confirm to Members that I am considering options for the future role of the hospital, and I will make a further statement on this in the coming weeks.

It is increasingly clear that the time when a large isolated specialist hospital of this kind was the correct model has passed. Decisions will have to be made, sooner rather than later, to secure a better future.
My priority continues to be the safety and well-being of all those who use the services provided on the Muckamore site, and any decisions about the future of these will only be taken in full consultation with patients and their families.'

The review published today was carried out by two former Directors of Social Work with extensive experience in health and social care leadership roles, the review concludes that leadership and governance of the resettlement programme has been less than adequate, and critically examines the rate of progress towards delivering successful resettlement outcomes for patients whose discharge has been delayed. The review acknowledges the impact of the Covid 19 pandemic on the pace of resettlement, and welcomes recent work by Trusts which has improved the resettlement trajectory.

The review found that policy and strategy in Northern Ireland for people with learning disabilities and their families is in urgent need of updating, and that an updated strategy should consolidate the long-standing goal that no-one should call a hospital their home. The report also concludes that there was no overarching plan for resettlement, despite it being identified as a priority in commissioning plans, with Trusts planning in isolation with inadequate communication of joint arrangements. The review panel also found that the voices of patients and their families were not adequately heard, and opportunities to learn from their experiences and expertise were missed.

The report also details: limited evidence of senior engagement with the independent social sector; a lack of consistency in individual care planning documentation and no agreed regional pathway for resettlement; limited evaluation of successes and failures, and that safeguarding remains an abiding concern for families.

Exhibit 75

Transforming care:

A national response to Winterbourne View Hospital

Department of Health Review: Final Report

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	18348
Title	Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report
Author	Department of Health
Publication Date	**December 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, GPs, Directors of Children's SSs
Circulation List	Medical Directors, PCT PEC Chairs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, Communications Leads, Emergency Care Leads, Voluntary Organisations/NDPBs
Description	The report sets out the governments final response to the events at Winterbourne View hospital. It sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging.
Cross Ref	Department of Health Review: Winterbourne View Hospital: Interim Report Winterbourne View Review: Concordat: A Programme of Action
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	Mental Health, Disability and Equality Department of Health Room 313A Richmond House 79 Whitehall SW1A 2NS
For Recipient's Use	

Transforming care:
A National response to Winterbourne View Hospital

Department of Health Review: Final Report

Contents

Ministerial Foreword

The scandal that unfolded at Winterbourne View is devastating.

Like many, I have felt shock, anger, dismay and deep regret that vulnerable people were able to be treated in such an unacceptable way, and that the serious concerns raised by their families were ignored by the authorities for so long.

This in-depth review, set up in the immediate aftermath of the Panorama programme in May 2011, is about the lessons we must learn and the actions we must take to prevent abuse from happening again.

It is also about promoting a culture and a way of working that actively challenges poor practice and promotes compassionate care across the system.

First and foremost, where serious abuse happens, there should be serious consequences for those responsible.

At Winterbourne View, the staff had committed criminal acts, and six were imprisoned as a result. However, the Serious Case Review showed a wider catalogue of failings at all levels, both from the operating company and across the wider system.

When failure occurs, repercussions should be felt at all levels of an organisation. Through proposed changes to the regulatory framework, we will send a clear message to owners, Directors and Board members: the care and welfare of residents is your active responsibility, so expect to be held to account if abuse or neglect takes place.

Yet Winterbourne View also exposed some wider issues in the care system.

There are far too many people with learning disabilities or autism staying too long in hospital or residential homes, and even though many are receiving good care in these settings, many should not be there and could lead happier lives elsewhere. This practice must end.

We should no more tolerate people being placed in inappropriate care settings than we would people receiving the wrong cancer treatment. That is why I am asking councils and clinical commissioning groups to put this right as a matter of urgency.

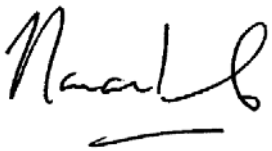
Equally, we should remember that not everything will be solved through action driven from the centre. Stories of poor care are a betrayal of the thousands of care workers doing extraordinary things to support and improve people's lives.

And while stronger regulation and inspection, quality information and clearer accountability are vital, so too is developing a supportive, open and positive culture in our care system.

I want staff to feel able to speak out when they see poor care taking place as well as getting the training and support they need to deal with the complex and challenging dilemmas they often face.

For me, this is the bigger leadership and cultural challenge that this scandal has exposed – and answering it will mean listening and involving people with learning disabilities and their families more than ever before.

As much as Winterbourne View fills us all with sorrow and anger, it should also fire us up to pursue real change and improvement in the future. It is a national imperative that there is a fundamental culture change so that those with learning disabilities or autism have exactly the same rights as anyone else to the best possible care and support. This Review is a key part of making that happen.



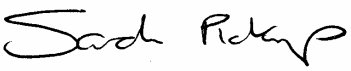
NORMAN LAMB
Minister of State for Care and Support

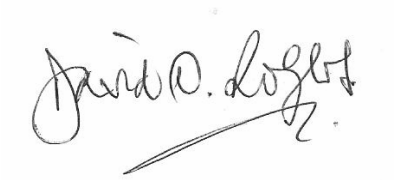
Joint Foreword

This report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. Our shared objective is to see the health and care system get to grips with past failings by listening to this very vulnerable group of people and their families, meeting their needs, and working together to commission the range of services and support which will enable them to lead fulfilling and safe lives in their communities.

The Concordat which accompanies this report sets out our commitment to work together, with individuals and families, and with the groups which represent them, to deliver real change, improve quality of care and ensure better outcomes. Together we will set the strategic direction and measure progress. This requires real system leadership across all sectors, including elected councillors as well as across health and care to reduce inequalities.

The new health and care system brings a greater opportunity for people to work together more creatively to develop local innovative solutions. We commit to doing this.





Sir David Nicholson KCB CBE

Chief Executive
NHS Commissioning Board

Sarah Pickup

President
Association of Directors of Adult Social Services

Councillor David Rogers

Chair, Community Wellbeing Board
Local Government Association

Executive summary

1. The abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health or local authorities, and concerns raised by a whistleblower went unheeded. The fact that it took a television documentary to raise the alarm was itself a mark of failings in the system.

2. This report sets out steps to respond to those failings, including tightening up the accountability of management and corporate boards for what goes on in their organisations. Though individual members of staff at Winterbourne View have been convicted, this case has revealed weaknesses in the system's ability to hold the leaders of care organisations to account. This is a gap in the care regulatory framework which the Government is committed to address.

3. The abuse in Winterbourne View is only part of the story. Many of the actions in this report cover the wider issue of how we care for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging.

4. CQC's inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospital who don't need to be there, and many stay there for far too long – sometimes for years.

5. The review has highlighted a widespread failure to design, commission and provide services which give people the support they need close to home, and which are in line with well established best practice. Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals.

6. For many people however, even the best hospital care will not be appropriate care. People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities or autism are doing just that.

7. This is the wider scandal that Winterbourne View revealed. We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer.

8. Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.

9. The Department of Health review drew on:

- a criminal investigation with 11 individuals prosecuted and sentenced;
- the Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes;
- the NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital;
- an independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012; and
- the experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

10. An interim report was published on 25 June 2012. This final report of the review can be published now that the criminal proceedings have concluded.

Programme of Action

11. This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

12. The Government's Mandate to the NHS Commissioning Board[1] says:

"The NHS Commissioning Board's **objective** is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people." (para 4.5)

13. We expect to see a fundamental change. This requires actions by many organisations including government. In summary, this means:

- all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014;
- by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning

[1] http://www.dh.gov.uk/health/2012/11/nhs-mandate/

disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out at **Annex A**;

- as a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;
- a new NHS and local government-led joint improvement team, with funding from the Department of Health, will be created to lead and support this transformation;
- we will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap;
- CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving people who use services and their families, and steps to ensure that services are in line with the agreed model of care; and
- with the improvement team we will monitor and report on progress nationally.

14. A full account of these actions, together with a range of further actions to support improvement of services – including, for instance, steps to improve workforce skills, and strengthening safeguarding arrangements – is set out in Parts 4-8. A timeline of the detailed actions is at **Annex B**.

15. Alongside this report, we are publishing a **Concordat** agreed with key external partners. It sets out a shared commitment to transform services, and specific actions which individual partners will deliver to make real change in the care and support for people with learning disabilities or autism with mental health conditions or behaviour that challenges.

16. This report focuses on the need for change, but there are places which already get this right. This shows that the change we intend to make is achievable. Alongside this report, we are publishing examples of good practice which demonstrate what can – and should be – done for all.

Part 1: Introduction

1.1 This Department of Health review responds to criminal abuse at Winterbourne View hospital revealed by the BBC Panorama programme in May 2011. It is equally concerned with the care and support experienced by all children, young people and adults with learning disabilities or autism who also have mental health conditions or behave in ways that are often described as challenging. For the purposes of this report, we describe this vulnerable group of people as "people with challenging behaviour".

1.2 There are currently an estimated 3,400 people in NHS-funded learning disability inpatient beds of which around 1,200 are in assessment and treatment units (usually known as A&T units)[2].

1.3 This report builds on the evidence and issues set out in the interim report published in June 2012[3].

1.4 The picture from investigations and reviews, and from people who use services, their families, and the groups which represent them[4] is of good services in some places, but too often they fall short. Too many people do not receive good quality care. The review found widespread poor service design, failure of commissioning, failure to transform services in line with established good practice[5], and failure to develop local services and expertise to provide a person-centred and multidisciplinary approach to care and support.

1.5 Starting now and by June 2014, we must – and we will – transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with challenging behaviour.

1.6 This is not easy. Developing the right range of services locally to build up necessary expertise is a complex task – though that will be made easier with pooled budgets. But there is clear – and readily available – guidance and evidence for what works[6]. That guidance has been available for years. There are no excuses for local health and care

[2] There is poor quality data about the numbers of people with challenging behaviour. In the interim report we focused on the 1,200 beds in A&T units in the CQC Count me in Census 2010. In this report we have used the larger estimate of 3,400 people in NHS funded inpatient beds (from the same census). This is because some people may be in rehabilitation or other types of unit which provide A&T services and we also want to avoid inpatient services simply re-badging themselves.

[3] *Department of Health Review: Winterbourne View Hospital:Interim Report Interim Report:* (June 2012) http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[4] see summaries of engagement with people with learning disabilities and families published alongside this report at www.dh.gov.uk/learningdisabilities

[5] see *Services for People with Learning disability and challenging behaviour or mental health needs* 2007, Prof Jim Mansell. http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicandgudiance/dh_080129

[6] see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129 Examples of good practice are published at http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

commissioners failing to come together to commission and design the services which will enable most people to live safely with support in their communities and prevent unnecessary admissions to hospital. There are no excuses for continuing to commission the wrong model of care.

1.7 The programme for change described below draws on actions in the interim report[7] to which external delivery partners have already committed. A more detailed action plan will be agreed and monitored by the national Learning Disability Programme Board chaired by the Minister of State for Care and Support. The Board will measure progress against milestones, monitor risks to delivery, and challenge partners, to ensure all of these commitments are delivered.

1.8 In addition to this monitoring, the Department of Health will publish a progress report in one year, and again as soon as possible following 1 June 2014, to ensure that the steps set out in this report are achieved.

[7] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

Part 2: Winterbourne View hospital

2.1 When the interim report of this review was published in June, we were unable to comment on what happened in Winterbourne View hospital as criminal proceedings against former members of staff had not completed. Subsequently, all 11 individuals charged have pleaded guilty to all charges and have been sentenced (with custodial sentences for six former staff). The Crown Prosecution Service treated these offences as disability hate crimes, crimes based on ignorance, prejudice and hate, and brought this aggravating factor to the attention of the court in sentencing.

2.2 We now have a very detailed and compelling picture of the serious abuse suffered by patients at Winterbourne View hospital and the systematic way in which staff abused patients and misused restraint as punishment for what staff saw as bad behaviour.

2.3 The Serious Case Review (SCR) commissioned by South Gloucestershire Council Adult Safeguarding Board published on 7 August 2012 gives a compelling and comprehensive chronology of events at the hospital and we do not intend to duplicate that here.[8]

2.4 But now we have that picture, along with other reports shared as evidence to the SCR including reports from the police, the CQC, and the review by NHS South of England of commissioning of services at Winterbourne View hospital, we are able to draw firm conclusions about what went wrong.

2.5 Opened in December 2006, Winterbourne View was a private hospital owned and operated by Castlebeck Care Limited. It was designed to accommodate 24 patients in two separate wards and was registered as a hospital with the stated purpose of providing assessment and treatment and rehabilitation for people with learning disabilities. By the time the hospital was closed in June 2011, the majority of patients (73%) had been admitted to the hospital under Mental Health Act powers. Although thirteen were informal patients at admission, six of these were then detained under Mental Health Act powers after admission. On average, it cost £3,500 per week to place a patient in Winterbourne View.

2.6 Forty-eight patients had been referred to Winterbourne View by 14 different English NHS commissioners (there had also been a few placements from Wales); meaning that there was no one commissioner with a lead or strong relationship with the hospital. Similarly, South Gloucestershire Council, in whose area the hospital was located, was not party to the majority of referrals to Winterbourne View hospital.

[8] South Gloucestershire Safeguarding Adults Board *Winterbourne View Hospital: A Serious Case Review* by Margaret Flynn (2012) http://www.southglos.gov.uk/Pages/Article%20Pages/Community%20Care%20-%20Housing/Older%20and%20disabled%20people/Winterbourne-View-11204.aspx

2.7 This also meant that although a significant minority of patients were local to the hospital **almost half of the patients at Winterbourne View were placed far away from their homes**. Of 48 patients:

- 13 were referred by commissioners located within 20 miles;
- a further 12 patients were referred by commissioners between 20 and 40 miles away;
- 14 patients were referred by commissioners between 40 and 120 miles away; and
- 9 patients were referred by commissioners more than 120 miles away.

2.8 For just under half of the people in Winterbourne View, the main reason for referral was management of a crisis – suggesting a real lack of planning for crises or local responsive services for people with this type of support need.

2.9 **People were staying at Winterbourne View hospital for lengthy periods**. The average length of stay at Winterbourne View was around 19 months but some patients had been there more than three years when the hospital closed – and this in a hospital which was open for less than five years.

2.10 There is little evidence of urgency in considering discharge and move-on plans for Winterbourne View patients. It is worth noting for instance that 10 patients detained under Mental Health Act powers remained in Winterbourne View after their period of detention ended – in one case for a further 18 months.

2.11 One of the most striking issues is the **very high number of recorded physical interventions** at Winterbourne View (ie of patients being physically held to prevent danger to themselves or others). The Serious Case Review notes that Castlebeck Care Ltd recorded a total of 558 physical interventions between 2010 and the first quarter of 2011, an average of over 1.2 physical interventions per day. One family provided evidence that their son was restrained 45 times in 5 months, and on one occasion was restrained “on and off” all day. It is very difficult to see how such high numbers of interventions could possibly be seen as normal.

2.12 Opportunities to pick up poor quality of care were repeatedly missed by multiple agencies. For instance:

- Winterbourne View patients attended NHS Accident and Emergency services on 78 occasions while Winterbourne View was open but there was no process in place for linking these so that an overall picture emerged;
- Between January 2008 and May 2011 police were involved in 29 incidents concerning Winterbourne View patients;
- Between January 2008 and May 2011, 40 safeguarding alerts were made to South Gloucestershire Council but these were treated as separate incidents. 27 were allegations of staff to patient assaults, 10 were patient on patient assaults and three were family related incidents.

2.13 The Serious Case Review provides evidence **of poor quality healthcare**, with routine healthcare needs not being attended to – for instance there were widespread dental problems and "most patients were plagued by constipation". Many patients were being given anti-psychotic and anti-depressant drugs without a consistent prescribing policy.

2.14 The Serious Case Review also sets out very clearly that for a substantial portion of the time in which Winterbourne View operated, families and other visitors were not allowed access to the wards or individual patients' bedrooms. This meant there was very little opportunity for outsiders to observe daily living in the hospital and enabled a **closed and punitive culture to develop on the top floor of the hospital**. Patients had limited access to advocacy and complaints were not dealt with.

2.15 There is strong and compelling evidence of **real management failure at the hospital.** The Serious Case Review says that on paper Castlebeck's policies, procedures, operational practices and clinical governance were impressive. The reality was very different:

- for much of the period in which Winterbourne View operated, there was **no Registered Manager** (even though that is a registration requirement);
- approaches to staff recruitment and training did not demonstrate a strong focus on quality. For example, staff job descriptions did not highlight desirability of experience in working with people with learning disabilities or autism and challenging behaviour – nor did job descriptions make any reference to the stated purpose of the hospital;
- there is little evidence of staff training in anything other than in restraint practices;
- although structurally a learning disability nurse-led organisation, it is clear that Winterbourne View had, by the time of filming by Panorama, become dominated to all intents and purposes by support workers rather than nurses**;** and
- there was very high staff turnover and sickness absence among the staff employed at the hospital.

2.16 All this suggests **that managers at the hospital and the parent company, as well as commissioners, regulators and adult safeguarding, had a number of opportunities to pick up indications that there were real problems at Winterbourne View, but failed to do so.**

2.17 The very high number of recorded restraints, high staff turnover, low levels of training undertaken by staff, the high number of safeguarding incidents and allegations of abuse by staff – all could have been followed up by the **hospital itself or by Castlebeck Care Ltd,** but were not to any meaningful extent. This failure by the provider to focus on clinical governance or key quality markers is striking, and a sign of an unacceptable breakdown in management and oversight within the company.

2.18 Equally it is striking that **adult safeguarding** systems failed to link together the information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts – some commissioners were aware of concerns – and failures to follow up concerns when commissioners became aware of them.

2.19 Despite the high cost of places at Winterbourne View (on average £3,500 per week) **commissioners** do not seem to have focused much on quality, or on monitoring how the hospital was providing services in line with its registered purpose – ie. assessing the needs of individuals and promoting their rehabilitation back home. The lack of any substantial evidence that people had meaningful activity to do in the day, the way in which access by outsiders to wards was restricted, reports of safeguarding alerts (where

these were shared with commissioners) should have been followed up rigorously, but were not. **This amounts to a serious failure of commissioning**.

2.20 The **CQC** acknowledged that they did not respond to the Winterbourne View hospital whistleblower and that neither they nor their predecessor organisations followed up on the outcomes of statutory notifications – and clearly failed to enforce the requirement for there to be a registered manager.

2.21 The **Mental Health Act Commissioner** was notified on more than one occasion of incidents, and in its annual report in May 2008 referenced the need for action to improve – but it was not followed up.

2.22 The **Police** have acknowledged that they took explanations from staff at face value. Avon and Somerset Constabulary police were involved in 29 incidents concerning Winterbourne View patients. Eight of the reported incidents were associated with staff using physical restraint on patients. The Police secured the successful prosecution of one member of staff prior to the Panorama programme.

What happened to people at Winterbourne View

2.23 Patients at Winterbourne View hospital were subject to horrific and sustained abuse, ill-treatment and neglect. The Serious Case Review has thrown down a challenge to health and social care commissioners to ensure that the individual patients and their families get the support they need to recover from their experience. The Department of Health supports that challenge.

> *Out of Sight: Stopping the abuse of people with a learning disability pr*ovides an update on what happened to Simon, one of the patients at Winterbourne View.
>
> Simon's Mum said:
> *Simon is now back living near us, and he is loving every minute of his life. He is at the same residential care home he was in before he was sent away, but the service has been adapted so that it meets his needs. They have done this by developing a flat for him adjoining the care home, where he lives with his support team. It is his own space, an oasis of quiet and calm.*'
>
> *Simon's package of care now costs about half as much as it did for him to be in Winterbourne View. The staff he has now have been wonderful and are truly dedicated. I know that not only is Simon happy, he is safe."*

2.24 But we know that not every one who was at Winterbourne View has had the same experience as Simon. Indeed, the second Panorama programme broadcast on 29 October 2012 showed that some others who had suffered abuse have continued to be moved to hospitals far from home.

2.25 DH asked NHS South of England to coordinate follow up on what happened to the 48 English NHS patients who had been in Winterbourne View hospital. In March 2012:

- 26 former patients had moved into a range of social care supported arrangements and 22 patients were in various inpatient facilities;
- 19 had been subject to a safeguarding alert in their new location;

- 27 people had required support related to the trauma experienced at Winterbourne View hospital.

2.26 This exercise was repeated in September 2012. At that point:

- Additional hospital discharges had taken place with 32 former patients in a range of social care settings and 16 patients in inpatient setting.
- there were initial safeguarding alerts or active safeguarding procedures for six people at the time of the exercise.

2.27 Whilst one cannot generalise from such a small group of patients, the fact that two thirds of those in Winterbourne View are now in social care supported arrangements gives a strong indication of what is possible.

2.28 DH will continue to seek assurance about what has happened to this group of people.

Part 3: The picture beyond Winterbourne View

3.1 The events at Winterbourne View triggered a wider review of care across England for people with challenging behaviour. This included a programme of CQC inspections of nearly 150 learning disability services[9] together with engagement by the Department of Health to seek the experiences and views of people with learning disabilities and people with autism – some of whom had experienced care in hospital settings – as well as families, organisations who represent the interests of this group of people, professionals and providers.

3.2 The interim report of the Department of Health review published in June 2012[10] set out the findings:

- too many people were placed in hospitals for assessment and treatment and staying there for too long;
- they were experiencing a model of care which went against published Government guidance that people should have access to the support and services they need locally, near to family and friends;
- there was widespread poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people; and
- all parts of the system have a part to play in driving up standards.

3.3 The interim report identified concerns about the quality of person centred planning, involvement of people and families in developing their care plan, and in ensuring personalised care and support.

3.4 In addition, the interim report summarised published good practice guidance including the 1993 Mansell report, updated and revised in 2007[11], which emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs or challenging behaviour; and
- that services/support should be provided locally where possible.

[9] The summary CQC report was published in June 2012. http://www.cqc.org.uk/public/reports-surveys-and-reviews/themed-inspections/review-learning-disability-services

[10] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[11] *Services for people with learning disabilities and challenging behaviour or mental health needs* October 2007, Professor Jim Mansell – see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

3.5 Three examples of good practice – Salford, Tower Hamlets and Cambridgeshire – were published alongside the interim report.[12]

3.6 As a first step to driving redesign, the interim report set out the model of care which practice demonstrates will give the best quality of life and support and improve outcomes. This is summarised in here and set out in detail at **Annex A.**

3.7 In summary, the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment. Evidence shows that community-based housing enables greater independence, inclusion and choice, and that challenging behaviour lessens with the right support. People with challenging behaviour benefit from personalised care, not large congregate settings[13]. Best practice is for children, young people and adults to live in small local community-based settings.

3.8 Where children, young people and adults need specialist support the default position should be to put this support into the person's home through specialist community teams and services, including crisis support.

- the individual and her/his family must be at the centre of all support - services designed around them and with their involvement, highly individualised and person-centred across health and social care (including access to personal budgets and personal health budgets where appropriate);
- people's homes should be in the community, supported by local services;
- people need holistic care throughout their life, starting in childhood;
- when someone needs additional support it should be provided as locally as possible; and
- when someone needs to be in hospital for a short period, this should be in small inpatient settings as near to their home as possible.

3.9 This means that people with challenging behaviour should only go into specialist hospital settings exceptionally and where there is good evidence that a hospital is the best setting to enable necessary assessment and treatment - not the only available placement. From the beginning, the reason for admission must be clearly stated and families should be involved in decision making. Where an individual lacks capacity and does not have a family to support them, the procedures of the Mental Capacity Act 2005 should be followed to ensure that decisions made are in her/his best interest and, if appropriate, an Independent Mental Capacity Advocate appointed.

3.10 Where someone is admitted to hospital the priority from the start should be rehabilitation and returning home. This requires a strong and continuing relationship between local commissioners and service providers and the hospital, focused on the individual patient's care plan, and a real effort to maintain links with their family and the home community. It also means for example, maintaining the person's tenancy of their home where relevant unless and until a more appropriate home in the community is found. Most of all, it is vital that families are involved in decision-making.

[12] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[13] NICE clinical guidelines for autism recommend that if residential care is needed for adults with autism it should usually be provided in small, local community-based units (of no more than six people and with well-supported single person accommodation).

3.11 Sending people out of area into hospital or large residential settings can cause real harm to individuals by weakening relationships with family and friends and taking them away from familiar places and community. It can damage continuity of care. It can also mean putting people into settings which they find stressful or frightening. This can damage mental health or increase the likelihood of challenging behaviour. There should always be clear and compelling reasons for sending any individual out of area. The individual and their family should always be involved and told these reasons. When this does happen, commissioners and the community team from the home area must keep in close contact with the individual and their family as well as the commissioner for the area where the individual is placed to assess progress and plan for their return to their own community.

Good Practice

The **Association of Supported Living** members contributed to a study on good commissioning in which they describe the ingredients to the successful outcomes they had achieved in moving people who at some point have been contained in institutions. Now everyone has a better life in community services which cost less. Prior to changes, costs ranged from £91,000 to £520,000 (for a private secure unit) per annum, following a move to supported living, high end costs reduced from £520,000 to £104,000 per annum.

3.12 The Government's Mandate to the NHS Commissioning Board makes clear that the presumption should always be that services are local and that people remain in their communities.

3.13 This model is achievable. It has been tried and tested and it works. The good practice examples published alongside the Interim Report are community-based and multidisciplinary. They can respond when someone presents with challenging behaviour, responding to that individual, their family, and care and support providers to seek explanations for the behaviour. That enables services working in partnership to develop interventions and support based on an understanding of the individual and their environment. Multidisciplinary approaches are essential because of the complexity of need and the way in which different perspectives contribute to agreeing appropriate interventions.

Part 4: The right care in the right place

4.1 A central part of our plan for action is to ensure that people with challenging behaviour only go into hospital if hospital care is genuinely the best option, and only stay in hospital for as long as it remains the best option. Our plan requires health and care partners to:

a. review all current placements, and support everyone inappropriately in hospital to move to community-based support;

b. in parallel, put in place a locally agreed joint plan to ensure high quality care and support services for all people with challenging behaviour that accord with the right model of care from childhood onwards; and

c. give national leadership and support for local change.

4.2 The patients at Winterbourne View were not listened to or believed when they told people about abuse. Their families were often not involved in decisions about where they were sent, parents and siblings found it increasingly difficult to visit and families' concerns and complaints often were not acted on. This failure to listen to people with challenging behaviour and their families is sadly a common experience and totally unacceptable. It leaves people feeling powerless.

4.3 We expect all actions in this programme to be appropriately informed by the views and needs of people with challenging behaviour and families in line with the NHS Constitution – which can mean providing appropriate advice, information and support. This will happen at all levels, locally and nationally:

- people with learning disabilities and families will be members of the Learning Disability Programme Board;
- CQC will involve self-advocates and families in inspections and in their stakeholder group;
- the NHSCB, LGA, and ADASS will involve them in planning and supporting changes in the way care is developed.

4.4 Changing attitudes to people with challenging behaviour is vital. Tackling disability hate crime is an issue the Department of Health takes very seriously. The Department is already taking steps to improve its understanding of disability hate crime and to deliver better outcomes for patients including those with learning disabilities.

4.a REVIEW ALL CURRENT PLACEMENTS AND SUPPORT EVERYONE INAPPROPRIATELY IN HOSPITAL TO MOVE TO COMMUNITY BASED SUPPORT

4.5 By 1 June 2014 we expect to see a rapid reduction in the number of people with challenging behaviour in hospitals or in large scale residential care - particularly those away from their home area. By that date, no-one should be inappropriately living in a hospital setting. This is a three stage process which involves:

- commissioners making sure they know who is in hospital and who is responsible for them;
- health and care commissioners working together and with partners to review the care people are receiving;
- commissioners working with individuals to agree personal care plans and bringing home or to appropriate community settings all those in hospital[14].

4.6 DH will closely monitor progress in bringing these numbers down. The Government's Mandate to the NHSCB emphasises the expectation for a substantial reduction in reliance on inpatient care for these groups of people.

4.7 Progress in this area will be dependent on developing the range of responsive local services which can prevent admissions to hospital or other large institutional settings and allow any existing patients to be moved to better settings, closer to home. This may involve better use of existing Mental Health services with the right reasonable adjustments, or the commissioning of new, smaller and more local inpatient units where they are needed. But the emphasis should be on designing community services in line with the best practice model. We would expect to see a dramatic and sustained reduction in the number of assessment and treatment units and beds as a result of this shift.

Agreeing who should be reviewed and who is responsible for them

4.8 Commissioners need to make sure they know who is in hospital and who is responsible for them.

Key Actions:

The NHS Commissioning Board will:

- **ensure by 1 April 2013 that all Primary Care Trusts develop local registers of all people with challenging behaviour in NHS-funded care;**

- **make clear to Clinical Commissioning Groups in their handover and legacy arrangements what is expected of them, including:**
  - **maintaining the local register from 1 April 2013; and**
  - **reviewing individuals' care with the Local Authority, including identifying who should be the first point of contact for each individual.**

[14] For a very small number of people with complex needs, this can be a lengthy process. However, we expect this process to be carried out as quickly as possible. If, by this time, there are a very small number of cases where plans are agreed but not yet fully implemented, progress will be closely monitored.

Reviewing care and agreeing personal care plans

4.9 People should have the right care and support package to meet their individual needs. The care plans of all inpatients with challenging behaviour will be reviewed individually. Commissioners will assess whether they can create a better, community-based support package tailored as far as possible to each individual's needs.

4.10 People with challenging behaviours and their families will have the support they need to ensure they can take an active part in these reviews - being provided with information, advice and independent advocacy, including peer advocacy.

4.11 Personal care plans should be enacted swiftly and safely. In many instances this will require the development of more personalised services in different settings so that individuals can be better supported at home or in the community. Although doing this can take time, the Department of Health expects it to be carried out with pace and a sense of urgency – whilst always putting the interest of the individual first.

4.12 Where responsibility transfers from the NHS to local government, councils should not be financially disadvantaged. The NHS should agree locally how any new burden on local authorities will be met, whether through a transfer of funding or as part of a pooled budget arrangement.

Key Actions

By 1 June 2013, health and care commissioners, working with service providers, people who use services and families will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.

Plans should be put into action as soon as possible, and all individuals should be receiving personalised care and support in the appropriate community settings no later than 1 June 2014.

4b. LOCALLY AGREED PLANS TO ENSURE HIGH QUALITY CARE AND SUPPORT SERVICES WHICH ACCORD WITH THE MODEL OF GOOD CARE

4.13 In parallel with the actions for people currently in hospital, every local area will put in place a locally agreed joint plan to ensure high quality care and support services for all people with challenging behaviour that accords with the model of good care. These plans should ensure that a new generation of inpatients does not take the place of people currently in hospital.

Commissioning the right model of care and challenging poor practice

4.14 We expect commissioners to work together to drive the move from hospital care to good quality local, community-based services, and account for how they do this. This involves:

- better joint working between health and care; and
- using the evidence on good practice.

4.15 Health and care commissioners are accountable for commissioning services to meet identified needs. It is essential that they work together to develop specific plans for improving health and care services for this particular group of people. This goes wider than health and adult social care; in particular, a strategic plan must also include children's services and specialist housing.

Gloucestershire County Council and NHS Gloucestershire have a (joint) strategic commissioning plan which includes bringing people back into the county*. "For at least two years we have had a joint LA & NHS Learning Disability commissioning team (Gloucestershire CC and NHS Gloucestershire). We work from a common plan and as lead commissioner I head up the team of 8 people. We have commissioners from both health and social care. Health team members are directly engaged with complex people including people 100% funded by health and both LA and NHS colleagues work with people placed out of county*".

Referrals for anyone needing additional assessment or treatment also go through this team to a specialist Learning Disability NHS service whose aim is to prevent admission for assessment and treatment. Social care commissioning colleagues in the team also access the NHS A&T service this way. This also means that if anyone's current services need additional resources to avoid breakdown, before the resources are allocated, the specialist NHS Learning Disability service would ensure this is necessary and value for money.

4.16 Local health and care commissioners and services should be commissioning integrated care – care co-ordinated and personalised around the needs of individuals with a presumption that care should be local and that people should stay in their communities. This is more likely to happen if:

- Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) take account of the health and care needs of people with challenging behaviour; and
- health and care commissioners pool budgets.

4.17 Pooled budgets with shared accountabilities are likely to facilitate the development of more integrated care. They may help overcome the lack of strong financial incentives on a single commissioner to invest in community services (eg where the cost of investment in supported living in local communities falls to councils while savings from reduced reliance on hospital services go to NHS commissioners). There should be a clear presumption that budgets should be pooled and that health and wellbeing boards should promote collaborative working and the use of pooled budgets.

4.18 Commissioners need to work with providers of specialist services to ensure that community learning disability teams have the additional, intensive support they need to keep people out of hospital – including in crises. They will also need to have access to local inpatient mental health services where these are genuinely required. This will reduce the need for hospital admissions out of area.

4.19 Finally, there is consensus that large hospital units are outdated and inappropriate and do not provide the care which people with challenging behaviour need. It is our clear expectation that commissioners should not place people in large hospitals. There may be a few people who need inpatient care, but this should be provided in smaller units and as close to home as possible. Any new, small specialist hospitals should only be built where JSNAs show a genuine unmet local need for such provision in a way which is consistent with good models of care. Local commissioners should have oversight of the services available in their areas and take the lead in discussing future need and what additional facilities are required. In addition, CQC will take account of the model of care in its revised guidance about compliance and in the registration and inspection of providers, as part of its new regulatory model.

Key Actions:

By April 2014, CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.

The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements.

Evidence on best practice

4.20 Commissioning needs to draw on the evidence of what is best practice in the care of people with challenging behaviour. The Model of Care set out in this report is based on well established evidence. To strengthen the evidence base, NICE is developing further standards and guidelines for this group of people, to go alongside the standards already published on autism clinical pathways.

Key Actions:

By Summer 2015 NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.

By Summer 2016 NICE will publish quality standards and clinical guidelines on mental health and learning disability.

4.21 NICE will also develop new quality standards on child maltreatment. They will focus on the recognition and response to concerns about abuse and neglect and effective interventions. These will support the use of the Government's statutory guidance, *Working Together to Safeguard Children.*[15]

Prioritising children and young people's services

4.22 Children and young people with challenging behaviour can face particular difficulties and crises as they move from child to adult services. Integrating care and support around their needs and ensuring that they have access to the services identified in their agreed care plan is vital.

4.23 For children and young people with special educational needs or disabilities the Mandate to the NHS Commissioning Board sets out the expectation that children will have access to the services identified in their agreed care plan and that parents of children who could benefit will have the option of a personal budget based on a single assessment across health, social care and education. This means:

- integrated planning around the needs of individual children; and
- identifying best outcomes and measuring progress.

4.24 Local health and care commissioners need to plan strategically to develop local services that properly meet the needs of children and young people in the area where they live.

Good practice:

Ealing services for children with additional needs set up "The Intensive Therapeutic & Short Break Service (ITSBS). The service provides a viable model for significantly reducing challenging behaviour and securing home placement stability for a small but significant number of children and young people whose challenging behaviour would otherwise most likely result in a

[15] https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN-v3.pdf

move to residential placements. Residential placement was avoided for all five young people who had been offered the service between 2008 and 2010. Residential placement has also been avoided for six out of the seven young people who were first offered the service between 2010 and 2011.

Key Actions:

The Department of Health will work with the Department of Education (DfE) to introduce from 2014 a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.

Both Departments will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood. This will report by June 2013.

4.25 Children and young people and their families need to be involved in this work.

4c. NATIONAL LEADERSHIP SUPPORTING LOCAL CHANGE

4.26 While changes to people's lives require action at a local level, with local commissioners and providers working together, change of this scale, ambition and pace requires **national leadership**. To provide leadership and support to the transformation of services locally, the LGA and the NHSCB will develop an improvement programme led by a senior sector manager. This will be in addition to the cross-government programme board.

Key Actions:

The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.

At a national level, from December 2012, the cross-government Learning Disability Programme Board chaired by the Minister of State for Care and Support will lead delivery of the programme of change by measuring progress against milestones, monitoring risks to delivery, and challenging external delivery partners to deliver to plan, regularly publishing updates.

4.27 Social care and health commissioners will be accountable to local populations and will be expected to demonstrate that they have involved users of care and their families in planning and commissioning appropriate local services to meet the needs of people with challenging behaviour. Families and self advocates have an important role to play in challenging local agencies to ensure that people have local services and the optimum model of care. There is a clear need both to challenge localities for failing to redesign services, and to provide practical support to help them do so.

Good Practice

There are many examples of good local practice in this area.

In **Salford,** in the last 5 years 16 people with a learning disability and behaviour that challenges living out of area have returned to their communities.

Beyond Limits have been commissioned by NHS Plymouth (now Devon CCG) to develop local personalised commissioning/provider processes and tailor-made services for people who have experienced long term, multiple placements and institutionalised living because their behaviours have challenged existing services. They are piloting this through facilitating planning for 20 people currently in out of area Specialist Assessment &Treatment Units and then providing support using personal Health Budgets.

4.28 Providers have a key role to play in redesigning service, working closely with commissioners, people who use services and families. The national market development forum within the Think Local Act Personal (TLAP) partnership will work with DH to identify barriers to reducing the need for specialist hospitals and by April 2013 will publish solutions for providing effective local services.

4.29 The Developing Care Markets for Quality and Choice programme will support local authorities to identify local needs for care services and produce market position statements, including for learning disability services.

4.30 The NHSCB will also work with ADASS to develop by April 2013 practical resources for commissioners of services for people with learning disabilities,[16] including:

- model service specifications;
- new NHS contract schedules for specialist learning disability services;
- models for rewarding best practice through the NHS Commissioning for Quality and Innovation (CQUIN) framework; and
- a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.

Key Action:

By March 2013 the NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A.

4.31 DH will ensure health and wellbeing boards have guidance and information to support them to understand the complex needs of people with challenging behaviour.

[16] This will build on the guidance published in October 2012, *Improving the health and wellbeing of people with learning disabilities: an evidence-based commissioning guide for clinical commissioning groups.* http://www.improvinghealthandlives.org.uk/publications/1134/Improving_the_Health_and_Wellbeing_of_People_with_Learning_Disabilities:_An_Evidence-Based_Commissioning_Guide_for_Clinical_Commissioning_Groups
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Part 5: Strengthening accountability and corporate responsibility for quality of care

5.1 Although 11 former members of staff at Winterbourne View have been sentenced in connection with the abuse of patients, this review has identified weaknesses in the system of accountability where leaders of organisations are not fully held to account for poor quality or for creating a culture where neglect and even abuse can happen.

Quality of care

5.2 **The primary responsibility for the quality of care rests with the providers of that care. Owners, Boards of Directors and Senior managers of organisations which provide care must take responsibility for ensuring the quality and safety of their services**. The requirements set out in law include:

- safe recruitment practices which select people who are suitable for working with people with learning disabilities or autism and behaviour that challenges;
- providing appropriate training for staff on how to support people with challenging behaviour;
- providing good management and right supervision;
- providing leadership in developing the right values and cultures in the organisation;
- having good governance systems in place; and
- providing good information to support people making choices about care and support, including the views of people who use services about their experience.

5.3 We also expect boards to demonstrate good practice and comply with further legal requirements, which include:

- Directors, management and leaders of organisations providing NHS or local authority-funded services must ensure that systems and processes are in place to provide assurance to themselves, service users, families, local Healthwatch and the public that essential requirements are being met and that they deliver high quality and appropriate care;
- the Boards of care providers should understand the quality of the care and support services they deliver; and
- organisations must identify a senior manager or, where appropriate a Director, to ensure that the organisation pays proper regard to quality, safety, and clinical governance for that organisation.

Key Action:

We expect Directors, management and leaders of organisations providing NHS or local authority-funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.

Sanctions to hold Boards to account when the quality of care is unacceptable:

5.4 There must be robust consequences for senior managers or Boards of Directors of services where through neglect the organisations they lead provide poor quality of care or where people experience neglect or abuse.

CQC's enforcement powers

5.5 CQC will take steps to strengthen the way it uses its existing powers to hold organisations to account for failure to meet legal obligations to service users. CQC registers providers at an organisational level. However, its inspections take place at the level at which services are delivered. As a result CQC has not always held organisations to account at a corporate level, but rather at the level of the regulated service. This needs to be addressed.

5.6 While most organisations providing care put in place governance arrangements that support safety and quality, some do not pay sufficient attention to this area. Where the leadership of an organisation allows a culture to develop that does not foster safety and quality in care, the people providing that leadership have to be held to account for the service failings. In the words of the serious case review, "Castlebeck Ltd's appreciation of events… was limited, not least because they took the financial rewards without any apparent accountability."

5.7 This is an unacceptable situation and must change. CQC already has powers to take action:

- CQC is able to take tough enforcement action against organisations that do not meet the registration requirements, including stopping them from providing specific services or operating from specific locations. In the most extreme cases CQC can cancel a provider's registration, stopping it from providing any health or adult social care;
- it is already an offence under the Health and Social Care Act 2008 not to meet the essential levels of safety and quality. This would include, for example, not making suitable arrangements to ensure that service users are safeguarded against the risk of abuse. As well as prosecuting the corporate provider for a failure to meet the registration requirements, CQC can prosecute individual directors or managers where the offence can be proven to have been committed by, or with the consent or connivance of, or attributable to any neglect on the part of that individual.

5.8 It is important that CQC makes full use of its existing powers to hold the corporate body to account. CQC will meet with executives of provider organisations when there are serious concerns about quality and safety issues to discuss their plans to deliver safe

and effective care. Since summer 2012, CQC has appointed corporate compliance managers to assess the quality and safety of care of large providers who operate across a large area.

Key Action:

CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.

Fit and proper person test

5.9 CQC will also consider whether it is able to use its existing powers to carry out a fit and proper person test of Board members as part of the registration of providers. One option for this could be to require providers to nominate an individual Board member with responsibility for quality who would be accountable to CQC for the quality of care. If this person did not meet the fit and proper person test, CQC could insist that another Board member is nominated. CQC could not use its existing powers to bar an individual from being a member of the Board, since Directors are not required to register with CQC.

5.10 DH will explore how a stronger fit and proper person test for board members of health and social care providers can be introduced to make it comparable to fit persons' tests in other sectors. This will include looking at:

- the tests applied by the Financial Services Authority, the Premier League and the Charity Commission, which look at an individual's past performance with regards to other regulatory systems;
- prior involvement with other companies which may have had their licences revoked, withdrawn or terminated; and
- if they or any business associated with them, has been suspended or criticised by a regulatory or professional body. Where individuals fail to meet these tests, regulators can deem them to be unsuitable to hold certain positions and organisations face regulatory action or risk being refused registration, where such persons are appointed. DH will examine if a similar approach could be applied to board members of health and social care providers.

Holding corporate bodies to account for poor care

5.11 There can be no excuse for Directors or managers allowing bullying or the sort of abusive culture seen in Winterbourne View. Individuals should not profit from others' misery.

5.12 DH will examine how corporate bodies, their Boards of Directors and financiers can currently be held to account under law for the provision of poor care and the harm experienced by people using those services.

5.13 There are a number of potential criminal offences for which a Board Director or Manager could be prosecuted:

- there are offences under general criminal law. For example, in cases where it is proved that an individual board member or manager has committed an offence against a person or aided and abetted the commission of any offence (such as an assault), then such individuals could also be prosecuted in accordance with general criminal law;
- organisations can be prosecuted for offences under the Corporate Manslaughter and Corporate Homicide Act 2007 if the service provider's organisation is managed in such a way that it caused a person's death. The track record of prosecution in such cases – despite new legislation being introduced expressly to address corporate failure – is thin.

Key Action:

The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps.

We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.

Developing leadership in Boards

5.14 Boards should ensure they have proper governance arrangements in place and take seriously their corporate responsibilities towards the people for whom they provide care. DH will explore with the National Skills Academy and the NHS Leadership Academy options to develop proposals on Board leadership development by March 2013.

Part 6: Tightening the regulation and inspection of providers

6.1 What happened at Winterbourne View raised profound questions about how regulation and inspection was working. As a result of Winterbourne View, and learning from their programme of inspecting nearly 150 learning disability hospitals, CQC is seeking to improve the way it regulates and inspects providers. In particular, CQC is committed to delivering on the recommendations set out in their Internal Management Review[17], the findings of the Serious Case Review, the evaluation of their inspection of nearly 150 learning disability services[18], and any relevant matters from the consultation on their strategy for 2013-16[19] to ensure that its regulation of providers is robust.

6.2 This means:

- checking how services fit with national guidance;
- improving inspection; and
- improving information sharing.

6.3 Providers are already required to have regard to national guidance, as one of the requirements of regulation monitored by CQC. The model of care at Annex A sets out an agreed framework for best practice in this area. CQC will take action to ensure this model of care is considered as part of inspection and registration of relevant services in their new regulatory model which will be implemented in 2013. CQC will also include reference to the model of care in their revised guidance about compliance, which will also be published in 2013. Where services are not provided in line with this model of care, CQC will seek assurance that the provider's approach still delivers care in line with national guidance and legal requirements.

Key Action:

CQC will use existing powers to seek assurance that providers have regard to national guidance and the good practice set out in the model of care at Annex A.

6.4 In addition, CQC will:

- share the information, data and details they have about prospective providers with the relevant CCGs and local authorities through their existing arrangements, who will, in turn, take account of the information and data shared by CQC when making decisions to commission care from the proposed service provider;

[17] CQC Internal Management Review of the regulation of Winterbourne View (October 2011) http://www.cqc.org.uk/sites/default/files/media/documents/20120730_wv_imr_final_report.pdf
[18] CQC Review of Learning Disability Services (June 2012) http://www.cqc.org.uk/search/apachesolr_search/evaluation%20of%20learning%20disability%20services
[19] CQC, The next phase: Our consultation on our strategy for 2013 to 2016 http://www.cqc.org.uk/sites/default/files/media/documents/cqc_strategy_consultation_2013-2016_tagged.pdf

- take steps now to strengthen the way we use existing powers to hold organisations to account for failures to provide quality care and report on changes to be made from Spring 2013;
- assess whether providers are delivering care consistent with the statement of purpose made at the time of registration, particularly in relation to length of stay and to whether treatment is being offered. Where it is not, CQC will take the necessary action (including, if necessary, enforcement action) to ensure that a provider addresses discrepancies either through changes to its services or changes to its statement of purpose;
- take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place;
- take enforcement action against providers that do not operate effective recruitment procedures to ensure that their staff are suitably skilled, of good character and legally entitled to do the work in question. Operating effective recruitment procedures is a legal requirement and providers must be able to demonstrate to CQC that they have adequate procedures in place. Evidence of effective recruitment can include a provider showing it has requested criminal records checks for eligible employees (including any staff who regularly provide care or treatment) alongside checking references and qualifications. Where a provider has not requested criminal records checks on eligible employees, it will have to assure CQC that its recruitment procedures are still effective and that it can be evidenced that it is reasonable for the check not to have been made. Providers also commit an offence if they knowingly engage a person who is barred in activities such as providing healthcare or personal care. From 2014 the government will commence an explicit duty to check that a person is not barred before engaging them in these activities;
- continue to run the stakeholder group that helped to shape the inspection of 150 learning disability services. It will continue to meet twice yearly and will be chaired by the CQC Chief Executive. CQC will review the role and function of the group as part of that work programme to make sure it continues to provide advice and critique on CQC's inspection and monitoring of providers;
- continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team;
- take a differentiated approach to inspections between different sectors of care provision to ensure the inspections are appropriate to the vulnerability and risk for the different care user groups (subject to the outcome of consultation on its new strategy);
- review, as part of its new strategy, the delivery of its responsibilities under s120 of the Mental Health Act 1983 for the general protection of patients detained under the Act which include wide powers to review the way in which the Act's functions and safeguards are working and investigating complaints by any person detained under the Act.

Key Actions:

CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.

CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance about compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the proposed changes to the registration process in respect of models of care for learning disability services in 2013.

6.5 From 2013 arrangements for checking criminal records will become quicker and simpler with the introduction of a new service that will make criminal records certificates more portable. When the new service is running, the Department of Health will review the regulatory requirements about criminal records checks and consider whether providers should routinely request a criminal record certificate on recruitment.

6.6 Monitor will begin licensing non-foundation trust providers of NHS funded services from April 2014. Monitor will consider strengthening Board-level governance by including internal reporting requirements in the licensing conditions. This is in line with the recommendations from the Serious Case Review. Monitor and CQC are required to co-operate with each other and share information.

6.7 In its recent consultation document on licence conditions, Monitor proposed two requirements for providers to meet before they could obtain a licence:

- a requirement for them to hold CQC registration; and
- to confirm that their governors and directors, or equivalent people, are fit and proper persons.

6.8 The proposal is that these requirements would also appear in the licence conditions, making them on-going obligations which providers would have to continue to meet in order to continue to hold a licence. Monitor and CQC will be under a legal duty to seek to ensure that the conditions are consistent.

6.9 Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons will introduce a new joint inspection of multi-agency arrangements for the protection of children in England from June 2013. This approach, which is currently being piloted, will focus on the effectiveness of local authority and partners' services for children who may be at risk of harm, including the effectiveness of early identification and early help. The inspectorates intend to publish the arrangements for the inspections by April 2013.

6.10 Ofsted is responsible for inspecting children's homes, as well as boarding and residential provision in schools. Under new inspection frameworks published in September 2012 they will make judgements on the overall effectiveness, outcomes for children and young people, quality of care, safeguarding as well as leadership and management. Under the framework inspectors are expected to consider residents views on the service, to observe interactions between staff and children and young people and to obtain the views of relevant parties including social workers and the authorities responsible for placements.

Part 7: Improving quality and safety

7.1 Ensuring that commissioners are commissioning the right services, that organisations are properly accountable, and that regulation is most effective will tackle many of the systemic problems revealed by Winterbourne View. However, the Serious Case Review and the other evidence we have received make it clear that the programme of change must go wider.

7.2 The actions we have described so far are primarily for the Department of Health, commissioners and regulators to lead. However, this wider programme lays much greater weight on the responsibility of providers, professional bodies and others to lead. It covers:

- making best practice normal;
- improving the capacity of the workforce;
- whistleblowing;
- the Mental Health Act and Mental Capacity Act;
- physical restraint;
- medication; and
- improving advocacy.

Making best practice normal

7.3 The fundamental responsibility for providing good quality care rests with providers. Representatives of provider organisations fully accept this. They have agreed to work together to develop options for improving quality, including bringing forward a pledge or code model based on shared principles along the lines of the TLAP Making it Real principles for learning disability providers.

7.4 Providers should involve people with learning disabilities and people with autism and their families in checking the quality of services.

Good Practice

Dimensions is a large social care provider that has made stringent efforts to monitor and improve quality and performance. It made a conscious decision to create a Compliance audit team separate from the operational management of services, believing that this tension would enable more objective and rigorous monitoring. The Dimensions Compliance team, together with a team of four Experts by Experience, work across each of the organisation's regions conducting service audits. The audits look at every aspect of the service from regulatory requirements, finance, health and safety and for evidence of better practice, including a two hour observation of staff interacting with the people they are supporting as well as on-going observation throughout the visit. The audit process gives a clear picture of what is happening in individual services and across the organisation, and forms part of the reporting of risk management up through its governance

structure, including the people it supports. The new systems are contributing to significant advances in quality and improved outcomes. Dimensions' intention is to promote best practice, ensure that it exceeds compliance requirements and demonstrate robust and rigorous processes of internal scrutiny in line with its vision and values.

7.5 Good practice guidance for the care of adults is well established[20]. And there will be new statutory guidance in relation to children in long-term residential care.

Key Action:

The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care (s85 and s86 of the Children Act 1989) in 2013.

Improving the capability of the workforce

7.6 Recruiting, training and managing the workforce is the responsibility of providers. The events at Winterbourne View highlighted that there are too many front-line staff who have not had the right training and support to enable them to care properly for people with challenging behaviour. This is a theme which has been reinforced by many of the families we have heard from.

7.7 It is crucial that staff who work with people with challenging behaviour are properly trained in essential skills. CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff. Better skills and training are an important part of raising standards overall and we expect providers to ensure the people they employ are properly trained. However, the Department of Health, commissioners and other organisations will play an important role in setting expectations, creating standards and offering advice.

7.8 We expect commissioners to assure themselves that providers are meeting proper training standards. Contracts with learning disability and autism hospitals should be dependent on assurances that staff are signed up to the proposed Code of Conduct which the Department of Health has commissioned from Skills for Health and Skills for care, and minimum induction and training standards for unregistered health and social care assistants are being met.

7.9 From April 2013 Health Education England (HEE) will have a duty to ensure we have an education and training system fit to supply a highly trained and high quality workforce. HEE will work with the Department of Health, providers, clinical leaders, and other partners to improve the skills and capability of the workforce to respond to the needs of people with challenging behaviour and will examine ways to ensure that skills include knowing when and how to raise concerns, (in other words 'whistleblow') including on disability hate crime.

[20] see *Services for People with Learning Disability and challenging behaviour or mental health needs* 2007, Prof. Jim Mansell, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

7.10 HEE will expect that all new entrants are tested for their values and interpersonal skills, and will reach out into schools and colleges to ensure that young people with the right values consider a career in healthcare. HEE will ensure the values set out in the NHS Constitution lie at the heart of all it does.

7.11 It is crucial that staff who work with people with challenging behaviour should be properly trained in essential skills. HEE are committed to ensuring that non-professional members of the workforce (ie bands 1-4) receive continuing development and training to provide a skilled and highly motivated workforce.

7.12 It is not sufficient to have a well-trained workforce. There also needs to be good clinical and managerial leadership. The National Skills Academy for Social Care, on behalf of the Department of Health, published a Leadership Qualities Framework for Adult Social Care in October 2012. This builds on the principle that leaders that demonstrate the right values and behaviours at every level of the sector provide the best foundation for transforming social care.

7.13 There will be concerted effort across the system over the next year to ensure health and care professionals understand and are guided in achieving minimum standards, and aspire to best practice.

Key Actions

CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.

By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach*[21] to support clinicians in community learning disability teams to deliver actions that provide better integrated services.

By April 2013 the Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.

Skills for Care will develop by February 2013 a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour.

Skills for Health and Skills for Care will develop by January 2013 national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.

[21] The Royal College of Psychiatrists and British Psychological Society and Royal College of Speech and Language Therapists: *A Unified Approach* (2007)

By end 2013 there will be a progress report on actions to implement the recommendations in *Strengthening the Commitment*, the report of the UK Modernising Learning Disability Nursing Review[22].

Confidence in Whistleblowing

7.14 When things go badly wrong, and local management is reluctant to change, members of staff must feel it is safe for them to raise their concerns more widely and that they will be listened to. The interim report of this review set out action already taken to encourage whistleblowing[23]. It also clarified roles within the system:

- **Government:** in ensuring that the legislative framework in the Public Interest Disclosure Act is adequate;
- **Employers**: in supporting staff to raise concerns by having a clear policy in place which makes it clear that staff who raise concerns will be supported and which provides ways to by-pass the immediate line management chain where necessary;
- **CQC**: in monitoring concerns about patient safety raised with it and ensuring that timely referrals are made to the professional regulators where necessary; and
- **Professionals and other health and care workers**: in raising concerns promptly.

7.15 CQC has strengthened its arrangements for responding to concerns that are raised with it by whistleblowers. Whistleblowing concerns are now monitored to ensure they are followed up and thoroughly investigated until completion and the information provided is included in regional risk registers, which list providers where 'major concerns' have been identified.

7.16 The Department of Health funds a free, confidential whistleblowing helpline for NHS and care staff and employers who need advice about raising concerns and for employers on best practice. The service, provided by Mencap, was extended for the first time to staff and employers in the social care sector. Mencap will shortly be announcing a campaign which aims to reduce the gap between those staff who know how to whistleblow and those who would feel comfortable in doing so.

7.17 In March 2012, we revised the NHS Constitution to include an expectation that staff will raise concerns, a pledge that concerns will be acted upon and an undertaking to give clarity around the existing legal rights to raise concerns. It is important that workers know to whom they can raise concerns and all employers should have a clear whistleblowing policy in place.

7.18 Where a doctor has good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, s/he has a duty to put the matter right if possible. Similar duties are laid on other professionals through their codes of conduct. In all cases, professionals must consider the wider implications of failing to report such concerns and the risks to patient safety.

7.19 The Department of Health has asked the LGA and NHSCB to take account of the recommendations of the Serious Case Review on whistleblowing**. Commissioners**

[22] *Strengthening the Commitment'http://www.scotland.gov.uk/Publications/2012/04/6465/downloads*
[23] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

should ensure that organisations contracting with the NHS or a local authority include a condition of employment on its workers to report concerns where:

- a criminal offence has been, is being or is likely to be committed;
- a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
- a miscarriage of justice has occurred, is occurring or is likely to occur;
- the health or safety of any individual has been, is being or is likely to be endangered;
- the environment has been, is being or is likely to be damaged; or
- information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

Improving safeguarding

7.20 Following consultation, **DfE is revising *Working Together to Safeguard Children*, statutory guidance on how organisations, agencies and individuals working with children should work together to safeguard and promote their welfare**. The guidance will be published in due course.

7.21 Events at Winterbourne View flagged the need to prioritise strengthening adult safeguarding arrangements. The Serious Case Review shows that adult safeguarding systems failed to link information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts and failures to follow up concerns when commissioners became aware of them. The Department of Health has already announced its intention to put Safeguarding Adults Boards on a stronger, statutory footing, better equipped both to prevent abuse and to respond when it occurs. By strengthening the safeguarding adults boards arrangements and placing health, NHS and the police as core partners on the boards we will help ensure better accountability, information sharing and a framework for action by all partners to protect adults from abuse.

Key Action:

The Department of Health will revise statutory guidance and good practice guidance to reflect new legislation and address findings from Winterbourne View, to be completed in time for the implementation of the Care and Support Bill (subject to parliamentary approval). In particular:

- **Safeguarding Adults Boards will be put on a statutory footing, subject to parliamentary approval of the Care and Support Bill;**
- **local authorities will be empowered to make safeguarding enquiries, and Boards will have a responsibility to carry out safeguarding adults reviews;**
- **the Safeguarding Adults Board will publish an annual report on the exercise of its functions and its success in achieving its strategic plan; and**
- **the Safeguarding Adults Board core membership will consist of the LA, NHS and Police organisations, convened by the LA. Individual boards will be able to appoint other members in line with local need.**

7.22 Local authorities should ensure that everyone involved in safeguarding is clear about their roles and responsibilities. All local authorities and their local safeguarding partners should ensure they have robust safeguarding boards and arrangements and have the

right information-sharing processes in place across health and care to identify and deal with safeguarding alerts. This requires a multi-agency approach including all partners. In recognition of the critical role of information sharing and multi-agency working in delivering successful outcomes for adults and children at risk, the Home Office is working in partnership with the Association of Chief Police Officers (ACPO), the Department of Health and the Department for Education to improve our understanding of the different local multi-agency models in place to support information sharing around safeguarding responses for vulnerable people.

7.23 **Local areas need to work in partnership, including, where necessary with police and criminal justice agencies, to ensure that people returning to communities are supported adequately. This may include working with integrated offender management teams where appropriate**.

7.24 NHS Accident and Emergency (A&E) staff need to be alert to adult safeguarding issues and have a clear understanding of what to do with any safeguarding concerns. The Department of Health will highlight to A&E departments the importance of detecting incidences of re-attendance from the same location /individual in their annual review of Clinical Quality Indicators.

7.25 ACPO recognise the importance of working together with statutory agencies, local authorities and safeguarding partners to enhance the service provided to vulnerable adults. ACPO has reviewed the overall learning from Winterbourne View and will ensure the following:

- the one direct recommendation relating to the police regarding the early identification of trends and patterns of abuse has been fully recognised by Avon & Somerset Police. A specific workstream has been created by the force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally; and
- all associated learning from the review will be incorporated into training and practice, including Authorised Professional Practice.

Applying protections of the Mental Health Act and the Mental Capacity Act

7.26 Nearly three-quarters of people at Winterbourne View hospital (73%) were detained under the Mental Health Act 1983. But it is clear that the principles and safeguards of the Mental Health Act were not properly applied. This was also true for some of the people who were informal patients, who also had their freedom and movement constrained. Some of the people we met said they and their families were given little say in where they were sent. This does not fit with the principles of personalisation in the NHS Constitution or the principles of the Mental Health Act 1983 and Mental Capacity Act 2005.

Key Actions:

The Department of Health will work with CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards (DOLS) provisions to protect individuals and their human rights and will report by Spring 2014.

During 2014 the Department of Health will update the Mental Health Act Code of Practice and this will take account of findings from this review.

Raising understanding of good practice and reducing the use of physical restraint

7.27 Physical restraint should only ever be used as a last resort and never used to punish or humiliate.

7.28 The CQC inspections revealed widespread uncertainty on the use of restraint, with some providers over-reliant on physical restraint rather than positive behaviour support and managing the environment to remove or contain the triggers which could cause someone to behave in a way which could be seen as challenging. In Winterbourne View, bullying, punishment and humiliation were disguised as restraint.

7.29 We need both to take enforcement action where restraint is used improperly or illegally and to clarify and spread better understanding on how to use restraint properly. Where CQC finds evidence of inappropriate or illegal use of restraint it will take enforcement action.

Key Actions:

The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.

With external partners, the Department of Health will publish by the end of 2013 guidance on best practice on positive behaviour support so that the physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and <u>never</u> to punish or humiliate.

7.30 This will include:

- a set of agreed values to promote change and raise standards to minimise the use of physical intervention;
- looking at different methods of restraint;
- a training framework for commissioners to enhance the skills of the workforce; and
- identification of information and data needs.

This work will look more widely than people with challenging behaviour and apply to anyone in the health and social care systems who may be subject to physical intervention.

Addressing the use of Medication

7.31 **We have heard deep concerns about over-use of antipsychotic and anti-depressant medicines**. Health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient, taking into account the views of the person if possible and their family and/or carer. Services should have systems and policies in place to ensure that this is done safely and in a timely manner and should carry out regular audits of medication prescribing and management, involving pharmacists, doctors and nurses.

Key Actions:

The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotics and anti-depressants.

The Department of Health will explore with the Royal College of Psychiatrists and others whether and how to commission an audit of use of medication for this group. As the first stage of this we will commission, by summer 2013, a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.

Improving information, advice and advocacy

7.32 Good information and advice, including advocacy, is important to help people with challenging behaviour and their families to understand the care available to them and make informed choices. But it is clear that there is a very wide variety in the quality and accessibility of information, advice and advocacy, including peer advocacy and support to self-advocate.

Good Practice

In Dudley the local authority is working with independent advocacy organisations and commissioners to develop a quality framework which we hope will be widely adopted.

Key Actions:

The Department of Health will work with independent advocacy organisations to:

- **identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs; and**
- **drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.**

7.33 It is vital that people who make complaints about their care, or the care of a family member are listened to and are given the support (including advocacy as appropriate) and advice they need to make that complaint. This includes complaints about abuse and disability hate crime.

7.34 The Care and Support White Paper[24] states that all providers are required, by law, to have a clear and effective complaints system, and this is monitored by the CQC. If a provider or local authority does not resolve a complaint to the satisfaction of the user, that person can ask the Local Government Ombudsman to investigate. The Ombudsman will be clearly signposted through the new national information website for care and support.

7.35 The Department of Health accepted the recommendations made by the Equality and Human Rights Commission, which includes putting in place robust and accessible systems so that residents living in institutions can be confident of reporting harassment by staff or other residents.

7.36 The Department for Health is strengthening the ways in which people can give feedback on their care and support. This Government supports the development of websites which allow those who use services and their family or carers, to give feedback to providers and commissioners about any poor, or indeed good practice.

7.37 The Department of Health will work with the LGA and Healthwatch England on involving people with learning disabilities and their families in local Healthwatch organisations. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards, and, for children and young people, Parent Carer Forums. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.

[24] *Caring for our Future: reforming care and support* , http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

Part 8: Monitoring and reporting on progress

8.1 How will government, the public, people with challenging behaviour and families know we are making progress? Transparency of information and robust monitoring are critical for delivering transformed care and support. This involves:

- auditing current provision;
- developing better information for the future; and
- national monitoring through the Learning Disability Programme Board, including service user and family representation.

Auditing current provision

8.2 In pursuing this review, it became clear that there is a lack of clarity on the number of people with challenging behaviour in hospital settings or who is responsible for them. There have been improvements, but much more needs to be done to establish a baseline.

Key Action:

By March 2013 the Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.

Developing better information systems

8.3 The Department of Health intends to establish key performance indicators (on, for example, numbers of people in hospital, length of stay, incidents of restraint, and number of safeguarding alerts) which will enable the Learning Disability Programme Board and local services to monitor progress.

Action:
The Department of Health, the Information Centre for Health and Social Care and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress from April 2013.

The Department of Health will develop a new learning disability minimum data set to be collected through the Information Centre from 2014/15.

The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.

Monitoring and transparency

8.4 We will monitor progress through the Learning Disability Programme Board. It will also be essential for the process to be transparent and open to scrutiny.

Key Actions:

The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments (Annex B). CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.

Regular updates to the Programme Board will be published on the Department of Health website, with all other papers and minutes for that Board.

The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013 and repeat this by December 2014.

Part 9: Conclusion

9.1 For too long, people with challenging behaviour have – as highlighted by Mencap and the Challenging Behaviour Foundation – been too much out of sight. Although there is ample authoritative guidance across health and care, and examples of good practice around the country, in too many places the needs of this highly vulnerable group of people are not being addressed. It is easy to see why families and groups who support people with challenging behaviour are sceptical about what will happen this time to deliver the transformation of care which people deserve.

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9.2 But we believe that the package of timetabled actions set out in this report and the accompanying Concordat, together with the commitment by national and local leaders to monitor and report on delivery against these will deliver real change. And this will be enabled by the reforms to health and care systems which give greater power to individuals and local communities to develop services which genuinely respond to local needs.

Annex A: The model of care

There are too many people challenging behaviour living in inpatient services for assessment and treatment and they are staying there for too long.

The closure of most long-stay hospitals in the 1980s and 1990s, and the recent closure of NHS campuses, means most people with learning disabilities, including those with behaviours that challenge now live in the community with support. But some still live (for short or longer periods) in NHS funded settings. Assessment and treatment units emerged as the most likely solution to meeting the needs of people with learning disabilities and complex mental health/behavioural issues post-institutional closure. However, there were opposing views between 'building based' services and increasing support to people in their natural communities as the preferred option.

Good practice guidance on supporting people with learning disabilities, autism and those with behaviour which challenge includes the 1993 Mansell report, updated and revised in 2007. Both emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs/challenging behaviour; and
- that services/support should be provided locally where possible.

Evidence shows that community-based housing enables greater independence, inclusion and choice and that challenging behaviour lessens with the right support. The Association of Supported Living's report *There is an Alternative* describes how 10 people with learning disabilities and challenging behaviour moved from institutional settings to community services providing better lives and savings of around £900,000 a year in total.

The CQC *Count me in* 2010 census showed only 2 learning disabled patients on Community Treatment Orders compared to over 3,000 mental health patients – suggesting a greater reliance on inpatient solutions for people with learning disabilities than for other people needing mental health support.

CQC found some people were staying many years in assessment and treatment units. Annex B estimates that, in March 2010, at least 660 people were in A&T in Learning Disability wards for more than 6 months.

This report sets out how the model of care set out in the Mansell reports fits with the new health and care system architecture focusing on key principles, desired outcomes for individuals, and a description of how the model should work in practice.

Key principles

The key principles of high quality services for people with learning disabilities and behaviour which challenges are set out below:

For people:

1. I and my family are at the centre of all support – services designed around me, highly individualised and person-centred;
2. My home is in the community – the aim is 100% of people living in the community, supported by local services;
3. I am treated as a whole person;
4. Where I need additional support, this is provided as locally as possible.

For services:

5. Services are for all, including those individuals presenting the greatest level of challenge;
6. Services follow a life-course approach i.e. planning and intervening early, starting from childhood and including crisis planning;
7. Services are provided locally;
8. Services focus on improving quality of care and quality of life;
9. Services focus on individual dignity and human rights;
10. Services are provided by skilled workers;
11. Services are integrated including good access to physical and mental health services as well as social care;
12. Services provide good value for money;
13. Where inpatient services are needed, planning to move back to community services starts from day one of admission.

Outcomes

A high quality service means that people with learning disabilities or autism and behaviour which challenges will be able to say:

1. I am safe;
2. I am treated with compassion, dignity and respect;
3. I am involved in decisions about my care;
4. I am protected from avoidable harm, but also have my own freedom to take risks;
5. I am helped to keep in touch with my family and friends;
6. Those around me and looking after me are well supported;
7. I am supported to make choices in my daily life;
8. I get the right treatment and medication for my condition;
9. I get good quality general healthcare;
10. I am supported to live safely in the community;
11. Where I have additional care needs, I get the support I need in the most appropriate setting;
12. My care is regularly reviewed to see if I should be moving on.

This is about personalisation, starting with the individual at the centre, living in the community. The first level of support for that individual includes the people, activities and support all people need in their every day lives – family, friends, circles of support, housing, employment and leisure.

Most people with learning disabilities or autism will need more support from a range of sources: their GP or other primary care services, advocacy, a care manager or support worker and could include short breaks. That support may change as needs change, and this will involve assessments of physical or mental health needs or environmental needs (such as loss of a parent, a relationship breakdown, unemployment) to identify what support should be provided.

For people who need further support – including where they have behaviour which challenges – the intensity of support should increase to match need. That should include intensive support services in the community, assessment and treatment services (which could be provided in a safe community setting), and, where appropriate, secure services. But the aim should always be to look to improvement, recovery, and returning a person to their home setting wherever possible.

Responsibility for safety and quality of care depends on all parts of the system working together:

i. **providers** have a duty of care to each individual they are responsible for, ensuring that services meet their individual needs and putting systems and processes in place to provide effective, efficient and high quality care;
ii. **commissioners** (NHS and local authorities) are responsible for planning for local needs, purchasing care that meets people's needs and building into contracts clear requirements about the quality and effectiveness of that care;
iii. **workforce,** including health and care professional and staff who have a duty of care to each individual they are responsible for; and
iv. **system and professional regulators** who are responsible for assuring the quality of care through the discharge of their duties and functions.

To achieve these outcomes a revised model of care as set out below needs to be delivered.

Roles and responsibilities

Good services meeting the needs of everybody must include:

<u>Information</u>

- **Councils, elected councillors, health bodies and all care providers, whether from the public, for-profit or not-for-profit sectors** should provide good quality, transparent, information, advice and advocacy support for individuals, families and carers.

<u>Community based support</u>

- **Councils and health commissioners** should ensure that general services (GPs, hospitals, libraries, leisure centres etc) are user-friendly and accessible to people with learning disabilities/autism so they can access what everyone else can access.

- **Community based mental health services** for this group should offer assertive outreach, 24-hour crisis resolution, a temporary place to go in crisis and general support to deal with the majority of additional support needs at home.
- **Housing** authorities should include a wide range of community housing options - shared, individual, extra care, shared lives scheme, domiciliary care, keyring, respite.
- **Social care commissioners** should ensure the availability of small-scale residential care for those who would benefit from it (eg because they have profound and multiple disabilities).
- **Councils and employment services** should offer support into employment.
- **Councils and providers of services** should enable a range of daytime activities.
- **Councils** should roll out personal budgets for all those who are eligible for care and support including those with profound and multiple disabilities and/or behaviours seen as challenging.
- Where appropriate, **health commissioners** should fund continuing health care.
- **Health and social care commissioners** should focus on early intervention and preventive support to seek to avoid crises (eg behavioural strategies). Where crises occur, they should have rapid response and crisis support on which they can call quickly.

Commissioning, assessment and care planning

- **Health and social care commissioners** should develop personalised services that meet people's needs. Key factors include;
- involving individuals - with support where needed - and families at all stages;
- planning for the whole life course, from birth to old age, starting with children's services;
- developing expertise in challenging behaviour;
- developing partnerships and pooling resources to work together on joint planning and support with integrated services – including:
    - multi-disciplinary teams to perform assessments, care planning, care assessment, care management and review,
    - joint commissioning – ideally with pooled budgets, and
    - shared risk management;
- **Health and social care commissioners** should use all available information from joint strategic needs assessments (JSNAs) and local health and wellbeing strategies to commission strategically **for innovation** and to develop person-centred community based services;
- **Health and social care commissioners** should commission personalised services tailored to the needs of individuals, ensuring a focus on improving that individual's health and well-being and agreed outcomes. Progress towards delivering outcomes should be regularly reviewed;
- **Health and social care commissioners** should start to plan from day one of admission to inpatient services for the move back to community;
- **Health and social care commissioners** should ensure close coordination between the commissioning of specialised services including secure services, and other health and care services;

- **Social care bodies** have ongoing responsibility for individuals, even where they are in NHS-funded acute or mental health services, including working with all partners to develop and work towards delivering a discharge plan;
- **Health and social care commissioners** should audit provision to assess which services are good at supporting people with challenging behaviour (the Health Self Assessment Framework is an effective way to monitor outcomes);
- **Health and social care commissioners** should develop effective links with children's services to ensure early planning at transition and joint services. The SEND Green Paper proposal for an integrated health, education and care plan from 0-25 will also help to ensure that children's services are similarly thinking about a young person's transition to adult services at an early stage.

Service Providers

- **All service providers** (community, residential, health, care, housing – public, for-profit and not-for-profit providers) have a duty of care to the individuals for whom they provide services and a legal duty to refer. This includes ensuring that:
    - people are safe and protected from harm;
    - their health and well-being are supported;
    - their care needs are met;
    - people are supported to make decisions about their daily lives;
    - people are supported to maintain friendships and family links.

Providers should:

- provide effective and appropriate leadership, management, mentoring and supervision. Good leadership is essential in setting the culture and values;
- have a whole organisation approach to Positive Behaviour Support training;
- recruit for values and ensure that staff have training for skills - mandatory training which can include training on value bases when working with people with learning disabilities, positive behaviour support, types of communication including non-verbal communication, active support and engaging in meaningful activities and Mental Capacity requirements. Best practice includes involving people with learning disabilities and families in the training;
- operate good clinical governance arrangements;
- monitor quality and safety of care;
- Work with commissioners to promote innovation – new and different ideas, especially for the most challenging.

Assessment and treatment services

- **Health and care commissioners** are responsible for commissioning assessment and treatment services where these are needed. The focus should be on services (which can be community based) rather than units**.** Where a person is at risk (or is putting others at risk) in a way that community support cannot help and needs to be moved to a safe place, **commissioners** should focus on this being provided close to home.
- **Health and care commissioners** should look to review any placement in assessment and treatment services regularly, and focus on moving the individual on into more appropriate community based services as soon as it is safe for the individual to do so.

- **Social care services** should be closely involved in decisions to admit to assessment and treatment services.
- All **assessment and treatment services providers** must comply with statutory guidance on the use of physical restraint.

Prisons and secure services

- **Social care services** should work closely with prison and secure services to ensure person centred planning and health action planning and to plan for appropriate provision when people move on from prison or secure services.
- **Offender management processes** should include health screening programmes that identify an offender's learning disability and any physical and/or mental health issues.

Workforce should demonstrate that they are providing quality care and support which includes:

- personal and professional accountability;
- training in working with people with complex needs and behaviour which challenges;
- developing good communication and involving advocates and families'
- monitoring an individual's progress and reviewing plans; and
- good understanding of the legislative framework and human rights;
- Taking action to report any concerns identified.

System and professional regulators

As a regulator, the Care Quality Commission (CQC) should:

- monitor whether services are meeting essential standards;
- take enforcement action if a provider is not compliant;
- monitor the operation of the Mental Health Act 1983.

Professional regulators such as the Nursing and Midwifery Council (NMC) and General Medical Council (GMC), have a role to play to protect and promote public safety. They do this by:

- setting and maintaining professional standards;and
- investigating and taking appropriate action where concerns are raised about registrants, which can include the registrant being removed from the register and where appropriate being referred to the Independent Safeguarding Authority (ISA).

The professional regulators have produced a leaflet to help the public to ensure that they receive the care and treatment from professionals who meet the right standards.

Annex B: Timetable of Actions

This Report sets out a range of national actions which the Department of Health and its partners will deliver to lead a redesign in care and support for people with learning disabilities or autism and mental health conditions or behaviours viewed as challenging.

The Department of Health is committed to working with partners to monitor progress, hold all players to account for delivery, and ensure better experiences and improved outcomes for this very vulnerable group of people.

No.	Date	Action
1.	From June 2012	CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team.
2.	From June 2012	CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place.
3.	From June 2012	CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.
4.	From November 2012	The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.
5.	From December 2012	The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions to protect individuals and their human rights and will report by Spring 2014.
6.	From December 2012	The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint**.**
7.	From December 2012	The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs.
8.	From December 2012	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.
9.	From December 2012	A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice,

No.	Date	Action
		including Authorised Professional Practice.
10.	From December 2012	The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;
11.	From December 2012	The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings.
12.	From December 2012	The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.
13.	By end of December 2012	The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.
14.	By end December 2012	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach* to support clinicians in community learning disability teams to deliver actions that provide better integrated services.
15.	By January 2013	Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.
16.	By February 2013	Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour
17.	By March 2013	The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.
18.	By March 2013	The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: ▪ model service specifications; ▪ new NHS contract schedules for specialist learning disability services; ▪ models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and ▪ a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.
19.	By March 2013	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and

No.	Date	Action
		adults with challenging behaviour built around the model of care in Annex A.
20.	By March 2013	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions.
21.	By March 2013	The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used.
22.	By 1 April 2013	The NHSCB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.
23.	By 1 April 2013	The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.
24.	By 1 April 2013	The National Quality Board will set out how the new health system should operate to improve and maintain quality.
25.	By 1 April 2013	The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards.
26.	From 1 April 2013	The NHSCB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.
27.	From April 2013	The NHSCB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours.
28.	From April 2013	Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.
29.	From April 2013	CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.
30.	From April 2013	CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities.
31.	From April 2013	CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration.
32.	From April 2013	Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.
33.	From April 2013	The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint

No.	Date	Action
		commissioning arrangements.
34.	From April 2013	The NHSCB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities.
35.	From April 2013	Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide.
36.	From April 2013	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.
37.	From April 2013	The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress.
38.	From April 2013	The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.
39.	From April 2013	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.
40.	By Spring 2013	The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.
41.	From Spring 2013	CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.
42.	By 1 June 2013	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.
43.	By Summer 2013	Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP)

No.	Date	Action
		Making it Real principles.
44.	By Summer 2013	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care.
45.	By summer 2013	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.
46.	By June 2013	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood.
47.	In 2013	The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.
48.	In 2013	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.
49.	In 2013	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy.
50.	In 2013	The Department for Education will revise the statutory guidance *Working together to safeguard Children.*
51.	In 2013	The Royal College of Psychiatrists, the Royal Pharmaceutical Society ad other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines.
52.	By December 2013	The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013.
53.	By end 2013	The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.
54.	By end 2013	There will be a progress report on actions to implement the recommendations in *Strengthening the Commitment* the report of the UK Modernising learning disability Nursing Review.
55.	By end 2013	CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance abut compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about

No.	Date	Action
		the proposed changes to our registration process about models of care for learning disability services in 2013.
56.	From 2014	The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.
57.	By April 2014	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.
58.	No later than 1 June 2014	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.
59.	In 2014	The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review.
60.	By December 2014	The Department of Health will publish a second annual report following up progress in delivering agreed actions.
61.	From 2014/15	The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre.
62.	By Summer 2015	NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.
63.	By Summer 2016	NICE will publish quality standards and clinical guidelines on mental health and learning disability.

Glossary

ACPO	Association of Chief Police Officers
A & E	Accident and Emergency
A & T	Assessment and Treatment
A4A	Action for advocacy
ADASS	Association of Directors for Adult Social Services
ADCS	Association of Directors of Children's Services
BBC	British Broadcasting Corporation
CCG	Clinical Commissioning Groups
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DfE	Department for Education
DH	Department of Health
DOLS	Deprivation of Liberty Safeguards
EOF	Education Outcomes Framework
GP	General Practitioner
HEE	Health Education England
JHWSs	Joint Health and Wellbeing Strategies
JSNAs	Joint Strategic Needs Assessments
LA	Local Authorities
LD	Learning Disability
LGA	Local Government Association
LINKS	Local involvement networks
NHS	National Health Service
NHSCB	National Health Service Commissioning Board
NICE	National Institute for Health and Clinical Excellence
NQB	National Quality Board
Ofsted	Office for Standards in Education, Children’s Services and Skills
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
SAB	Safeguarding Adults Boards
SCR	Serious Case Review
TLAP	Think Local Act Personal

Exhibit 76

To: Andrew Browne

From: Phelim Quinn

cc: Glenn Houston

Date: 8 June 2011

Regulated Services for People with a Learning Disability

Introduction

Following the Chief Medical Officer's request for assurances in respect of regulated services for people with a learning disability, the following report has been complied. The report sets out RQIA's systems aimed at maintaining oversight of the range of regulated and statutory sector learning disability services and its ability to respond to incidents and other forms of information and intelligence that may give rise to concerns about the way in which services are being provided.

This report sets out:

- A profile of learning disability services regulated by RQIA.
- A description of processes used by RQIA to maintain assurance levels in services. These include:
  - RQIA's inspection process
  - incident notification system
  - a description of relevant enforcement activity
- A range of current concerns in regulated sector services, and the regulatory activities in place.
- The profile and inspection of hospital wards caring for patients with a learning disability.

Registration Information

RQIA has responsibility for the registration and inspection of various establishments and agencies for adults with a learning disability. There are three service types within this group; they are, residential care, day care settings and nursing homes. Services are categorised as learning disability or elderly learning disability (those over 65 years). These regulated services are provided by both the statutory and independent sectors. The table below indicates that RQIA has 244 registered services providing a total number of 7,841 places for this user group.

RQIA also has responsibility for the registration of other services, which although not specific to learning disability also do have significant numbers of service users with a learning disability. These services include domiciliary care agencies, adult placement agencies and children's homes.

Total Number of Registered Services and Approved Places

Number of establishments registered to provide services for users with learning lisability as at 1 June 2011				
Sector	**Day Care Setting (DCS)**	**Nursing (NH)**	**Residential (RC)**	**Total**
Independent	23	53	81	**157**
Statutory	65	2	20	**87**
Total	**88**	**55**	**101**	**244**

Maximum number of approved places in establishments registered to provide services for users with learning disability as at 1 June 2011				
Sector	**Day Care Setting (DCS)**	**Nursing (NH)**	**Residential (RC)**	**Total**
Independent	604	2,107	1,111	**3,822**
Statutory	3,725	19	275	**4,019**
Total	**4,329**	**2,126**	**1,386**	**7,841**

Inspection Planning Approach

In recent years RQIA has developed its approach to inspection of regulated services, this methodology is called the Inspection Planning Approach (IPA). This approach enables RQIA inspectors to vary the type, intensity and frequency of inspections, while remaining consistent with the minimum level of inspection outlined within legislation. This approach allows inspection activity to target regulation resources where they are needed - predominantly in those services that RQIA perceived as operating at higher risk and avoiding excessive regulation on services that consistently perform well.

Two underlying principles to RQIA's approach are:

- **Proportionality:** only intervening when necessary
- **Targeting:** regulation focussed on the problem and minimising any unintended consequences of regulation

Inspectors use their knowledge of services to plan inspection activity. This allows regulatory intervention to deliver improvements and compliance with regulations and standards. RQIA collates and analyses this information and intelligence on an internal data base (the inspection planning tool). The information held on the data base includes:

- information about the service's historical compliance with standards and regulations
- incident notifications (frequency, type and risk assessment)
- outcomes of pre inspection self-assessments
- complaints about the service
- registration details
- other forms on information received about the service, held in the establishment or agency file

Planning the Inspection Programme

An Inspection Planning Tool (IPT) is completed by inspectors for all services at the commencement of each calendar year. This IPT draws together all the information identified above. Using this information the inspector will identify the appropriate planned inspection activity. Inspectors review the individual IPTs on an ongoing basis with their line manager, identifying emerging concerns in relation to the individual service and adjusting regulatory intervention in accordance with any revision in the risk profile being presented.

Current Issues in Regulated Services for Persons with a Learning Disability.

The following section provides an overview of current issues and concerns RQIA are dealing with in respect of regulated services for persons with a learning disability. This overview is presented in accordance with regulated categories of registration. In the main RQIA are satisfied with the care of people with learning disabilities within regulated services.

Residential care homes

General Issues

In general, inspectors report a high quality of service provision in residential care homes accommodating people with a learning disability. Some described the very active engagement and involvement of residents in the 'running' of the homes and how there is active involvement in staff recruitment.

Issues relating to specific services

Mary Murray House – this care home had one vulnerable adult case allegedly involving a member of staff who was suspended pending investigation. A staff member who witnessed this incident and did not report it was also suspended and underwent disciplinary proceedings. The incident was disclosed by a staff member who had just received training in protection of vulnerable adults. We are waiting the outcome of this investigation. PSNI and SEHSCT involved.

Sense VRH - in this care home specific concerns about how management responded to a protection of vulnerable adult issue as this had not been immediately reported to the respective trust nor were RQIA notified of it. The organisation had commenced an investigation. There were concerns regarding how a complaint made by the parent of a learning disability individual who is blind was responded to. This has been subsequently resolved.

Areas of Concern

The main areas of concern are more general and relate to:

- The pooling of resident's mobility allowances to fund transport, without specific mechanisms ensuring safeguards for residents' finances.
- The lack of advocacy support to those who have limited or no visits from relatives.
- Variability in the way in which challenging behaviours are managed across services and the lack of regional guidance on such strategies.
- Inconsistency in the way in which social workers / care managers are assigned to individual cases and the quality of how individual care needs are being reviewed and maintained.

Day Care Settings

General Issues

Inspectors provided positive comments in relation to day care services for those people with a learning disability.

Issues relating to specific services

George Sloan and My Ways centres – These centres were operating without being registered by the Northern HSC Trust.

Areas of Concern

No issues of concern regarding direct service provision. However, some inspectors have highlighted that:

- There are no guidelines regarding staffing levels and the number/size of services a registered manager can be responsible for
- There are community services being offered by trusts/other organisations as an 'alternative to traditional day care' which at this time RQIA does not regulate. As a result there are limited safeguards in respect of the quality and safety of services being provided.

Domiciliary Care Agencies

Background

RQIA regulate around 80 services registered as domiciliary care agencies that provide service specifically for people with learning disabilities. There are a further significant range of services that are provided for people including those who have learning disabilities. It is not possible to be more precise about numbers because (a) there are no categories of care in respect of domiciliary care agencies, and so (b) the profile of users may well have changed since our last inspections. It should also be noted that services described as domiciliary care agencies consist of conventional domiciliary care and supported living services. As what is registered is the premises from which the service is operated, a single registration may in fact cover service delivery in a number of discrete locations.

General Issues

Findings in respect of these services have been generally satisfactory in relation to care issues. There are three areas of concern that have emerged in respect of a significant number of services:

- **Management of finances:** several supported living schemes have been identified where Disability Living Allowance paid to individual service users in respect of their mobility needs has been gathered and "pooled" to create transport schemes. These arrangements do not allow for individuals to pay for only the service that they receive and "pooled" finance arrangements disadvantage some people by allowing cross-subsidising of other service users. This concern has been addressed using our standard stepped enforcement approach.
- **Mandatory training:** in a number of supported living services, issues around shortfalls in training for what are quite small staff groups have been noted. As this has included training in adult protection awareness, there has been the potential for this to have safety consequences for people using services. This concern has been addressed using our standard stepped enforcement approach.

- **Adult protection arrangements:** some services have not been able to demonstrate adult protection policies and procedures that are fully compliant with regional guidance and that contain clear definitions appropriate for front line staff. This issue has been addressed using our standard stepped enforcement approach.

Using domiciliary care regulations RQIA is currently in discussions with four agencies in relation to the current practice of charging service users for transport. All of these establishments provide for young adults with a learning disability.

More recently a number of inspectors from the agencies team and mental health team have raised a number of additional concerns in relation to the management of service user money. This includes the practice of staff withdrawing large amounts of monies on behalf of service users, with a learning disability, by means of bank cards with pin numbers.

As a result of these concerns financial inspections of learning disability establishments and agencies have recently been prioritised.

Issues relating to specific services

Manor Healthcare (Broadacres Supported Living)

Enforcement action was taken on 16 February 2011 (issue of failure to comply notices) in respect of this service where four people with learning disabilities live. The concerns were about management of finances, record-keeping associated with management of finances and the operation of a pooled transport scheme which has involved equal charging of all users without taking account of use. The agency was found to be compliant with regulation in this area on 5 May 2011.

Autism Initiatives

Within one cluster of supported living services, concerns have been highlighted in a recent series of inspections involving use of restrictive practices that had not been defined within a care plan, staff training in use of physical interventions and both staff training in adult protection awareness and inadequate adult protection procedures. This service is currently subject of four failure to comply notices issued on 27 May 2011. Service managers have presented a plan for achieving compliance and we will shortly be assessing progress on these key issues.

Adult Placement Agencies

General issues

During the past year there has been only minor variation in this sector with four services registered.

The major care related issue has been that agencies have experienced difficulty in securing engagement of adult placement carers with the training that is arranged for their support, generally relating to the carers' perceptions that training is not required as many of them have provided care for many years. This is an issue clearly identified as a priority area within the draft standards and RQIA will be meeting with the managers of the adult placement agencies in late June to discuss this issue further and agree a way forward.

Nursing Homes

General Issues

Inspectors indicate that there are no serious safety and treatment issues raised with regards to individual nursing homes caring for individuals with a learning disability. In some homes, requirements and recommendations are made as a result of the inspections undertaken. In the main, homes are working to progress the requirements made by RQIA. A number relate to care practices, record keeping, staffing, finance and environment.

Those homes that have identified as requiring high intensity and frequency of inspections are planned in accordance with RQIA's inspection planning approach.

Protection of vulnerable adult referrals have been made, a number of which are inclusive of resident against resident, these are dealt with through the trust and care management teams. Any protection of vulnerable adult referrals involving staff and residents are notified to the local Trust in line with the DHSSPS guidelines. When appropriate, staff alleged to be involved in abuse are suspended pending investigation. PSNI are involved by the trust line with regional protocols.

Issues relating to specific services

In February 2011 two homes within the same company Manor Health Care, Queenscourt and Kingscourt nursing homes caring for individuals with a learning disability were served notices of failure to comply with regulations. These enforcement notices in respect of Manor Health Care were identified through the RQIA specialist finance inspection regime. The notices were issued in relation to failures in the control of service users' monies which have also been a recurring theme in other similar establishments, failures include:

- control of benefits and personal allowance via appointeeship

- control of bank accounts on behalf of service user (including use of bank card with pin number)
- management of mobility monies for provision of a transport scheme
- authorisation for purchases made on behalf of service user
- types of purchases made from personal monies, in particular items classified as care related or business use
- mobility monies being deducted over a number of years (£5,000 in one case) for use of transport, service user did not avail of transport service. In another case a patient was confined to bed yet mobility monies were still deducted over a three year period.
- inadequate records maintained on behalf of service user (mainly in relation to above)

Children's Learning Disability Homes

Introduction

Currently RQIA has registered 12 children's home which offer 62 registered placements for children and young people. These young people may have varying levels of learning disability and challenging behaviours. They receive either permanent accommodation or respite care.

Provider	Number	Reg.places	Tot. users
BHSCT	2	8	13
WHSCT	1	6	36
NHSCT	2	9	70
SHSCT	2	9	58
SEHSCT	1	8	60
Barnardos	1	4	28
Orana	1	4	40
Praxis	2	14	53
Total	12	62	358

Respite Care

In line with the legislation and policy all young people can have up to 90 days per annum of respite. Once a young person has been assessed as in need of respite and been accommodated for over 24 hours the child/ young person will become subject to Looked After Children's arrangements. This ensures that each child has a family/childcare or disability social worker who must visit the child at least once a month. The child or young person will also have at least two looked after child reviews annually. These reviews are multiagency and include a review of the placement, education, health, and family support. All attempts are made to ensure the child's/young person's views are sought and shared at these meetings. This meeting will discuss and agree the care plan for the young person for the next six months. Any significant incidents or events from the previous six months are also discussed. However, if there

are issues arising before these scheduled meetings any of the professionals or family can request that the social worker call a strategy meeting.

All of the young people will have a crisis intervention management plan in place. This plan should clearly state how a child or young person's behaviour should be managed in the event of displays of challenging behaviour. This plan is agreed with social worker, family and other relevant leading professionals from learning disability services. All staff in the respite units have been trained in various techniques of managing challenging physical behaviour and these include Therapeutic Crisis Intervention (TCI), Management of Actual or Physical Aggression (MAPA) and British Institute of Learning Disability Physical Intervention Accreditation Scheme (BILD PIAS). Children and young people should be assessed to determine which intervention is most appropriate to their level of risk and understanding.

All restraints of children and young people are recorded and subject of close scrutiny by senior management and of regular monthly monitoring by external management. These records are also inspected by RQIA inspectors.

RQIA has established service user participation initiatives in conjunction with Barnardo's Disabled Children and Young People's Participation Project (Sixth Sense Project). These young adults have undergone extensive training and are at varying stages of assisting professional inspectors in the inspections of respite homes for children with disabilities. Their specific role is to solely elicit and represent the views of this group. They use a wide range of methods using modern technology to communicate with the young people and their findings and recommendations for improvements are reflected in the homes inspection report.

Permanent Care

BHSCT has opened a home for children with challenging behaviour in response to the Bamford Review. This involves moving young people out of long stay hospitals and into the community. These children are all subject to LAC arrangements.

Emerging Issues from Recent Inspection Activity

The inspectors report that in the main they are satisfied with the care offered to the children and young people who live or receive respite in registered children homes.

One emerging pattern has been that six homes have received or are in the process of receiving enforcement action over breaches to their statements of purpose. Trusts report that they have difficulty in finding suitable accommodation for individual young people and the result is young people placed on a long term basis in respite homes.

One unit has two staff who have been suspended due to an inappropriate restraint on a young person. This is being investigated by the trust and the young person was not physically injured during the incident.

In one unit MAPA techniques are being used to take blood samples from a young person. The trust management and other professionals feel that this is the safest way to take the samples as it reduces harm to the child and others.

One unit does not have a manager in place despite a number of attempts by the trust to recruit one. Another unit has a nurse acting manager at the moment as the permanent manager is suspended for management competency.

Other general issues relate to the high use of bank staff and low levels of qualified staff in one unit.

One unit, Rainbow Lodge, works with children and young people with very complex and challenging behaviours. As a result there are higher levels than normal of restraint within the unit. The unit has involved the challenging behaviour unit from the trust; they work closely to support staff and young people. There are also high levels of support within the unit by psychology lead professionals. The manager also maintains close oversight of any restraints which take place.

How RQIA manages notifiable events

Each set of regulations places a responsibility on individual service providers to report incidents and events to RQIA. Since April 2010 RQIA has introduced an information management system for the recording and reporting of these incidents.

Once an incident has occurred in a service the provider must complete the appropriate documentation and return it to RQIA within 24 hours. RQIA records the receipt of the incident form and forwards this to the relevant inspector for the service. The inspector reviews each incident and risk assesses each event to an agreed method. Depending on the risk assessment the inspector may close the incident having been satisfied that the service has managed the event appropriately. If there are additional concerns or more detail is required, the inspector will open a workbook in which all additional information is stored and will continue to monitor the situation. This incident will not be closed until the inspector is satisfied that all necessary measures have been introduced to minimise or avoid a re occurrence.

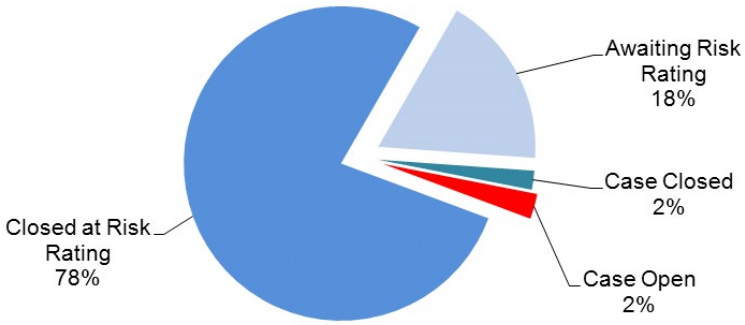
The table below indicates the overall number of incidents which have occurred within learning disability regulated services for a calendar year. (1 June 2010 to 31 May 2011). The children's services team has commenced use of the system since April 211 and domiciliary care agencies have very few reportable events which they must report and in line with regulation (these figures can only be produced for the whole sector and not learning disability specific.)

Number of Events Reported in Services with Learning Disability Users between 1 June 2010 and 31 May 2011					
Event Type		**Day Care Setting (DCS)**	**Nursing (NH)**	**Residential (RC)**	**Total**
A1 Theft/Burglary		**3**	**4**	**8**	**15**
A2 Absence		**5**	**6**	**21**	**32**
G1 Death		**1**	**286**	**34**	**321**
G2 Injury		**24**	**138**	**79**	**241**
G3 Accident		**68**	**157**	**226**	**451**
G4 Illness		**6**	**59**	**84**	**149**
G5 Infectious Disease		**1**	**20**	**2**	**23**
G6 Misconduct	Damage to property			2	2
	Financial/Material		2	3	5
	Institutional			1	1
	Misuse of drugs	1	2	1	4
	Neglect/ Omission		2		2
	Physical	13	13	24	50
	Psychological/Emotional	2	3	4	9
	Sexual	3	3	12	18
	Uncategorised	1	6	4	11
G6 Misconduct Total		**20**	**31**	**51**	**102**
G7 Police Incident		**7**	**9**	**21**	**37**
G8 Other Event	Behavioural Issue	132	66	731	929
	Estates Issue	1	14	12	27
	Medication Issue	13	44	90	147
	Psychological/Emotional			1	1
	Suicide/Self Harm	5	4	14	23
	Uncategorised	24	112	111	247
G8 Other Event Total		**175**	**240**	**959**	**1,374**
Total		**310**	**950**	**1,485**	**2,745**

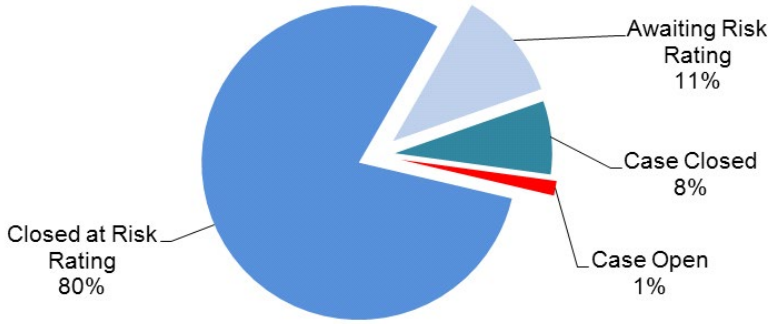
Status of Incidents (31 May 2010 -6 June 2011)

The three charts below indicate how around 80% of incidents have been risk assessed and dealt with almost immediately. This provides evidence that the majority of reportable events are assessed as low risk and that the inspectors are satified that the service has managed the incident appropriately. Those incidents waiting to be risk assessed demonstrate that the inspector has reviewed the information but requires further detail from the providers or is awaiting the outcome from the provider or trust investigations.

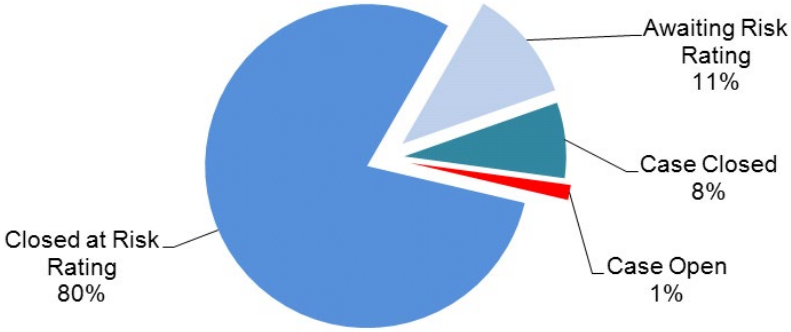
Day Care Settings



Nursing Homes



Residential Care Homes



Services monitored by RQIA under the Mental Health (NI) Order 1986

Introduction

RQIA's Mental Health and Learning Disability Team has a specific remit in the monitoring and oversight of the care and treatment of patients with learning disability under The Mental Health (Northern Ireland) Order 1986.

This includes direct face to face contact with patients in the form of inspections and patient experience reviews, as well as indirect contact in the form of questionnaires and talking to carers and relatives / representatives. Monitoring of detention forms and guardianship, as well as reviewing patients' records and documentation, dealing with complaints and whistleblowing concerns and reviewing adverse incidents all contribute to a robust and comprehensive oversight into the care and treatment provided.

Inspection

There are 22 in patient wards in Northern Ireland in which children and adults with a learning disability receive care on an ongoing basis. The profile of these services is as follows:

Belfast Health and Social Care Trust	14 wards
Southern Health and Social Care Trust	5 wards
Western Health and Social Care Trust	3 wards

In the last year RQIA has carried out 17 announced inspections and one unannounced inspection to these wards. RQIA's inspection process is underpinned by human rights indicators, and inspections have focused on the human rights theme of Fairness. Within this theme there are 13 expectation statements with associated indicators.

The inspection of each ward takes place over a two day period and involves the review documentation including patients' notes, care plans, risk assessments and notes of meetings as well as staff training records, policies and procedures and incident reports. A key part of this inspection process is talking directly to patients, their relatives and carers as well as staff to ascertain their experience of the care.

Number of patients with a Learning Disability interviewed during inspection process to inpatient facilities 2010-2011

Hospital	Number of patients interviewed
Lakeview Hospital (WHSCT)	12
Longstone Hospital (SHSCT)	9
Muckamore Hospital (BHSCT	32
Total	50

Numbers of Relatives / Carers of patients with a learning disability interviewed during inspection process to inpatient facilities 2010 – 2011 along with returned questionnaires.

Hospital	Relatives/Carers Interviewed	Questionnaires returned
Lakeview Hospital (WHSCT)	7	6
Longstone Hospital (SHSCT)	1	17
Muckamore Hospital (BHSCT	3	30
Total	11	53

Current Concerns from Hospital Ward Inspections
There are numerous recommendations arising from the inspection visits which are included in the inspection report for each facility. These recommendations are included in a Quality Improvement Plan which is issued to Chief Executive and includes action points to be addressed.

Recommendations have been made in relation to the following areas:

1. Insufficient / inadequate access to independent advocacy services.
2. Variation in information given to patients in respect of their rights under the 1986 Order
3. Variation in information given to patients on the detention process under the 1986 Order.
4. Inadequate or insufficient information provided regarding the right to complain, lack of opportunities for patients to comment on services.
5. Patients not consistently provided with user friendly information about ward routines, restrictions.
6. Care plans not person-centred, little evidence of patients' involvement in needs assessment or care planning.
7. Weekly multidisciplinary reviews are not available to all patients, particularly long stay patients who have annual reviews.
8. Not all patients have an opportunity to meet their consultant in private to discuss care and treatment; long stay patients would appear to have least access to the consultant.
9. One to one therapeutic time with primary nurse is variable across care settings.
10. Involvement with other health professional is variable across settings, access to psychology, behaviour support and social work are of particular concern.
11. There are significant numbers of 'delayed discharge' patients awaiting resettlement with no clear strategy to meet the resettlement needs of these patients.
12. Issues have been identified in relation to professional standards regarding reporting and record keeping; training records did not reflect uptake of training in mandatory areas, e.g. protection of vulnerable adults, child protection.

Other recommendations relate to estates and environmental issues however in one facility (Longstone) an issue in relation to patients' finances was escalated to Director of Mental Health and Learning Disability Services. This was subsequently resolved with the trust.

Patient Experience Reviews

An important function of the MHLD team is to keep under review the care and treatment provided to detained patients (Article 86 the Mental Health (Northern Ireland) Order 1986). This has involved offering each detained patient the opportunity to participate in a private interview with RQIA staff to discuss the care and treatment provided.

While this is a separate process from the Inspection programme, findings will contribute to the overall assessment of each facility and areas of concern have been raised with ward staff on the day of the interviews. The patient experience reviews were carried out in July, August and September 2010 and the numbers are included below.

Number of Learning Disability patients interviewed during Patient Experience Reviews July, August, September 2010

Hospital	Number of patients interviewed
Lakeview Hospital (WHSCT)	0*
Longstone Hospital (SHSCT)	4
Muckamore Hospital (BHSCT	48
Total	52

*There were no detained patients in Lakeview at the time the patient experience reviews were conducted, therefore, no patients were interviewed during this process.

Monitoring Detention Forms

Monitoring and scrutiny of detention forms is another important aspect of the oversight role which the MHLD team has in relation to detained patients. The number of detention forms (600) which relate to patients with a learning disability is low compared to those detained with mental health conditions (a total of 9,465 forms). However, the accuracy rate is high and there are a lower number of errors recorded on forms.

Form Analysis 01 April - 31 March 2011					
Trust Area	Facility Name	Total Forms received	Average time to receipt	Percentage Late >4 days	Percentage Unsatisfactory
BHSCT	Muckamore Abbey	478	6.08	79.71%	0.21%
BHSCT	The Iveagh Centre	33	10.15	90.91%	6.06%
SHSCT	Longstone	69	5.12	60.87%	0.00%
WHSCT	Lakeview	20	4.10	50.00%	0.00%

Guardianship

In the year 2010-11 there were 44 individuals with a learning disability who were subject to guardianship under The Mental Health (Northern Ireland) Order 1986. The process has been assessed by RQIA as robust and ensures that the individuals subject to guardianship have an annual review of their care plan and treatment and the prescribed forms, systems and processes are reviewed by the MHLD team.

Monitoring of Untoward Incidents

All serious adverse incidents are monitored by the MHLD team. The trusts' investigation of incidents is reviewed and where it relates to a facility, this is recorded in the facility folder and included in the inspection process. This will involve review of documentation and care plans during inspections.

Mechanism for dealing with concerns, complaints and/or whistleblowing.

An unannounced visit was carried out in Mourne Ward, Longstone Hospital, Armagh, on 28 April, 2010 in response to a number of concerns brought to the attention of RQIA from an anonymous source.

The recommendations from this inspection were followed up through a further inspection in January 2011. In the main most of the recommendations made had been dealt with appropriately. Following this inspection and other announced inspections to wards in this hospital, an escalation letter in relation to patient care was forwarded to the Director of Mental Health and Learning Disability services. RQIA has maintained further follow up inspections and monitoring of the wards in Longstone hospital as a result of these inspections.

Review Activity

As part of its planned three year programme of reviews, and in line with requests form DHSSPS for commissioned review activity, RQIA has completed a review of child and adolescent mental health services (CAMHS) across Northern Ireland. A number of findings and recommendations have specific relevance to the provision of these services to children and young people with learning disabilities.

During the current year RQIA will carry out reviews on statutory, community learning disability services, safeguarding children and vulnerable adults in mental health and learning disability hospitals and an assessment of the implementation of the DHSSPS guidelines on risk assessment in mental health and learning disability services.

Summary and Conclusions

The regulation and oversight activity outlined above demonstrates how RQIA systems and processes have evolved to in line with legislation and policy changes to provide assurances to the DHSSPS and the public of Northern Ireland.

A number of concerns have been highlighted through RQIA's inspection and review activities. All of these issues remain areas of high priority for RQIA and will inform the ongoing programme of inspection of regulated sector services, the inspection and patient experience review programme in line with responsibilities under the Mental Health Order.

Phelim Quinn
Director of Operations and Chief Nurse Advisor

Exhibit 77

MEMO

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

From: Sean Holland

cc:

Date: 22 April 2013

To: Grade 3s
Chief Professional Officers
Grade 5s

Introduction

The purpose of this minute is to highlight the outcome of the Winterbourne View reports and, in particular, the Actions specified in the DH response of December 2012. This final report is called *Transforming Care: A national response to Winterbourne View Hospital*. This final report states that staff mistreated and abused patients, and management allowed a culture of abuse to flourish. The warning signs were not picked up and concerns raised by a whistleblower went unheeded.

In addition to the final report, and also in December2012, a *DH Winterbourne View Review Concordat: Programme of Action* was published. This highlighted the signed commitment of 50 organsiations/agencies to work together in the interests of change, and specified the respective responsibilities/actions of these organisations on how they were going to take forward action. The Government will publish a progress report on these actions in December 2013.

All reports are available on www.dh.gov.uk/health/2012/12/final-winterbourne/

Whilst accepting that the environment of health and social care is very different in Northern Ireland compared to England, there are a number of lessons which might be drawn from these reports particularly in respect of governance and accountability, inspection methodologies, standards for commissioning and provision of services, safety and quality and the sharing of information on adverse incidents. In addition, there are a range of issues relating to care planning, and medicines management. There are also a number of actions which impact on current guidance, professional practice, training and those which interface with the Departments of Education and Justice.

It is important to understand that whilst the abuse occurred in a private hospital setting, and many of the clients had learning disabilities, the DH action plan covers patients/clients with challenging behaviour. This includes those with mental health, learning disability, autism, EMI care settings, dementia patients in long-stay hospital wards, and other causes of challenging behaviour such as acquired brain injury.

DH Action Plan

There are 63 actions within the DH Action Plan and this is backed by the Concordat which provided more detail on action and responsibilities. DH has a comprehensive national and local structure in place to progress change and monitor it.

The DH Programme of Action includes:-

a) *"By Spring 2013, the department will set out proposals to strengthen accountability of boards and directors and senior managers for the safety and quality of care which their organisations provide;*

b) *By June 2013, all current placements will be reviewed, everyone in hospital inappropriately will move to community–based support as quickly as possible and no later than June 2014;*

c) *By April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice;*

d) *As a consequence, there will be a dramatic reduction in hospital placements for this group of patients;*

e) *The Care Quality Commission will strengthen inspection and regulation of hospital and care homes for this group of people, including unannounced inspections involving people who use services and their families;*

f) *A new NHS and local government–led joint improvement plan will be created to lead and support this transformation."*

For Preliminary Action

In order to raise awareness across the DHSSPS on the content of these reports and to inform discussion on how the "corporate" DHSSPS might apprise Minister on how it might respond, if considered appropriate, the following are provided for your consideration and preliminary action:-

1. A brief summary paper on Winterbourne and it failings; **(TAB 1)**

2. MHDOP Directorate preliminary analysis of the 63 DH recommendations with gaps/issues highlighted in red type for the consideration of other relevant directorates/groups; **(TAB 2)**

3. The Concordat Actions (8 summary actions which complement the 63 actions above which all statutory, voluntary, professional, regulatory and independent sector organisations have signed up to **(TAB 3**).

I should be most grateful for a preliminary response, by adding to the **TAB 2**, especially where red typeface has posed questions. Your response will inform a further discussion at Top Management Group on what might be DHSSPS next steps including any potential links with the Francis Inquiry report and the handling of the most recent Confidential Inquiry Report on Learning Disability.

I should be grateful for a response (by tracked changes), **by 30 April 2013**, to Christine McGuire, Integrated Projects Unit, Mental Health, Disability and Older People's Directorate.

SEAN HOLLAND

Tab 1

Consideration of the Department of Health Transforming Care: A national response to the Winterbourne View Hospital Review

Background

1. The review was set up following a BBC Panorama programme in May 2011 exposing significant flaws in the treatment of Vunerable Adults in the Winterbourne View private hospital. The follow up Serious Case Review found an additional catalogue of failings across the wider health care system.

2. The report focuses on the care provided for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging. These people are referred to as people with challenging behaviour throughout the report.

The Report findings

3. The report found:

- that too many people do not receive good quality care,
- that there is widespread poor service design,
- there are failures of commissioning,
- there is failure to transform services in line with established good practice, and
- that there is failure to develop local services and expertise to provide a person-centred and multidisciplinary approach to care and support.

4. Throughout the report there is concern that:

- too many people are placed in hospitals when there is no need
- that people remain in hospitals for too long sometimes years
- that people are placed away from friends and family,
- people with challenging behaviour are not believed when they complain; and
- that families are not consulted about the care of people with challenging behaviour.

Failings

5. As with many cases that have come to the public notice there appears to have been a number of warning signs at Winterbourne View that were not picked up or acted on by health or local authorities. These include;

- high numbers of referrals to A&E,
- the number of police call outs to the hospital,
- the number of recorded restraints,
- restriction on access for family and friends to certain parts of the hospital,
- the number of complaints from family as well as those in the hospitals, and

- concerns raised by a whistleblower.

Conclusions

6. The report states hospitals are not homes and that the “priority for someone being admitted to hospital should be, from the start, their rehabilitation and referral home”. “In summary, the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment”.

7. The report states that where specialist support is needed for people with challenging behaviour the default position should be:

    - to put this support into the person’s home through specialist community teams and services, including crisis support and
    - to ensure the individual and her/his family is at the centre of all support.

    This is in line with the DHSSPS current commitment in Transforming Your Care.

The Way forward

8. Services should be:

    - designed around people and with their involvement,
    - highly individualised and person centred across health and social care (including access to personal budgets and personal health budgets where appropriate);
    - people’s homes should be in the community, supported by local services;
    - people need holistic care throughout their life, starting in childhood;
    - when someone needs additional support it should be provided as locally as possible;
    - when someone needs to be in hospital for a short period, this should be in small inpatient settings as near to their home as possible.

9. People should only go into specialist hospital settings exceptionally and where there is good evidence that a hospital is the best setting to enable necessary assessment and treatment - not the only available placement. From the beginning, the reason for admission must be clearly stated and families should be involved in decision making.

10. When people with challenging behaviour have to be admitted to hospital service providers and the hospital should:

    - focused on the individual patient’s care plan,
    - make a real effort to maintain links with their family and the home community for example, maintaining the person’s tenancy of their home where relevant unless and until a more appropriate home in the community is found.
    - it is vital that families are involved in decision-making.

Action Plan Timetable

11. There are a total of **63 national actions** tabled in the report to be taken forward by the Department of Health and its partners. Many of the targets are already being addressed by DHSSPS under Transforming Your Care and the Bamford Review. Annex A lists the targets along with the comments on where they sit within the NI HSC system and the actions and targets currently taking forward similar views.

Concordat

12. The Concordat to the report also pledges to “safeguard people’s dignity and rights through a commitment to the development of personalised, local, high quality services alongside the closure of large-scale inpatient services and by ensuring that failures when they do occur are dealt with quickly and decisively through improved safeguarding arrangements”.

13. The Concordat has eight key actions each with a number of sub actions. There are also a number of actions for the DH and each of its partners (Annex B). Of the 32 DH actions in the concordat 26 are taken directly from the main review leaving an additional six to be considered. (Annex C).

TAB 2

Department of Health Transforming Care:
A national response to the Winterbourne View Hospital Review
Action Plan

Key actions

Date		**Action**	Responsibility	Comments
1.	From June 2012	CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team.	RQIA/SQS	Would need to check with RQIA whether or not they use service users for inspections?
2.	From June 2012	CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place.	RQIA	Should be in place
3.	From June 2012	CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.	RQIA/SQS	Do RQIA check on the level of training of staff and numbers?
4.	From November 2012	The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the	DHSSPS	Interdepartmental Ministerial and Senior Officials Group in place Bamford Action Plan in place

		head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.		MDT – Bamford taskforce in place at HSCB level
5.	From December 2012	The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions to protect individuals and their human rights and will report by Spring 2014.	DHSSPS/MHDOP	Mental Health The DOL was considered under the Bamford Action Plan completed in 2011, no actions have been taken forward into the 2012/15 Action Plan. (Interim Guidance revised in Oct 2012 – to be carried forward by Mental Capacity Bill)
6.	From December 2012	The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.	DHSSPS/RQIA/OSS/MHDOP	Is the Guidance on Restraint and Seclusion in Health and Personal Social Services produced in 2005 still relevant? Will be superseded by additional protections under the MC Bill.
7.	From December 2012	The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs.	DHSSPS/MHDOP	Advocacy commissioning guide developed in 2012 *Bamford Action 27 requires the implementation of the Regional Advocacy Policy Guide for Commissioners.* TYC Rec 70 *Advocacy and support for people with a learning disability, including*

				peer and independent advocacy
8.	From December 2012	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.	As Above	As Above
9.	From December 2012	A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice,	PSNI	Will need to clarify with DoJ – possibly through a per sec letter to highlight Winterbourne
10.	From December 2012	The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;	NISCC/DHSSPS- OSS	OSS to clarify
11.	From December 2012	The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings.	MHDOP	Would need to keep abreast of this national development and consider for local endorsement
12.	From December 2012	The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.	MHDOP	Would need to keep abreast of this national development and consider for local endorsement

13.	By end of December 2012	The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.	DHSSPS Board RQIA/MHDOP	Note that Bamford Taskforce and Inter-ministerial Group are in place. But none include the regulator- RQIA We will need Ministerial endorsement in respect of Leadership arrangement – possibly through inter-ministerial group
14.	By end December 2012	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach* to support clinicians in community learning disability teams to deliver actions that provide better integrated services.	DHSSPS/CMO/ CNO Group HSC/DHSSPS MHDOP	This Professional Senate is a clinical Forum Would need to keep abreast of national developments and possibly endorse locally TYC *Target 65* *Support from integrated care partnerships to improve clinicians' awareness of the needs of individuals with a learning disability* Bamford 2012/15 Action Plan action 53 - Development of UK wide framework for learning disability nurses

				action 47 - Improve services for children with challenging behaviours and their carers
15.	By January 2013	Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.	HRD/OSS/NISCC	Are these transferrable? Have we anything equivalent?
16.	By February 2013	Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour	HSS/OSS/NISCC	Are these transferrable? Have we anything equivalent?
17.	By March 2013	The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.	DHSSPS/MHDOP /HSCB	No audit in place locally, but could be commissioned through GAIN by DHSSPS, especially in challenging behaviour (ie not MH or LD) However, the Community Integration Project lead by HSCB does know the figures for LD and MH for resettlement The figures for forensic MH are also known. Issue is EMI and slow stream rehabilitation - the actual number of patients and needs in hospital settings is not known(ie beds are

				known but not patient numbers and disability But delayed discharge targets in place and resourcedfor 13/14. Bamford 2012/15 Action Plan action 51 Complete and maintain a map of learning disability services across Northern Ireland action 47 -- Improve services for children with challenging behaviours and their carers Service Mapping for MH and LD
18.	By March 2013	The NHS-CB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: □□model service specifications; □□new NHS contract schedules for specialist learning disability services; □□models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and □□a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.	HSC Board LCGs	Dedicated commissioning group for MH/LD in HSCB. Commissioning specification in place DES in place for learning disability in GP practices LD service framework in place and MH No self- assessment framework TYC sections on LD and MH, and older people
19.	By March 2013	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning	HSCB/SCD/MHDOP	Likely gap in commissioning/provision as

		specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A		challenging behaviour in children has many causes which would need both paediatric assessment, diagnosis and early intervention and possible social care input. ASD covered -pathway in place Possible inclusion ini paediatric Review?
20.	By March 2013	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions.	CMO Group/ DHSSPS	Will need to keep abreast of national developments and possible consideration of local endorsement
21.	By March 2013	The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used.	As above	As above
22.	By 1 April 2013	The NHS CB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.	HSCB/HSC Trusts	Definite gap in commissioning and service provision locallly – relates to inpatient care
23.	By 1 April 2013	The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.	As above	As above
24.	By 1 April 2013	The National Quality Board will set out how the new health system should operate to improve and maintain quality.	DHSSPS/MHDOP/HSCB	Home is the hub and personalisation – are core elements of TYC and commissioning plan

25.	By 1 April 2013	The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards.	OSS/DHSSPS	Any views on existing measures
26.	From 1 April 2013	The NHS-CB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.	N/A	N/A
27.	From April 2013	The NHS-CB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours.	Board LCGs/ICPs	Work done on ASD pathway but not on the challenging behaviour DES in place for LD through general practice
28.	From April 2013	Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.	DHSSPS – HRD with Leadership Centre?	No specific education programme action locally – possibly linked to a Francis initiative on culture? More specifically: Bamford 2012/15 Action Plan actions 32 - Promote recovery orientated practice throughout all mental health services 53 - Development of UK wide framework for learning disability nurses

				57 - Improve the experience of people with LD using acute general hospitals based on the GAIN Guidelines "Caring for people with a learning disability in general hospital settings"
29.	From April 2013	CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.	RQIA/SQS	Would need to be followed up to see how, if at all, inspection standards, methodology changes
30.	From April 2013	CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities.	RQIA	Systems already in place
31.	From April 2013	CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration.	RQIA	Systems already in place
32.	From April 2013	Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.	RQIA/SQS	No equivalent here
33.	From April 2013	The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHS-CB, ADASS and ADCS will promote and facilitate joint	Board/ DHSSPS	This rec relates to the integration of Health and social care budgets. Some crossover with TYC recommendation 15 *more integrated planning and delivery of support for older people,*

				with joined up services and budgets in the health adn social care, and pilots to explore budgetary integration beyond health and social care Note that at present here, NI has no equivalent to Part 11 of Welfare Reform Act to allow for further integration of budgets beyond health and social care – pilots ongoing in England
34.	From April 2013	The NHS-CB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities.	DHSSPS/HSC Board and Trusts	TYC *ethos* Also -cross governmental ASD strategy will be issued in 2013 by DHSSPS as per ASD legislation
35.	From April 2013	Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide.	HSC Board and Trusts	Should be in place
36.	From April 2013	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.	DHSSPS/CAGU/HSC Board/Trusts	Could governance arrangements be strengthened- Note that Controls Assurance do not apply to the regulated sector- but specific statutory obligations, departmental guidance, professional requirements could be written into their contracts Who is the assurance to be

				provided to Trusts, HSCB or should RQIA be responsible? Following GB lead could each organisation nominate one member of their Board with responsibility for quality who would be accountable to RQIA for quality of care. It needs to be made clear to these organisations' Boards that they need proper governance arrangements in place and that they need to take seriously their corporate responsibilities. In relation to our ALBs we our strengthening assurance on quality by having specific agenda items relating to quality at accountability meetings & will be reviewed by CAGU & SQSD in relation to Francis report and Winterbourne
37.	From April 2013	The Department of Health, the Health and Social Care Information Centre and the NHS- CB will develop measures and key performance indicators to support commissioners in monitoring their progress.	DHSSPS Board	Commissioning Plan Direction in place Bamford HSC Taskforce outcomes and BMG Outcomes paper attached to the 2012/15 Action plan
38.	From April 2013	The NHS-CB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.	DHSSPS/CMO Group PHA	?? Taken forward through public health framework

39.	From April 2013	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.	DHSSPS PCC	Section 75 of the NI Order and rural proofing of all Strategies and legislation Bamford HSC Taskforce New Bamford Sub -groups (to be set up) PPI Policy Guidance Anything else we should/might be doing?
40.	By Spring 2013	The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.	DHSSPS/CAGU/SQS/ CMO Group Board RQIA	Leadership and accountability enhancements - Possible overlap with Francis on Duty of Candour Unclear of impact on RQIA and associated legislation Need to determine how they can be held to account under current law. There has to be serious consequences for organisations that provide poor quality of care or where people experience neglect/abuse e.g. prosecutions, closure. Fit & proper person tests- can we legally use criteria eg involvement with a criticised organisation not to select people

41.	From Spring 2013	CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.	RQIA/SQS	Are we doing enough?
42.	By 1 June 2013	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.	DHSSPS/MHDOP/ Board and Trusts	Major impact on HSC services to review inpatient care plans for all those with challenging behaviour. England are pressing ahead with this and not just for LD/ASD but all in "acute" hospitals with challenging behaviour e.g. stroke, dementia, ABI, etc.
43.	By Summer 2013	Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP)	Trusts/Vol/Independent sector/MHDOP	Should we do something similar? Bamford processes already in palce
44.	By Summer 2013	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care.	DHSSPS	TYC Target 64 *Further development of the current enhanced health services on a NI basis.* In line with the Bamford ethos; would need to keep abreast of national initiatives
45.	By summer 2013	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of	DHSSPS/Pharmacy/SQS/ CMO Group	See QUB press release regarding the prescribing of medication to people in homes but of course,

		medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.	Medicines Governance	recommendation is much wider than this May require further work?
46.	By June 2013	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood.	DHSSPS	TYC *Target 63* *Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)* Transitions are covered in the Bamford Action Plan 2012/15 action *52* - Improve transitions planning for all children with statement of special educational needs
47.	In 2013	The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.	DHSSPS /Family Policy unit DE	Consider the role of Looked after Children Any more to be done?
48.	In 2013	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.	DHSSPS DE	Bamford Action Plan 2012/15 action26 for DE - Take forward and implement Review of Special Educational Needs & Inclusion

49.	In 2013	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy.	DHSSPS	See Regional Advocacy Policy Guide for Commissioners. And the associated action plan
50.	In 2013	The Department for Education will revise the statutory guidance *Working together to safeguard Children.*	DE/DHSSPS/OSS/ Family Policy	Do we need to do anything??
51.	In 2013	The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines.	DHSSPS/Pharmacy/ CMO Group	Keep abreast of professional guidance See also action 45 Is there anything more that we should be doing on psychotropic medication?
52.	By December 2013	The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013.	DHSSPS	Bamofr Interministrerail
53.	By end 2013	The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.	DHSSPS/OSS/ MHDOP	Guidance on Restraint and Seclusion in Health and Personal Social Services. But should we be issuing guidance on positive behaviour support?
54.	By end 2013	There will be a progress report on actions to implement the recommendations in *Strengthening the Commitment* the report of the UK Modernising learning disability Nursing Review.	DHSSPS/NMAG/HRD	"The Strengthening the Commitment", the report of the UK Modernising Learning Disabilities Nursing Review is across all four UK

				governments. Any report on the actions will require feed in from the DHSSPS
55.	By end 2013	CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance abut compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about he proposed changes to our registration process about models of care for learning disability services in 2013.	RQIA/SQS	Would need SQS input on what "quality and safety regulations" are
56.	From 2014	The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.	DE DHSSPS/MHDOP	This may be covered in NI by Special Educational Needs - Code of Practice Review of Special Educational Needs and Inclusion Every School a Good School – The Way Forward for Special Educational Needs and Inclusion Bamford Action Plan 2012/15 action 52 Improve transitions planning for all children with statement of special educational needs

57.	By April 2014	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.	DHSSPS Board DSD Housing Executive	Different system here. Already integrated commissioning model in place on supporting people Bamford Action Plan 2012/15 action 14 and 15 Supported Housing Supported Housing currently has joint funding
58.	No later than 1 June 2014	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.	DHSSPS Board /MHDOP	TYC Target *62* *Close long stay institutions and complete resettlement by 2015. (Mental Health)* *Target 71* *Commitment to closing long stay institutions and to completing the resettlement process by 2015.(Learning Disability)* Personalisation underpins TYC
59.	In 2014	The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review.	DHSSPS	New Code of Practice here will emerge from Mental Capacity Bill Need to keep abreast of developments

60.	By December 2014	The Department of Health will publish a second annual report following up progress in delivering agreed actions.	DHSSPS	This Department will need to consider corporate response to the Winterbourne review, if any.
61.	From 2014/15	The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre.	DHSSPS	TYC target 69 *Development of information resources for people with a learning disability to support access to required services.* Would have to link to ICT Programme to implement
62.	By Summer 2015	NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.	DHSSPS endorsement process/SQS	Keep abreast of developments Nice guidance produced in March 2013 MH and LD Service frameworks in place
63.	By Summer 2016	NICE will publish quality standards and clinical guidelines on mental health and learning disability.	DHSSPS endorsement process/SQS	MH and LD Service frameworks in place

TAB 3

Concordat Programme of Actions

Key Actions

The key summary actions within the Concordat are:-

1. **Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014.**

2. **Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care. These plans should ensure that a new generation of inpatients does not take the place of people currently in hospital.**

3. **There will be national leadership and support for local change. The Local Government Association and NHS-CB will establish a joint improvement programme to provide leadership and support to transform services locally.**

4. **Planning will start from childhood.**

5. **Improving the quality and safety of care.**

6. **Accountability and corporate responsibility for the quality of care will be strengthened.**

7. **Regulation and inspection of providers will be tightened.**

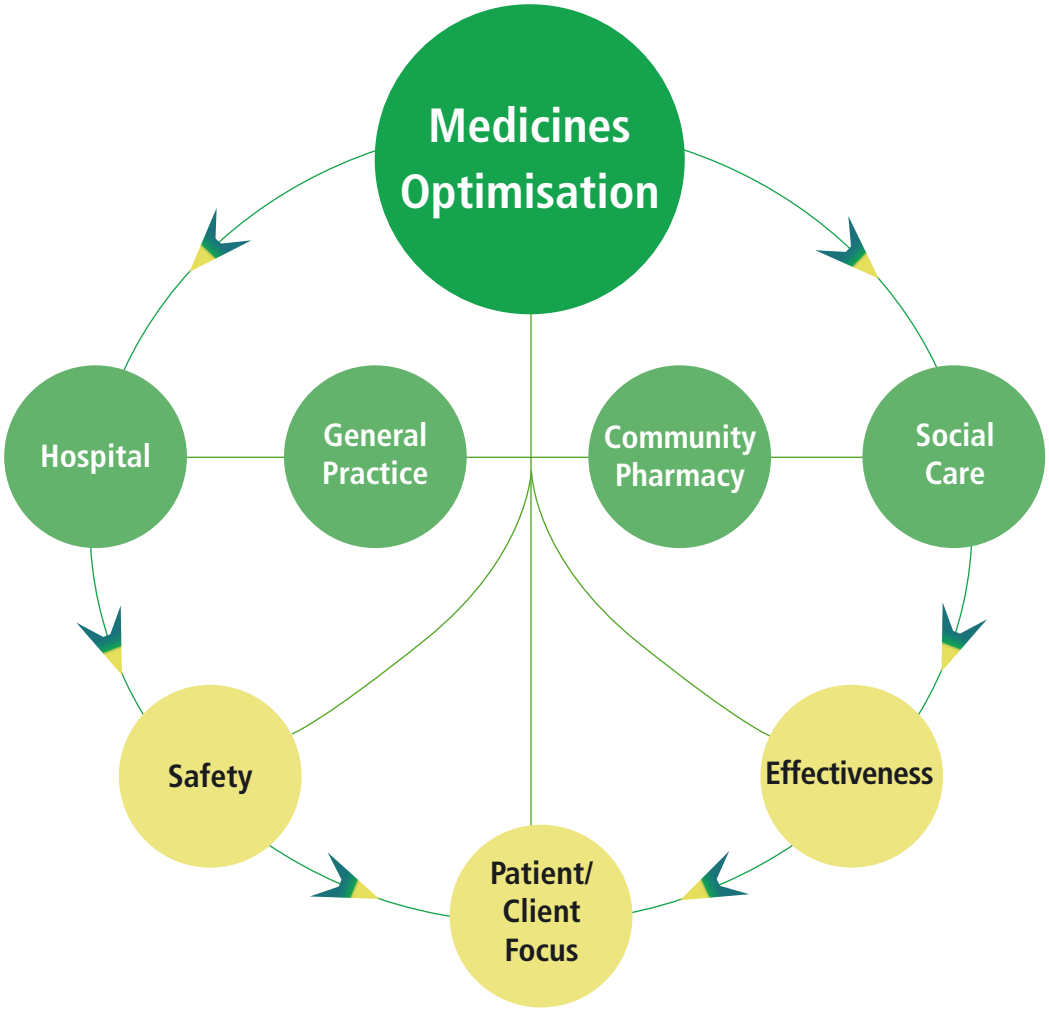
8. **Progress in transforming care and redesigning services will be monitored and reported.**

See www.dh.gov.uk/health/2012/12/final-winterbourne/ for more detail underpinning the above and for respective roles and responsibilities.

Exhibit 78

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Northern Ireland Medicines Optimisation Quality Framework



March 2016

Contents

FOREWORD

Minister for Health, Social Services and Public Safety

As Minister for Health, Social Services and Public Safety, my mission is to improve the health and well-being of all people of Northern Ireland. Whilst healthier lifestyle choices may be all that is required for some people to maintain health, most will need medicines at some stage to treat or prevent illness.

Medicines are the most common medical intervention used in the health service with an annual expenditure of over £550m. In comparison with other UK countries the volume and cost of medicines used per head of population in Northern Ireland is high. With an aging population and a rising number of people with long term conditions, demand is expected to increase.

Unfortunately evidence shows variance in best practices relating to the appropriate, safe and effective use of medicines and many people do not take their medicines as prescribed resulting in sub optimal health outcomes, wasted medicines and pressure on acute health and social care services.

The Medicines Optimisation Quality Framework aims to support better health outcomes for our population by focusing attention on gaining the best possible outcome from medicines every time that they are prescribed, dispensed or administered.

The Framework supports quality improvement through the consistent delivery of recognised best practice and supports the development and implementation of new, evidence based best practice. Implementation will involve an innovation and change programme involving multi-disciplinary professionals working together and with patients.

Much has been done in recent years to improve the way medicines are used and Northern Ireland is recognised as one of the leading regions in Europe in addressing the health and social care needs of the older population through innovation in medicines management. However, more action is needed to gain optimal outcomes from medicines and provide a sustainable approach to clinical and cost-effectiveness whilst reducing avoidable adverse events and waste.

Everyone has a responsibility to improve medicines use and patients need to become more involved in decisions about their treatment and better informed about the role of medicines in their care. By encouraging dialogue and listening to patients' concerns about their medicines, we can empower them to make informed decisions to improve health outcomes.

The Framework promotes multidisciplinary working and recognises the role of pharmacists in integrated teams within primary and secondary care. I welcome this and would like to see an increased utilisation of pharmacists' clinical skills working collaboratively with other health and social care professionals optimising patients' medicines use.

The development of the Framework has been overseen by a multi-disciplinary and multi-agency Steering Group established by the Department of Health, Social Services and Public Safety. Members of the Steering Group included representatives from the Health and Social Care Board, Public Health Agency, Business Services Organisation, Royal College of General Practitioners, the Pharmaceutical Industry, Community and Hospital Pharmacy, Nursing, Social Care, Patient Client Council, RQIA, Local Commissioning Groups, and the Community Development Health Network.

I wish to thank the contribution made by all those individuals involved in its development. It establishes a solid foundation from which the application of good practice and continuous improvement and innovation in medicines use will ensure the best outcomes for the citizens of Northern Ireland.

SIMON HAMILTON MLA
Minister for Health, Social Services and Public Safety

EXECUTIVE SUMMARY

Introduction

In continuing to provide a world class Health Service, the Department is committed to supporting innovative ways of ensuring that services are safe, that they improve the health and wellbeing of our population and at the same time make the best use of available resources. As medicines are a critical element of what the health service delivers to help patients[1], the Department has developed this Medicines Optimisation Quality Framework so that patients and health care professionals can work together to make the most of their medicines.

This Medicines Optimisation Quality Framework provides strategic direction for actions to improve the use of medicines for the benefit of the health and wellbeing of people in Northern Ireland. The framework builds on existing quality systems and infrastructure to deliver improvements through evidence based services and technologies and seeks to consolidate good practice and support consistency and quality improvement across Health and Social Care (HSC).

Some people maintain a healthy lifestyle without using medicines but for others, medicines play an important part in maintaining their health and treating or preventing illness. However, there is evidence that patients do not always gain the optimal benefit from their medicines and a new approach is needed that focuses on optimising health outcomes when medicines are prescribed, dispensed or administered. Medicines Optimisation is defined by the National Institute of Health and Care Excellence (NICE) as "a person centred approach to safe and effective medicines use to ensure that people gain the best possible outcomes from their medicines."

The overall aim of this Framework is to maximise health gain for patients through the appropriate, safe and optimum use of their medicines. It is split into five main sections.

Section 1: The Quality Framework – summarising what the framework is designed to do, who it is aimed at, what it seeks to deliver and lists its key recommendations. The Framework supports a patient focused approach in which patients are involved in decisions about their medicines and are supported by multidisciplinary[2] professionals working together to deliver best practice.

Section 2: The NI Regional Medicines Optimisation Model – outlining what should be done at each stage of the patient pathway in each of four different settings (hospital, general practice, community pharmacy, social care) to help gain the best outcomes from medicines.

Section 3: 10 Quality Standards – addressing the priority issues for medicines optimisation in Northern Ireland within the three overarching quality domains of safety, effectiveness and patient/client focus. The Quality Standards describe the best practices that should be delivered in each setting, identify gaps in best practices and the actions needed to address them.

1 Throughout the Quality Framework when patients are referred to this also refers to their families and carers.

2 Multidisciplinary includes all health and social care professionals involved in the prescribing, dispensing and administration of medicines. This includes specialist and generalist roles in medicine, nursing, pharmacy, allied health and social care.

Section 4: Implementation through an Integrated Innovation and Change Programme – applying a strategic approach to support and drive continuous improvement through the development and implementation of best practices in medicines optimisation with four components:

- a regional action plan for medicines optimisation;
- a medicines optimisation innovation centre;
- a medicines optimisation network; and
- a regional database to monitor improvement.

Section 5: Contains a summary of the nine overarching key recommendations to introduce and support the Regional Model for Medicines Optimisation.

1. A Regional Model for Medicines Optimisation should be introduced which outlines what patients can expect when medicines are included in their treatment as they access services in HSC settings.
2. The model should be delivered by a mutli-disciplinary medicines optimisation workforce trained and competent in medicines optimisation, with the involvement of pharmacists in all settings.
3. The medicines optimisation workforce should deliver regional services and roles which are commissioned and co-ordinated across all HSC organisations and related agencies involved in the prescribing, dispensing and administering of medicines.
4. The services and roles should aim to consistently deliver regional best practices in compliance with new Quality Standards for Medicines Optimisation.
5. Regional best practices should always be co-designed with patients, following the principles of Personal and Public Involvement (PPI).
6. An innovation and change programme should be implemented, linked to HSC commissioning plans, to support the development, testing and scaling up of technology and service solutions to deliver consistent best practices related to the Quality Standards.
7. Regional systems should be implemented supporting HSC connectivity, electronic transmission of prescriptions and access to the Electronic Care Record, prescribing support, Northern Ireland Formulary and enhanced data analysis.
8. Within the HSC a regional organisational infrastructure for medicines optimisation should be maintained that incorporates the Medicines Governance Team, Pharmacy and Medicines Management Team, Regional Pharmaceutical Procurement Service, Medicines Information service, Medicines Optimisation Innovation Centre (MOIC)[3].
9. A new regional database for medicines optimisation should be developed to monitor progress and enable comparisons regionally and with other UK countries.

3 www.themoic.com

JOINT INTRODUCTION

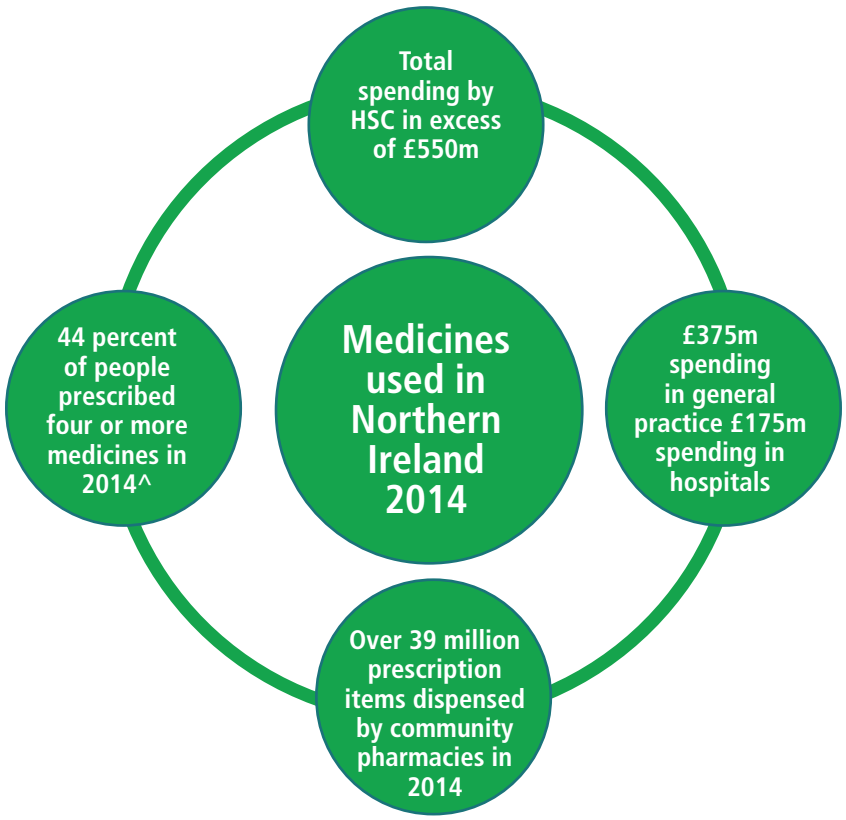
Chief Medical Officer and Chief Pharmaceutical Officer

1. Medicines play an important role in maintaining wellbeing, preventing illness and managing disease. Most people will take a medicine at some point in their lives. This could be a short term curative treatment, for example, a course of antibiotics for an infection or long term treatment for high blood pressure to prevent heart disease.

2. Medicines are the most common medical intervention within our population and at any one time 70% of the population[4] is taking prescribed or over the counter medicines to treat or prevent ill-health.

3. From a financial aspect, medicines expenditure equates to over £550m/annum in Northern Ireland, representing 14% of the total HSC budget and is the second largest cost after salaries.

Figure 1: Medicines Use in Northern Ireland 2014



4 Office of National Statistics Health Statistics 1997
^ Figure based on the definition of a medicine as having a unique number used in the dictionary of medicines and devices (DM+D)

4. As the population ages and the prevalence of chronic disease increases the need for medicines is expected to rise. This will place direct pressure on prescribing budgets and lead to an increased demand across HSC services, particularly those involved with the prescribing, dispensing and administration of medicines.

5. To date, health policy has sought to address these challenges by supporting regional best practice relating to Pharmaceutical Care[5] and Medicines Management[6]. This has introduced a range of services and systems[7] for the safe and effective use of medicines, often associated with the 'five rights'.

Table 1: The Five Rights of Medicines Administration[8]

• The Right Patient
• The Right Medication
• The Right Dose
• The Right Time and Frequency of Administration
• The Right Route

6. With over 14 years of expertise in developing good practice in the area of Pharmaceutical Care and Medicines Management, Northern Ireland was recognised in 2013 as one of the leading regions in Europe with 3 star reference site status for medicines management[9].

7. However, evidence shows that medicines use remains sub-optimal, with patients failing to gain the expected benefits of treatment and services coming under increasing pressure as their care needs escalate. For example:

5 Hepler CD & Strand LM. Opportunities and responsibilities in pharmaceutical care. American Journal of Health Systems Pharmacy 1990; 47: 533-543

6 Medicines management has been defined as "encompassing the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care.

7 See Annex A, Table 12 – Examples of regional best practice in medicines management.

8 Jones and Bartlett, Nurse's Drug Handbook, 2009

9 European Innovation Programme- https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/rs_catalogue.pdf

Table 2: Examples of Sub-optimal Medicines Use

Ten days after starting a new medicine, 61% of patients feel they are lacking information and only 16% of patients who are prescribed a new medicine are taking it as prescribed, experiencing no problems and receiving as much information as they believe they need[10].
One in 15 hospital admissions are medication related, with two-thirds of these being preventable[11].
One in 20 prescriptions in General Practice contains an error, with a higher prevalence associated with prescriptions for the elderly and those taking 10 or more medications[12].
Prescribing errors in hospital in-patients affect 7% of medication orders, 2% of patient days and 50% of hospital admissions[13].
An estimated £18m of medicines are wasted annually in Northern Ireland[14].

8. To address these challenges and the demands of an aging population with increasingly complex medicines needs, a new approach is needed which shifts the focus to Medicines Optimisation. This will ensure that patient facing medicines services are provided in support of improving care and to enable transformation of HSC services through closer cooperation between multidisciplinary professionals and HSC organisations.

9. **Medicines optimisation** is defined by the National Institute for Health and Care Excellence (NICE) as "a person centred approach to safe and effective medicines use to ensure that people obtain the best possible outcomes from their medicines". This has evolved from the four principles of medicines optimisation developed by the Royal Pharmaceutical Society in 2013.

10 Barber et al. Patients' problems with new medication for chronic conditions. Quality and safety in healthcare 2004.

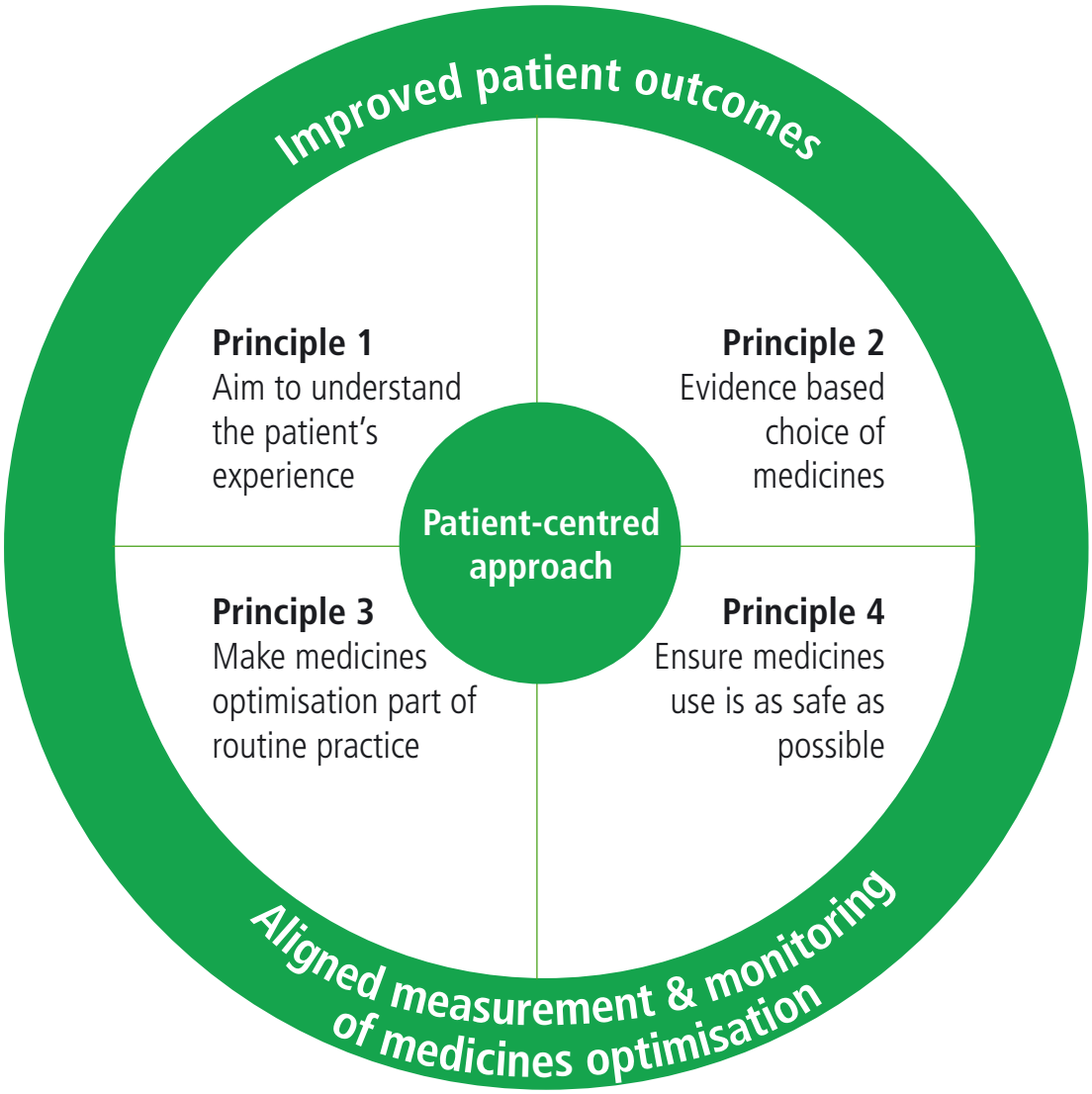
11 Garfield S, Barber N, Walley P, Willson A, Eliasson L. Quality of medication use in primary care--mapping the problem, working to a solution: a systematic review of the literature. BMC Medicine 2009; 7:50.

12 http://www.gmc-uk.org/Investigating_the_prevalence_and_causes_of_prescribing_errors_in_general_practice___The_PRACtICe_study_Reoprt_May_2012_48605085.pdf

13 Lewis PJ, Dornan T, Taylor D, Tully MP, Wass V, Ashcroft DM. Prevalence, incidence and nature of prescribing errors in hospital inpatients: a systematic review. Drug Saf 2009; 32(5):379-389.

14 Evaluation of the Scale, Causes and Costs of Waste Medicines, University of London and York 2010.

Figure 2: Patient Centred Approach Model[15]



10. In Northern Ireland the shift to medicines optimisation has started with the implementation of NICE Guideline NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes[16] and the recommendations of the Regulation and Quality Improvement Authority (RQIA) Review of Medicines Optimisation in Primary Care[17].

11. However, to deliver sustainable and measurable improvements at a regional level a strategic approach is needed and the Medicines Optimisation Quality Framework has been developed to provide the necessary direction to support this.

15 https://www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf

16 https://www.nice.org.uk/guidance/ng5

17 http://www.rqia.org.uk/cms_resources/RQIA%20Medicines%20Optimisation%20in%20Primary%20Care%20Review%20July%202015.pdf

SECTION 1

THE QUALITY FRAMEWORK

1.1 The Medicines Optimisation Quality Framework provides a roadmap for improving how medicines are used across the HSC system (HSC). Building on existing quality systems and infrastructure, it seeks to deliver improvements in care through evidence based services and technologies that lead to better health outcomes for patients.

1.2 Primarily aimed at those with responsibility for, and influence on, commissioning decisions and front line service delivery in Northern Ireland, the Framework is underpinned by existing HSC responsibilities for ensuring the efficient use of resources and facilitating integration.

1.3 The Framework aims to support both patient care and the transformation of the HSC system by helping to deliver:

- better health outcomes for patients through the appropriate use of medicines, taken as prescribed;
- better informed patients who are engaged and involved in decisions about their medicines;
- improved medicines safety at transitions of care;
- an active medicines safety culture within HSC organisations;
- reduced variance in medicines use through the consistent delivery of medicines management best practices;
- improved intra and inter professional collaboration and a HSC workforce who recognise their role in medicines optimisation and are trained and competent to deliver it as part of routine practice;
- better use of resources through the consistent, evidence based and cost effective prescribing of medicines; and
- the development and implementation of best practice solutions in medicines optimisation across the HSC.

1.4 The Framework introduces a Regional[18] Model for Medicines Optimisation to engage health and social care professionals across the HSC in delivering best practices, supported by quality standards and an integrated innovation and change programme.

1.5 The Framework makes nine key recommendations to introduce and support the Regional Model for Medicines Optimisation.

18 Regional relates to the whole of Northern Ireland

Table 3: Recommendations

1.	A Regional Model for Medicines Optimisation should be introduced which outlines what patients can expect when medicines are included in their treatment as they access services in HSC settings.
2.	The model should be delivered by a multi-disciplinary medicines optimisation workforce trained and competent in medicines optimisation, with the involvement of pharmacists in all settings.
3.	The medicines optimisation workforce should deliver regional services and roles which are commissioned and coordinated across all HSC organisations and related agencies involved in the prescribing, dispensing and administration of medicines.
4.	The services and roles should aim to consistently deliver regional best practices in compliance with new Quality Standards for Medicines Optimisation.
5.	Regional best practices should always be co-designed with patients, following the principles of Personal and Public Involvement (PPI).
6.	An innovation and change programme should be implemented, linked to HSC commissioning plans, to support the development, testing and scaling up of technology and service solutions to deliver consistent best practices related to the Quality Standards.
7.	Regional systems should be implemented supporting HSC connectivity, electronic transmission of prescriptions and access to the Electronic Care Record, prescribing support, Northern Ireland Formulary and enhanced data analysis.
8.	Within the HSC a regional organisational infrastructure for medicines optimisation should be maintained that incorporates, the Medicines Governance Team, Pharmacy and Medicines Management Team, Regional Pharmaceutical Procurement Service, Medicines Information Service, Medicines Optimisation Innovation Centre (MOIC).
9.	A new regional database for medicines optimisation should be developed to monitor progress and enable comparisons regionally and with other UK countries.

1.6 The Framework complements existing health policy, Transforming Your Care[19] principles, recommendations in the Donaldson report[20] and is specifically aligned with the Quality 2020[21] strategic themes of safety, effectiveness and patient/client focus.

1.7 It promotes multidisciplinary approaches which include all health and social care professionals

19 https://www.dhsspsni.gov.uk/topics/health-policy/transforming-your-care

20 https://www.dhsspsni.gov.uk/topics/health-policy/donaldson-report

21 https://www.dhsspsni.gov.uk/publications/quality-2020-ten-year-strategy-protect-and-improve-quality-health-and-social-care

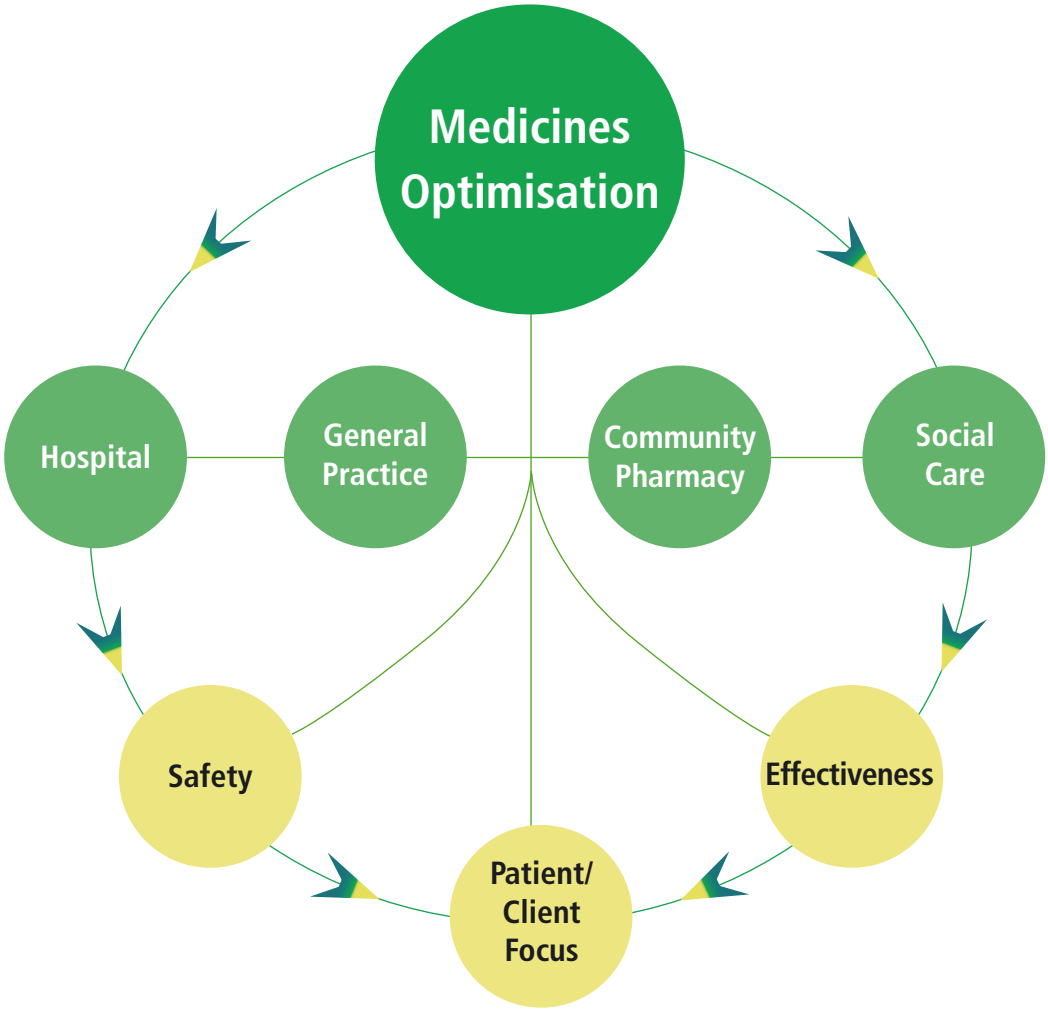
involved in the prescribing, dispensing and administration of medicines. This includes specialist and generalist roles in medicine, nursing, pharmacy, allied health and social care. NICE Guideline NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes recommends that organisations consider a multidisciplinary team approach to improve patient outcomes with the integration of pharmacists. Historically this has not always been the case and the Framework addresses gaps in pharmacist to patient facing interventions in HSC settings.

1.8 The Framework seeks to build on the experience of the past, using existing medicines management services across the HSC as the foundation for improvement where possible. These services and the history of medicines management in Northern Ireland in the period 2000 - 2014 is described in detail in Annex A.

1.9 It has been developed in anticipation of demographic and financial challenges facing the HSC which require a renewed focus on gaining the best possible outcomes for patients from medicines at an affordable cost for the HSC. A detailed description of these challenges is included in Annex B.

SECTION 2

The Northern Ireland Medicines Optimisation Model



2.1 When medicines are prescribed patients should be involved in decisions about their use, know why the medicine is needed, understand the expected outcome, the duration of treatment and be informed of any risks or side effects.

2.2 When medicines are supplied, pharmacists should ensure that they are dispensed safely, that patients receive appropriate information to enable safe and effective use and are offered support to help them take their medicines as prescribed and on time, if needed. Pharmacists are also well placed to advise patients when the presentation of their medicine changes and provide reassurance of continued efficacy.

2.3 During treatment, patients should have their medicines reviewed on a regular basis and if a GP or other authorised health professional involved in assessing the patient makes a clinical decision that there is no health benefit or clinical need for the patient to continue taking the medication, the medication should be stopped.

2.4 When medicines for long term conditions are started, stopped or changed, patients should have their treatment regimen checked to ensure it remains safe and effective.

2.5 In day to day practice, medicines optimisation relies on partnerships between patients and health and social care professionals and aims to help more patients to self manage, to take their medicines correctly, reduce harm, avoid taking unnecessary medicines, cut down on waste and improve medicines safety. Ultimately it can help encourage patients to take increased ownership of their treatment and support care closer to home.

2.6 Within the HSC, success in medicines optimisation is reliant on multidisciplinary teams with the correct skill mix working collaboratively, delivering best practices, supported by quality systems and the necessary regional organisational infrastructure as illustrated by the diagram at the beginning of section 1.

2.7 The model is based on the principles of the Integrated Medicines Management[22] (IMM) service in secondary care which targets the work of pharmacists at specific points in the patient journey on admission, during the hospital stay and at discharge.

2.8 The model seeks to deliver IMM consistently across secondary care and expand the pharmacist role into the interface and intermediate care[23], to general practice, community pharmacy and social care.

22 https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/northern-ireland-clinical-pharmacy-standards-2013.pdf

23 Intermediate care means step up/step down beds

2.9 It supports the integration of pharmacists in multidisciplinary teams, providing support with medicines at key points of the patient's journey based on an assessment of need, for example, when a new treatment is started, after discharge from hospital or during a medication review.

2.10 At the interface the model includes roles for consultant pharmacists[24] and specialist outreach pharmacists[25] working with intermediate care, nursing home settings and GP practices, with links to community pharmacy.

2.11 The model introduces a new role for pharmacists working in General Practice. 'Practice-based' pharmacists integrated with and working collaboratively with pharmacists in community pharmacy and secondary care will utilise more fully the clinical skills of the profession to improve patient outcomes.

2.12 In community pharmacy the model includes enhanced roles for pharmacists that will support better outcomes from medicines by working with patients to provide appropriate information and advice when medicines are dispensed and to support adherence and safer transitions through services such as Medicines Use Reviews[26] [27].

2.13 The model recognises the role of nurses and care workers in helping people with their medicines in residential, nursing and domiciliary care settings and the need for regional best practices that support role clarification, accredited training and support systems for staff.

2.14 The model recommends the optimal delivery of existing roles and commissioned services which are already supported by HSC contractual or service level agreements and funding streams as well as the need for new roles and services.

2.15 To deliver the model consistently in all settings additional recurrent funding will need to be targeted to support new roles and infrastructure which demonstrate clinical and cost effectiveness outcomes.

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24 The term consultant pharmacist refers to a pharmacist who has advanced roles in patient care, research and education in a specific medical speciality or expert area of practice.

25 Specialist outreach pharmacists are pharmacists in secondary care who carry out patient medication reviews and follow up in GP practices and are linked with specialist secondary care clinical teams.

26 www.cpwales.org.uk/Contractors-Area/Pharmacy-Contact---Services/DMR/DMR-Evaluation_Final-Report_13082014.aspx

27 http://www.elht.nhs.uk/Downloads-docs/Departmental/Refer-to-Pharmacy/Electonic%20referral%20from%20hospital%20to%20community%20pharmacy%20NWC%20AHSN%20report.pdf

2.16 To monitor progress a regional medicines optimisation database is proposed, based on NHS England's medicines optimisation dashboard,[28] to identify outcome measurements. This will largely bring together existing data related to medicines use from different sources across the region to monitor trends, enable benchmarking and help drive quality improvements using baselines established in recent years from, for example, health surveys. Categories of outcome measurements will include:

- patient/client satisfaction;
- medicines safety incident reporting;
- cost effective use of medicines;
- impact on acute health services; and
- achievement of expected therapeutic outcomes.

Table 4: Examples of Outcome Measurements

Outcome Measure	Examples of Indicators	Source for baseline data
Patient/client satisfaction	• On admission to hospital did a member of pharmacy staff discuss/ check what medicines you were currently taking?	• Northern Ireland Inpatient Survey 2014 [29]
	• Percentage of people prescribed medicines in the previous 12 months involved as much as they wanted to be in decisions about prescribed medicines	• Northern Ireland Health Survey 2012/13 & 2014/15 [30]
Medicines safety incident reporting	• Levels of reported medication incidents and yellow card reporting	• Northern Ireland Medicines Governance network [31] • Medicines and Healthcare Products Regulatory Agency (MHRA) [32]
Cost effective use of medicines	• Percentage compliance with the Northern Ireland Medicines Formulary and generic dispensing rates	• DHSSPS Commissioning Plan Direction 2015/16 [33]

28 https://www.england.nhs.uk/ourwork/pe/mo-dash/

29 https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/inpatient-patient-experience-survey-2014.pdf

30 https://www.dhsspsni.gov.uk/articles/health-survey-northern-ireland#toc-0

31 http://www.medicinesgovernance.hscni.net

32 https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency

33 https://www.dhsspsni.gov.uk/publications/ministerial-priorities

Outcome Measure	Examples of Indicators	Source for baseline data
Impact on acute health services	• Number and proportion of unplanned admissions to hospital for medicines related factors and non-adherence	• DHSSPS Commissioning Plan Direction 2015/16
Achievement of expected therapeutic outcomes	• Percentage underlying achievement for Quality and Outcomes Framework (QOF) clinical indicators	• QOF [34]

2.17 The Northern Ireland Medicines Optimisation Quality Framework is a 'living document' with examples of current best practice medicines optimisation in each of the four settings in Tables 5 to 8. This will provide a necessary short term focus on improving standards and reducing variance and provide a firm foundation on which to build the evidence base and develop services in all settings.

The Medicines Optimisation Model

What patients can expect when medicines are included in their treatment

Tables 5-8 below provide a summary of what patients can expect as routine practice with regards to medicines optimisation in different settings – Hospital, General Practice, Community Pharmacy and Social Care. The activities described are generic and can be applied across different areas of practice in each setting.

34 https://www.dhsspsni.gov.uk/topics/dhssps-statistics-and-research/quality-outcomes-framework-qof

Table 5: What you should expect when you are admitted to hospital as routine practice

Hospital

On Admission

- Patients bring their medicines to hospital so that they can be checked and used where possible.
- Within 24 hours of admission or sooner if clinically necessary, patients have their medicines reconciled by a trained and competent healthcare professional, ideally by a pharmacist. Medicines reconciliation[35] involves collecting information about current medicines, checking for omissions, duplications and other discrepancies and then documenting and communicating any changes. Patients, family members or carers should be involved in this process.
- Within 24 hours of admission, a clinical management plan is developed which includes discharge planning to help prevent delays on discharge.
- If patients move from one ward to another within a hospital, medicines reconciliation may need to occur again.

Following Medical Assessment/Accurate Diagnosis

- Patients are involved in decisions about their current and any new medicines, their needs, preferences and values taken into account and receive appropriate, tailored information about new medicines and the expected health outcomes.
- Patients have the opportunity to speak to a healthcare professional and ask questions about their medicines.
- During the inpatient stay, prescription charts are monitored by a pharmacist and reviewed in conjunction with medical notes and relevant medical laboratory results.
- Patient responses to medication therapy are monitored and best practices relating to 'high risk medicines' are followed.

Administration of medicines

- On some wards patients may be able to administer their own medicines. However, if this is not possible medicines are administered on time following a check that the direction to administer is appropriate and other related factors are taken into consideration.

35 Medicines reconciliation, as defined by the Institute for Healthcare Improvement, is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. The term 'medicines' also includes over the counter or complementary medicines, and any discrepancies should be resolved. The medicines reconciliation process will vary depending on the care setting that the person has just moved into – for example, from primary care into hospital, or from hospital to a care home.

On discharge

- Prior to discharge the medicines reconciliation process is repeated.
- Patients receive an appropriate supply of their prescribed medicines which may be a combination of inpatient and discharge medicines dispensed as a single supply labelled for discharge. They are provided with accurate, up-to date information about their ongoing treatment where necessary.
- Patients are educated to ensure that they can use their medicines and devices for example inhalers appropriately.
- Patients know who to contact if they have a query about their medicines after discharge.
- Accurate and up-to date information about medicines is shared with healthcare professionals and communicated in the most effective and secure way such as electronically, ideally within 24 hours of discharge.
- Following discharge from hospital, patients are followed up to ensure that they are completely clear about their medicine regimens.

Other Hospital/Trust Services

- Patients attending outpatient clinics should expect:
  - to be involved in decisions about their medicines with their needs, preferences and values taken into account;
  - their response to medicines to be reviewed;
  - to have the opportunity to speak to a healthcare professional and ask questions about their medicines; and
  - to receive appropriate, tailored information about new medicines and the expected health outcomes.
- Patients in Intermediate Care settings (i.e. step up/step down beds) should have the same quality of care as in hospital.
- Patients receiving specialist outreach services and other services at the interface should expect:
  - links to be established between specialist secondary care clinical teams and primary care;
  - to be followed up in primary care; and
  - to have clinical medication reviews carried out.
- Patients in nursing, residential and children's homes (see table 7)

Table 6: What you should expect from general practice as routine practice

General Practice

- Patients registering with the practice for the first time have a medicines reconciliation check.
- During consultations, patients are involved in decisions about their current and any new medicines, their needs, preferences and values taken into account and receive appropriate, tailored information about new medicines and the expected health outcomes.
- Patients taking multiple medicines or taking 'high risk medicines' are identified and, where appropriate, receive additional information and advice to help take their medicines safely and effectively.
- Patients on repeat medications have checks carried out before issue of prescriptions to reduce the risk of waste.
- All patients on repeat medication have an annual clinical medication review with a GP or pharmacist. (This may be more frequent depending on the individual's care plan or type of medication).
- Patient responses to medication therapy are monitored. Medicines that are not beneficial and not evidence based are not continued.
- Patients with problems taking their medicines as prescribed (non-adherent) are referred for an adherence assessment.
- Patients are involved in decisions about their medicines and are encouraged to ask questions about their treatment and to be open about stopping medication.
- Patients discharged from hospital/other care setting have their medicines reconciled by a trained and competent healthcare professional as soon as possible, before a prescription or new supply of medicines is issued and within one week of the GP practice receiving the information. Patients, family members or carers should be involved in this process and any changes documented.
- Prescribers have up to date information to support clinically appropriate and safe prescribing.
- Prescribers have access to a pharmacist for information and advice about polypharmacy patients taking multiple medicines.
- Practices provide information about prescribed medicines to hospitals and other appropriately authorised health and social care professionals to assist medicines safety during transitions of care.

Table 7: What you should expect from your community pharmacy as routine practice

Community Pharmacy

- On presentation of a prescription the pharmacist will carry out a clinical check of the prescription using the patient's medication record before it is dispensed. This will inform the level of information and advice that is needed for the patient to take their medicines safely and effectively.
- High quality medicines are dispensed safely.
- Patients receive appropriate information and advice with the supply of medicines, particularly if a new medicine or a 'high risk medicine' is supplied.
- If the presentation of a repeat medicine changes, the patient is advised of this change and reassured of continued efficacy.
- Patients are offered a medicines use review after a significant change in their medication. For example, following discharge from hospital or after starting a new treatment regimen.
- Patients having problems taking their medicines as prescribed have their adherence needs assessed and appropriate support provided.
- Patients are asked if they need all their repeat medicines before they are supplied to reduce the risk of waste.
- Pharmacists work closely with other health and social care professionals to ensure patients are on the most appropriate medication and have contact with pharmacists working in local GP practices and hospitals.
- To support safe transitions, pharmacies provide information about medicines supplies to the pharmacist or pharmacy technician conducting a medicines reconciliation check after admission to hospital or to appropriately authorised health and social care professionals in a nursing or residential home.
- On discharge from hospital, community pharmacy receives information on the patient's current medication and medication changes to support safe transfer.
- Pharmacies may provide other services such as clinical medication reviews and monitor health outcomes from medicines to support medicines optimisation.

Table 8: What you should expect from social care as routine practice

Nursing homes

- When individuals first move into a nursing home and at each transition of care thereafter their medicines are checked with their GP Practice and Community Pharmacy.
- Adequate supplies of medicines are always available and prescription ordering systems in homes are carefully managed and monitored to avoid over-ordering and waste.
- Individuals with specific medication needs such as Parkinson's Disease or Diabetes or those taking multiple or 'high risk medicines' are identified and receive the appropriate care in line with best practice.
- Individuals who take their own medicines are monitored to ensure they are taking them as prescribed.
- Medicines are administered on time following a check that the direction to administer is appropriate.
- Individuals taking repeat medication have an annual clinical medication review; the frequency of the review may vary depending on the care plan.
- Staff in nursing homes have contact with pharmacists in the community to assist with queries about medication.

Residential homes

- When individuals first move into a residential home and at each transition of care thereafter their medicines are checked with their GP Practice and Community Pharmacy.
- Adequate supplies of medicines are always available and prescription ordering systems in homes are carefully managed and monitored to avoid over-ordering and waste.
- Residential care home staff who manage medicines are trained and competent.
- Residents self-administer their own medicines where the risks have been assessed and the competence of the resident to self-administer is confirmed. Any changes to the risk assessment are recorded and the arrangements for self-administering medicines are kept under review.
- Residential care home staff receive training on 'High Risk Medicines' and have easy access to information about all medicines.
- Staff have contact with pharmacists in the community to assist with queries about medication.

Children's homes

- When a child/young person first moves into a children's home and at each transition of care thereafter their medicines are checked with their GP Practice and Community Pharmacy.
- Adequate supplies of medicines are always available and prescription ordering systems in homes are carefully managed and monitored to avoid over-ordering and waste.
- The management of medicines is undertaken by trained and competent staff and systems are in place to review staff competency.
- Robust systems are in place for the management of self-administered medicines.
- Prior written consent is obtained from a person holding parental responsibility for each child or young person for the administration of any prescribed or non-prescribed medicine.
- Staff receive training on 'High Risk Medicines' and have easy access to information about all medicines.
- Staff have contact with pharmacists in the community to assist with queries about medication.

Domiciliary care

- Nurses and care workers have clearly defined roles in helping with medicines taking.
- Administration of, or assistance with, medication is facilitated when requested in situations where an individual is unable to self-administer.
- Administration or assistance with medication is detailed in a care plan and forms part of a risk assessment.
- Policies and procedures identify the parameters and circumstances for care workers administering or assisting with medication. They identify the limits and tasks that may not be undertaken without additional training.
- Care workers who administer medicines are trained and competent. A record is kept of all medicines management training completed by care workers and retained for inspection
- When necessary, training in specific techniques (e.g. the administration of eye/ear drops or the application of prescribed creams/lotions) is provided for named care workers by a qualified healthcare professional.

- The care worker documents, on each occasion, the administration or assistance with medication.
- Care workers involved in the management of an individual's medication agree the arrangements for the safe storage within the individual's home. Appropriate information is available about the individual's current medication and staff are aware of any changes following a transition of care, such as discharge from hospital.
- Training on 'High Risk Medicines' is provided and staff have easy access to information about all medicines.
- Staff have contact with pharmacists in the community to assist with queries about medication.
- If an individual is having difficulties in managing their medicines, staff can refer them to the community pharmacist for assistance.

SECTION 3

Quality Standards for Medicines Optimisation

Quality Domain	Medicines Optimisation Standards
Patient/Client Focus Patients are involved in decisions about their treatment with medicines.	1. Safer Prescribing with Patient Involvement
	2. Better Information about Medicines
	3. Supporting Adherence and Independence
Safety Preventing and minimising harm related to medicines use.	4. Safer Transitions of Care
	5. Risk Stratification of Medicines
	6. Safety/Reporting and Learning Culture
Effectiveness Right patient, right medicine, right time, right outcome, right cost.	7. Access to Medicines you Need
	8. Clinical and Cost Effective Use of Medicines and Reduced Waste
	9. Clinical Medication Review
	10. Administration

3.1 In support of the Regional Medicines Optimisation Model new minimum quality standards will drive consistency and bring about a common understanding about what service providers are expected to provide and what patients can expect to receive when medicines are included as part of their treatment.

3.2 The ten standards address the priority issues for medicines optimisation in Northern Ireland within the three overarching quality domains of safety, effectiveness and patient/client focus and are compatible with the draft NICE Quality Standard on Medicines Optimisation[36].

3.3 The standards support delivery of best practice which should be developed and implemented in partnership with patients on an ongoing basis, actively seeking their views and listening to their experiences. For example via the Public Health Agency's 10,000 Voices[37] initiative, involving patients in hospital and learning from their experience through projects like ThinkSAFE[38] and through regular health surveys which can be useful in determining behaviours and attitudes.

36 A NICE Quality Standard for Medicines Optimisation is expected in March 2016. NICE quality standards may be used to inform best practice in Northern Ireland but are not currently formally endorsed by DHSSPS or mandatory within the HSC.

37 http://www.publichealth.hscni.net/publications/10000-voices-improving-patient-experience

38 http://www.thinksafe.care/

STANDARDS

Standard 1 - Safer Prescribing with Patient Involvement
Prescribing is carried out in a manner which promotes safety and optimal health outcomes, with patients involved in decisions about their treatment.

Standard 2 – Better Information about Medicines
Patients/carers receive the information they need to take their medicines safely and effectively.

Standard 3 – Supporting Adherence and Independence
People are helped to remain independent and self manage their medicines where possible but receive support with adherence when needed.

Standard 4 – Safer Transitions of Care
Checks occur at each transition of care to ensure that the transfer of medicines and medicines information between patients, carers and health and social care workers is safe, accurate and timely.

Standard 5 – Risk Stratification of Medicines
Patients who may be at risk because of the medicines that they use receive the appropriate help to take their medicines safely.

Standard 6 – Safety/Reporting and Learning Culture
Organisations promote an open and transparent culture with evidence of processes for the reporting, prevention, detection, communication and cascade of learning from medication incidents and adverse drug reactions.

Standard 7 – Access to Medicines you Need
Patients have appropriate, equitable and timely access to quality assured, evidence-based and cost-effective medicines.

Standard 8 - Clinical and Cost Effective Use of Medicines and Reduced Waste
Within organisations a culture exists promoting a shared responsibility for the appropriate, clinical and cost effective use of medicines supported by systems for avoiding unnecessary waste.

Standard 9 – Clinical Medication Review
Clinical medication reviews are carried out with the patient and occur on a regular basis, at least annually.

Standard 10 – Administration
Following an initial check that the direction to administer a medicine is appropriate, patients who have their medicines administered receive them on time and as prescribed.

Standard 1 - Safer Prescribing with Patient Involvement

Prescribing is carried out in a manner which promotes safety and optimal health outcomes, with patients involved in decisions about their treatment.

Why is the standard needed?

UK studies have highlighted the prevalence of prescribing errors in primary and secondary care showing that medication errors are common and are associated with considerable risk of potentially avoidable patient harm[39] [40]. Studies have also shown that the prevalence of error and potentially inappropriate prescribing are greater for people taking multiple medicines (polypharmacy); generally older people and those living in residential and nursing homes[41] [42]. A range of safer prescribing initiatives are in place to address these issues and a number of tools are available and in development for prescribing support. For example, the pharmacy-led technology intervention (PINCER)[43] has been demonstrated as an effective method for reducing the range of medication errors in general practice. In secondary care, computerised prescriber order entry and decision support have also been shown to improve safety[44].

Modern prescribing practice recognises the importance of involving patients in decisions about their treatment and medication. In this area prescribers are guided by the 2009 NICE Clinical Guideline 76, '*Involving patients in decisions about prescribed medicines and supporting adherence*' which recommends improving communication and increasing patient involvement in decisions about prescribed medicines; a better understanding of the patient's perspective and the provision of more information for patients[45]. This guideline now overlaps with the NICE Guideline NG5 Medicines optimisation. Patients having problems because of

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39 Investigating the prevalence and cause of prescribing errors in general practice http://www.gmc-uk.org/Investigating_the_prevalence_and_causes_of_prescribing_errors_in_general_practice___The_PRACtICe_study_Reoprt_May_2012_48605085.pdf.

40 Dornan et al. An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education. EQIP Study. 2009 A report to the GMC

41 Bradley et al. Potentially Inappropriate Prescribing and cost outcomes for older people: a cross-sectional study using the Northern Ireland Enhanced Prescribing Database. Eur J Clin Pharmacol, 2012

42 Alldred et al. Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. Quality and Safety in Health Care. 2009

43 Avery et al: A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. Lancet 2012

44 Bates D W. Using information technology to reduce rates of medication errors in hospitals. BMJ 2000 Mar 18; 320(7237): 788-791

45 https://www.nice.org.uk/guidance/cg76

language barriers need the support of advocates and language formats that they understand to ensure they are involved in decision making. Health and social care professionals who don't have English as their first language may also need support to ensure they have the necessary communication skills.

Doctors also comply with the GMC Good Practice in Prescribing Medicines and Devices 2013 which provides comprehensive advice on the prescribing of medicines to serve the patient's needs with agreement for the treatment proposed. In addition, the Service Frameworks for older people, mental health, learning disability and children all include standards for patient choice and shared decision making. However, time pressures for doctors may make this difficult to achieve and support from other healthcare professionals in supporting patients in decision making is needed.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• Patients are involved in decisions about their treatment. • To support clinically appropriate and safe prescribing, prescribers have access to end to end paperless prescribing and administration systems.	• Sufficient time to enable an informed discussion with the patient/carer can be an issue. • An ePrescribing & Medicines Administration (EPMA) system should be developed.
General Practice	• Patients are involved in decisions about their treatment. • Prescribers have access to pharmaceutical advice and up to date information to support clinically appropriate and safe prescribing.	• Routine GP consultation times may be insufficient for some patients. • Pharmacists and electronic prescribing support systems such as PINCER are not available in all GP practices.
Community pharmacy	• Increase in number of pharmacists trained as Independent Prescribers, built on a strong clinical foundation and working in Community Pharmacy settings. • Access to Electronic Care Record (ECR).	• Low numbers of Pharmacist Independent Prescribers working in community pharmacies. • No access currently to ECRs.
Patients	• Patients are involved in decisions about their prescribed medicines.	• Patients do not see themselves as equal partners in decision making.

Actions needed to address the gaps

- In secondary care an ePrescribing & Medicines Administration (EPMA) system and the computerisation of records and processes should be introduced, linked to general practice and community pharmacy (see standard 10).
- GP practices should have pharmacists available to advise on complex medicines and polypharmacy, to conduct clinical medication reviews and to help patients with information and advice to take their medicines safely and effectively.
- In GP practices the role of technology enabled screening tools and clinical decision support systems during prescribing for optimising medicines selection and reducing medication errors should be considered. See NICE Guideline NG5 recommendation 1.7, clinical decision support.
- The Northern Ireland Formulary should be integrated within GP and community pharmacy systems and an EPMA system.
- Greater awareness of the patient's role in decision making should be promoted.
- The use of patient decision aids in consultations involving medicines should be explored. See NICE NG5 recommendation 1.6, patient decision aids.
- Consideration should be given to how patients with low health literacy, where there are language barriers and those patients with mental health incapacity will be more readily included in their treatment decisions where possible.
- Community pharmacists should develop clinically and train as independent prescribers.
- Community pharmacists should have access to ECRs.
- The hybrid independent prescribing model should be expanded where doctors diagnose and routine prescribing is then carried out by non-medical prescribers.
- There should be a greater multi-disciplinary approach to prescribing in the most appropriate setting for the patient to ensure medicines use is optimised.

Standard 2 – Better Information about Medicines

Patients/carers receive the information they need to take their medicines safely and effectively.

Why is the standard needed?

Ten days after starting a new medicine, 61% of patients feel they are lacking information and only 16% of patients who are prescribed a new medicine are taking it as prescribed, experiencing no problems and receiving as much information as they believe they need[46]. Good quality information is essential for greater patient involvement and shared clinical decision making and sufficient high quality information alongside good professional interaction is key to helping clinical decision making[47]. In December 2009 NICE was certified as a quality provider of health and social care information by the Information Standard[48] - a certification scheme for health and social care information aimed at the public. When NICE guidelines are being developed the principles of the Information Standard are followed to ensure key messages of the guideline are summarised in everyday language for users of health and care services, carers and the public. The regional public health strategy Making Life Better states that we need to empower people to make informed decisions about their health by improving health literacy which includes providing appropriate and accessible health information (making greater use of modern communication technology) and advice to all, which is evidence informed and tailored to meet specific needs[49].

Information needs to be accessible to all and communicated effectively at a level that will help patients to manage their condition effectively as opposed to just providing information. Limited health literacy capabilities have implications regarding medicines use and not having English as a first language can also impact significantly on the ability to assimilate and use information related to medicines.

The timing and method of communicating information to enable patients to understand their medicines needs to be considered and the medicines optimisation model allows clarification of the roles of health and social care professionals at particular points in the patient journey.

46 Barber et al. Patients' problems with new medication for chronic conditions. Quality and safety in healthcare 2004.

47 Coulter et al. Assessing the quality of information to support people in making decisions about their health and healthcare. Picker Institute, 2006.

48 https://www.england.nhs.uk/tis/

49 https://www.dhsspsni.gov.uk/articles/making-life-better-strategic-framework-public-health

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• Patients receive appropriate, tailored, reliable information about their medicines and support during pre admission clinics and pre discharge counseling. • Patients on specialist medicines have access to a healthcare professional for appropriate advice and tailored, reliable information and support.	• Sufficient time to enable healthcare professionals provide patients with appropriate, tailored, reliable information and support can be an issue • There is no regionally agreed support system for patients post discharge.
General Practice	• Patients receive appropriate, tailored, reliable information and support about medicines when first prescribed and during clinical medication reviews. • Better integration of existing services for example GP referral to Community Pharmacy for medicines use reviews (MURs)/managing your medicines service	• GP consultation times may not be sufficient to provide appropriate, tailored, reliable information and support about medicines required by the patient.
Community pharmacy	• Patients receive appropriate, tailored, reliable advice, information and support when medicines are supplied. • MURs are provided to improve patient knowledge, adherence and use of their medicines. • It is a legal requirement that all medicines are supplied with a Patient Information Leaflet (PIL) provided by the pharmaceutical manufacturer.	• The provision of appropriate, tailored advice, information and support with medicines supplies is inconsistent. • MURs available in community pharmacies while offered by over 90% of community pharmacies, are currently capped in number and limited by patient condition. • The content of the PIL can be both difficult to read and comprehend and supplies with split packs can be problematic.
Social Care	• Nursing and social care staff have access to appropriate up to date information sources for medicines.	• Access to accessible and appropriate up to date information about medicines is limited especially for domiciliary care workers.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Patients	• Patients are aware of where to access the recommended, reliable sources of information on medicines. • Patients have access to information about medicines via the patient zone on the Northern Ireland Formulary website, a patient portal on the NIDirect website and other websites, for example NHS choices. Patients with mental illness have access to information about their medicines via the Choice and Medication website. • Patient helpline available for advice and information.	• Patient awareness of recommended, reliable sources of information is low. • There isn't a regional patient helpline however a helpline pilot is underway in BHSCT and WHSCT.

Actions needed to address the gaps

- A regional system should be agreed to support patients with their medicines after discharge from hospital.
- In GP practices, pharmacists should be available so that patients can be referred to them for appropriate, tailored, reliable information, advice and support to help them take their medicines safely and effectively.
- Community pharmacies should follow a Standard Operating Procedure (SOP) for the risk stratified provision of appropriate support, information and advice with supply of medicines. Information sources for patients should be promoted [patient portal].
- Increased use of technology to direct patients to information resources.
- If the pilot demonstrates benefits a regional patient helpline should be available for advice and information with appropriate signposting to existing national help lines.
- There should be increased availability of the current MUR service in community pharmacy and it should be developed further to include other conditions in particular for those patients prescribed new medications or recently discharged from hospital.
- Health and social care professionals should be trained on how to communicate information effectively to patients.
- Any information provided on internet sites for patients should be in a style accredited by the Plain English Campaign[50] or the Information Standard.

50 http://www.plainenglish.co.uk/

Standard 3 – Supporting Adherence and Independence

People are helped to remain independent and self manage their medicines where possible but receive support with adherence when needed.

Why is the standard needed?

UK evidence shows that 30-50% of long term conditions sufferers do not take their medicines as prescribed[51]. Consequences of non-adherence include poorer than expected clinical outcomes; reduced quality of life; deterioration of health and unplanned admissions to hospital. In the UK the NHS costs of hospital admissions resulting from people not taking medicines as recommended were estimated at £36-196 m in 2006-7[52]. A Cochrane review 'Interventions for enhancing medication adherence' concluded that improving medicines-taking may have a far greater impact on clinical outcomes than improvements in treatments[53].

It is important that people are helped to remain independent and self-manage their medicines for as long as they are able, with the confidence that they will be supported if the time comes when they need more help. Self management should provide people with the knowledge and skills they need to manage their own condition more confidently and to make daily decisions which can maintain or enhance their health and well-being as well as their clinical, emotional and social outcomes[54]. The King's fund paper, 'supporting people to manage their health – an introduction to patient activation describes the patient activation measure (PAM) which measures an individual's knowledge, skill and confidence for self-management. It is stated that patient activation is a better predictor of health outcomes than known socio-demographic factors such as ethnicity and age[55]. Good communication and effective systems can help support people, particularly as they age, to stay in control of ordering, collecting and taking their prescribed medicines.

51 Horne R, Weinman J, Barber N, Elliott R, Morgan M. Concordance, adherence and compliance in medicine-taking. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D. 2005.

52 NICE Costing Statement: Medicines Adherence: involving patients in decisions about prescribed medicines

53 Cochrane review: Interventions for enhancing medication adherence, 2008

54 DHSSPS Living with Long Term Conditions Strategy, 2012

55 Supporting People to Manage Their Health – An Introduction to Patient Activation. The King's Fund, 2014

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• On admission to hospital, patients with sub-optimal adherence are identified through the NI Single Assessment Tool (NISAT) and/or IMM Medicines Reconciliation. Their needs are assessed and appropriate post-discharge support is arranged prior to discharge. • Improved clinical coding of the incidence of unplanned admissions to hospital associated with non-concordance.	• There is no common approach to using NISAT, identifying and assessing non-adherence and to the provision of solutions or support at discharge. • The IMM service is currently only available for 50% of beds. • The clinical coding of medicines related admissions including non-concordance is under reported.
General Practice	• Patients who are experiencing problems adhering to their medicines are identified and referred for assessment.	• There is no common regional approach to identifying and assessing non-adherence and to the provision of solutions.
Community pharmacy	• Patients with sub-optimal adherence are identified through the targeted medication use review (MUR) service which is offered by over 90% of community pharmacies and the Manage Your Medicines Service. • Adjustments are made to medicines packs and adherence aids provided to assist patients to take their medicines more effectively. • On the request of GPs community pharmacies can supply medicines weekly for high risk patients when it is essential to protect the patient and prevent life-threatening non-compliance.	• The targeted MUR Service is limited to patients with respiratory disease and/or diabetes and MURs are currently capped in number. • The Manage Your Medicines Service has low uptake. • There is no common regional approach to identifying and assessing non-adherence and to the provision of solutions. However a Medicines Adherence Support Service (MASS) pilot has been carried out and is currently being evaluated.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Social Care	• Patients should have the necessary support to remain independent and manage their medicines for as long as possible without the need for interventions such as Monitored Dosage Systems (MDS).	• Although healthcare professionals undertake many specialist clinics and invest significantly in supporting patients in medicine adherence and independence including for example inhaler techniques and discussions regarding adverse drug reactions (ADRs) there is still a heavy reliance on a one size fits all approach through MDS.
Patients	• Patients have access to a wide range of patient education/self management and training programmes provided within the HSC and by voluntary and community organisations to help provide the skills and tools they need to self-care/manage for example the Pain Toolkit[56] and Beating the Blues[57] • Patients have self-management plans to support self management of their chronic or long term condition using medicines	• There is low awareness of the resources available. • There is no regional approach to self-management plans to empower patients to be more involved in managing their chronic or long term condition(s).
Other	• Patients have access to tele-monitoring services which enable them to monitor e.g. BP at home, avoiding visits to GP or A&E with their readings being monitored remotely and help available if required.	• Tele-monitoring services are still under development.

56 http://www.paintoolkit.org/

57 http://www.beatingtheblues.co.uk/

Actions needed to address the gaps

- An integrated regional system for identifying and assessing non-adherence and providing solutions should be agreed with defined roles for secondary care, general practice, community pharmacy services and social care.
- Appropriate clinical pharmacy staffing levels particularly in emergency departments to identify and help manage adherence/ adverse drug reaction related admissions.
- Guidance for health and social care professionals on the availability of adherence solutions other than MDS.
- The roles of nurses and care staff in medicines optimisation in domiciliary care settings should be reviewed, clarified and agreed regionally with accredited training and competency based assessments for care staff.
- A range of low and high tech solutions to support adherence should be developed with patient involvement and commissioned.
- The MUR service should be developed for patients with multi-morbidities and polypharmacy.
- Development of new referral mechanisms to community pharmacists for patients who require adherence support..
- A regional system for improving the quality of coding for medicines related factors to identify admissions due to poor adherence should be developed and implemented.
- The availability of self help information relating to medicines and adherence should be promoted.
- Self-management plans should be developed to support patients with a chronic or long term condition(s). See NICE Guideline NG5 recommendation 1.5, self-management plans.

Standard 4 – Safer Transitions of Care

Checks occur at each transition of care to ensure that the transfer of medicines and medicines information between patients, carers and health and social care workers is safe, accurate and timely.

Why is the standard needed?

When patients move between care settings it is important that their medicines and information about their medicines transfers safely and accurately with them, to avoid harm. Over half of all hospital medication errors occur at interfaces of care, most commonly on admission to hospital[58]. A report for the General Medical Council in 2012 investigating the prevalence of prescribing errors in general practice highlighted risks at the primary/secondary care interface with significant problems concerning correspondence about medications particularly at the time of hospital discharge[59]. Older people, those taking multiple and higher risk medicines are most at risk. Risks also exist at transitions of care with intermediate care, community settings including residential, nursing or children's homes, transfers between GP practices and entering or leaving prison. The Donaldson Report highlighted the role that pharmacy can offer at transitions between hospital and the community.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• Integrated Medicines Management (IMM) Service providing electronic medicines reconciliation at transitions; post-discharge communication with GPs, community pharmacies and other health and social care workers.	• The IMM service is limited to around 50% of hospital beds mainly during weekdays from 8:00am to 6:00 pm and delivery of the service varies between HSC Trusts. • Electronic medicines reconciliation is not available in all Trusts.

58 Garfield S, Barber N, Walley P, Willson A, Eliasson L. Quality of medication use in primary care--mapping the problem, working to a solution: a systematic review of the literature. BMC Medicine 2009; 7:50.

59 Investigating the prevalence and cause of prescribing errors in general practice http://www.gmc-uk.org/Investigating_the_prevalence_and_causes_of_prescribing_errors_in_general_practice___The_PRACtICe_study_Reoprt_May_2012_48605085.pdf

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital contd	• Consultant pharmacists led services/Senior Clinical Pharmacists supporting appropriate polypharmacy in older people in intermediate care and nursing/ residential homes. • Regional Guidelines for the Supply of 'Take Home Medication' from Northern Ireland Emergency Departments [60] developed by GAIN • Regional Guidelines for Immediate Discharge Documentation for Patients Being Discharged from Secondary into Primary Care[61] developed by GAIN, 2011	• Consultant Pharmacist-led services for older people are not available in all Trusts.
General Practice	• GP practices provide information relating to prescribed medicines to secondary care and to appropriately authorised health and social care professionals looking after patients in care homes[62] or their own homes. • GPs receive timely notification electronically when their patients are admitted to hospital and receive timely and accurate information about medication changes on discharge.	• There is no agreed approach to the timely provision of this information. • GPs do not always receive timely notification that their patients have been admitted to hospital and post discharge medicines information is not always reconciled to the GP list before a prescription or new supply of medicines are issued and within 1 week of the GP practice receiving the information. • No process currently in place to ensure that GP practices are advised if any of their patients are admitted to prison.

60 http://www.gain-ni.org/images/Uploads/Guidelines/Regional_Guidelines_for_the_supply_of_Take_Home_Medication_from_Northern_Ireland_Emergency_Departments_DEC_2014.pdf
61 http://www.gain-ni.org/images/Uploads/Guidelines/Immediate-Discharge-secondary-into-primary.pdf
62 Where reference is made to' care homes 'this means Nursing Home, Residential Home and Children's Homes.

Provider	What best practice should be delivered	Gaps in delivery of best practice
General Practice contd	• People discharged from an acute care setting to primary care have their medicines documented in the discharge summary and reconciled in the GP list as soon as is practically possible, before a prescription or new supply of medicines is issued and within 1 week of the GP practice receiving the information. • GP practices are notified if a patient is admitted to prison and on release. Prescribing information from the Prison health GP IT EMIS system should be uploaded onto, and available on, the ECR.	• Prison health can see ECR when prisoner arrives in prison, but cannot add to it, so that no information about prescribing during the prison stay is available to the patient's GP on release of the patient.
Community pharmacy	• With patient agreement a nominated community pharmacy receives post discharge medicines information from secondary care electronically. • The Royal Pharmaceutical Society Innovators' Forum has produced a toolkit[63] to support safer transition from secondary care to community pharmacy. • Information relating to medicines supplied is provided on request to secondary care and to appropriately authorised health and social care professionals in care homes. • There is a defined role for community pharmacy to support safer transitions at discharge.	• HSC Trusts do not routinely provide information to community pharmacies post discharge. • There is no specific role or service for community pharmacy to support safer transitions for patients at discharge. • The ECR is not yet accessible to community pharmacies.

63 http://www.rpharms.com/support-pdfs/3649---rps---hospital-toolkit-brochure-web.pdf

Provider	What best practice should be delivered	Gaps in delivery of best practice
Social Care	• Nursing staff conduct medicines checks for new patients in nursing homes and independent healthcare settings. • Medicines checks are completed by social care workers when children move into a children's home or change day care setting[64]. • Domiciliary care staff are made aware of changes to patients' medicines following transitions of care. • Community nurses and appropriately authorised health and social care staff have visibility of medicines prescribed through access to ECR.	• Community Nurses can contact GPs to discuss a patient's medication on transfers of care however the ECR is not accessible to them. • The ECR is not accessible to appropriately authorised health and social care professionals in care homes. • When patients are discharged from hospital or return home from a care setting there is no system to make domiciliary care workers, who assist them with their medicines aware of changes to their medication.
Patients	• Patients bring their current medication and related information with them to hospital and all Trusts have policies for using patients own drugs where possible. • Patients are responsible for knowing what medicines they are currently prescribed and why. • Patients have access wherever possible to ECR and/ or a patient passport and are aware of who else has what information, under what circumstances and with what safeguards.	• The patient's role in managing their own medicines and medicines information during transitions of care is not well understood. • Patients are not involved in decisions about their medicines as much as they should be to enable them to take responsibility for knowing what they are prescribed and why. • Patient view allows patients internet access to their own records but access to the ECR is needed to improve co-ordination of care

64 https://www.dhsspsni.gov.uk/articles/care-standards

Actions needed to address the gaps

- An Integrated Medicines Management Service with electronic medicines reconciliation should be delivered consistently across HSC Trusts which includes hospital attendance without admission for example at outpatient clinics. See also NICE Guideline NG5 recommendation 1.3, medicines reconciliation.
- A regional consultant pharmacist led service should be commissioned for managing polypharmacy in older people in intermediate care, nursing and residential care settings.
- There should be 'one single source of truth' for example ECR regarding patient's medications which is up to date and can be accessed by patients and shared by all healthcare professionals. See also NICE Guideline NG5 recommendation 1.2, medicines-related communications systems when patients move from one care setting to another.
- A regional protocol for safe transitions in the community should be developed to ensure that medicines checks occur at each transition of care with defined roles for GPs, Community Pharmacists, and health and social care workers in care settings, facilitated by appropriate access to the ECR.
- Electronic communication between hospitals and GPs should be improved to notify when patients are admitted to hospital and provide timely and accurate medicines information on discharge
- A process should be established to ensure that GP practices are advised if a patient is admitted to prison.
- Information about prescribing during a prison stay should be uploaded onto the ECR for the patient's GP to see on release of the patient.
- The patient's role in managing their own medicines and related information during transitions of care should be promoted.

Standard 5 – Risk Stratification of Medicines

Patients who may be at risk because of the medicines that they use receive the appropriate help to take their medicines safely.

Why is the standard needed?

Although the use of all medicines is associated with a level of risk, some medicines are known to carry a greater risk of side effects, adverse events and/or admission to hospital than others. A systematic review of medicines related admissions to hospital found that four groups of drugs account for more than 50% of the drug groups associated with preventable drug-related hospital admissions - antiplatelets, diuretics, NSAIDs and anticoagulants[65]. In addition, a review was carried out of medication incidents reported to the National Reporting and Learning System in England and Wales over a 6 year period. The top 5 medicines for which the clinical outcome was death or severe harm were opioids, antibiotics, warfarin, low molecular weight heparins and insulin[66]. Antimicrobial resistance is among the civil emergencies listed in the Cabinet Office's National Risk Register of Civil Emergencies[67]. In Northern Ireland, antimicrobial prescribing is high and the prevalence of systemic antimicrobial prescribing in residential homes was found to be relatively high compared with care homes (particularly nursing homes) in other countries[68]. By measuring and addressing performance indicators, the quality of antibiotic prescribing could be improved[69]. The misuse of prescription and over the counter drugs is a significant public health and social issue in Northern Ireland, resulting in negative impacts on physical and mental health, and there have been an increasing number of deaths related to the misuse of a range of prescription drugs. There are particular issues in relation to poly-drug use, especially when combined with alcohol and the use of hypnotics which are associated with increased mortality, even in patients taking fewer than 18 Doses/Year[70]. Other medicines also require caution in use including some specialist 'red and amber list' medicines which may need ongoing patient monitoring. These are initiated by a hospital prescriber and may be delivered directly to a patient's home with associated services (homecare services). Risks of harm are higher for some patient groups, for example, older people, those taking multiple medicines (polypharmacy), and for whom careful adherence is critical for example in the treatment of diabetes, Parkinson's Disease and some mental health conditions. A useful tool, SPARRA[71] (Scottish Patients at Risk of Readmission and Admission) has been developed by the Information Services Department, Scotland which can be used to predict an individual's risk of being admitted to hospital as an emergency inpatient within the next year.

65 Which drugs cause preventable admissions to hospital? A systematic review. www.ncbi.nlm.nih.gov/pubmed/16803468

66 Cousins DH, Gerrett D, Warner B. A review of medication incidents reported to the National Reporting and Learning System in England and Wales over 6 years. Br J Clin Pharmacol; 2012 Oct; 74(4):597-604

67 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419549/20150331_2015-NRR-WA_Final.pdf

68 McClean et al. Antimicrobial prescribing in residential homes. J Antimicrob Chemother, 2012.

69 Maripu H et al. An audit of antimicrobial treatment of lower respiratory and urinary tract infections in a hospital setting. Eur J Hosp Pharm 2014;21:139-144

70 Kripke DF et al. Hypnotics' association with mortality or cancer: a matched cohort study. Pharmacology and therapeutics, 2012

71 http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• There is an agreed approach across Trusts for the management of patients taking high risk or specialist medicines which includes specialist pharmacists with a strategic responsibility for high risk medicines across Trusts. • Clinicians record medicines related issues as causative factors for admission/ re-admission in patients' notes, supporting accurate clinical coding and monitoring trends across Trusts. • A regional electronic antimicrobial surveillance system is in operation which includes resistance tracking, alert functionality and antimicrobial stewardship. • The pharmacy management system (JAC) has high risk medicines flagged	• The interface pharmacist network provides pharmaceutical care for some groups of patients on specialist medicines. This varies depending on service delivery and capacity and would not encompass all medicines on the red amber list. Other specialist pharmacists also play a significant role. There is inconsistency in the level of information provided to patients, carers and social care workers when high risk medicines are prescribed and dispensed. • There is low awareness among medical staff of medicines related issues as causative factors for admission/ re-admission leading to under reporting in patient's notes, incomplete clinical coding and lack of data for monitoring trends. • A system for surveillance and monitoring of antimicrobial resistance and antimicrobial stewardship with alert functionality is not available in all Trusts. • High risk medicines are not highlighted on JAC, the pharmacy management system.

Provider	What best practice should be delivered	Gaps in delivery of best practice
General Practice	• Patient safety tools are in use for example PINCER, STOPP/START and the GRASP suite of tools • Proactive case management and targeting care to those most at risk through a primary care enhanced service for risk stratification is included in the work of ICPs. • All patients on high risk medicines receive appropriate help to take their medicines safely. • A regional electronic antimicrobial surveillance system is in operation which includes resistance tracking, alert functionality and antimicrobial stewardship which collects data from GP practices across the region. • Patients' records including the ECR highlight the use of high risk and specialist medicines. • A local enhanced service (LES) for those patients in nursing and residential homes supports those who may have more complex needs supported by pharmacist prescribers and case management nurses in primary care.	• There is no regional multi-disciplinary approach to the management of patients on high risk medicines. • A surveillance system to capture microbiological data in general practice is not available across the region. • Examples of high risk medicines are available on a poster for practices however there is no agreed system for highlighting high risk and specialist medicines on patient records and ECR. • The LES for nursing and residential homes does not currently specify management of patients on high risk medicines.
Community pharmacy	• Risk stratified provision of appropriate support, information and advice with supply of medicines. • Community pharmacies have access to up to date information relating to patient medication including high risk and specialist medicines.	• Examples of high risk medicines are available on a poster for community pharmacies however there is no protocol which they use to stratify risk. • Community pharmacies do not currently have access to the ECR.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Social Care	• Patients in nursing and residential homes taking high risk medicines are identified and receive appropriate care. • In domiciliary care there is compliance aid support for at risk patients based on a person's physical capability/cognitive ability/mental health difficulties. • The roles of nurses and care staff support patients on high risk medicines in domiciliary care settings agreed regionally with accredited training and competency based assessments for care staff. • Consistent provision to social care workers of information regarding patients on high risk medicines. • A regional electronic antimicrobial surveillance system is in operation which includes resistance tracking, alert functionality and antimicrobial stewardship which collects data from nursing and residential homes across the region.	• The roles of nurses and care staff supporting patients on high risk medicines in domiciliary care settings is unclear. • A surveillance system to capture microbiological data in nursing/residential homes is not available across the region.
Patients	• Patients with a greater awareness of high risk medicines and empowered to seek support, information and advice in the use of these medicines.	• There is a lack of knowledge among patients regarding high risk medicines to enable them to manage them appropriately.

Actions needed to address the gaps

- A regional risk stratification tool should be developed and implemented in primary and secondary care which includes outpatients to identify patients who may be at risk because of the medicines they use.
- Patients and carers should be made aware when high risk medicines are prescribed and dispensed and receive the necessary support and information to assist safe and effective use.
- An ePrescribing & Medicines Administration (EPMA) system and JAC in hospitals should highlight when high risk medicines are being used.
- Increased use of patient safety tools for example PINCER, STOPP/START and the GRASP suite of tools.
- The ECR should highlight when high risk and specialist medicines are being used.
- Information to patients and their GPs regarding specialist medicines should be consistently provided.
- A regional plan to improve reporting/clinical coding of the incidence of unplanned admissions to hospital associated with medicines should be developed and implemented.
- GP and community pharmacy computer systems should have high risk and specialist medicines highlighted.
- High risk patients should be prioritised for regular clinical medication reviews (See Standard 9).
- Roles and responsibilities relating to risk stratification and medicines optimisation should be included in ICP patient pathways for at risk patient groups.
- A regional antimicrobial prescribing and surveillance system should be established which includes resistance tracking, an alert functionality and antimicrobial stewardship.
- The roles of nurses and care staff in medicines optimisation in domiciliary care settings should be reviewed, clarified and agreed regionally with accredited training and competency based assessments for care staff.
- For high risk drugs there should be shared care guidelines not only with the GP but also with the patients chosen community pharmacist.

Standard 6 – Safety/Reporting and Learning Culture

Organisations promote an open and transparent culture with evidence of processes for the reporting, prevention, detection, communication and cascade of learning from medication incidents and adverse drug reactions.

Why is the standard needed?

The medicines governance teams in primary and secondary care are well established in promoting medication incident reporting, developing risk management processes, implementing regional best practice policies and risk education. However there is variance in the degree to which medicines incidents are reported across the HSC and reluctance from community pharmacies to report due to current legislative penalties for errors. One of the recommendations of the Donaldson Report was a need to make incident reports really count.

The MHRA has received over 700,000 UK spontaneous adverse drug reactions (ADRs) since the scheme was first started and typically they receive around 25,000 reports per year. In the 5 years prior to June 2013, there have been 2,110 ADR reports reported to MHRA from Northern Ireland. We need to improve our reporting of medicines incidents including ADRs across the HSC and raise public awareness of patient reporting of ADRs.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• All medicines incidents and ADRs are reported via the appropriate mechanisms • All near miss information from pharmacist interventions are captured electronically to enable learning. • A modified risk assessment tool based on the national quality assurance and fit for purpose and medicines error potential tools is used in the procurement process. However, there is a need for other tools to identify medication safety risks.	• The rates of medicines incident reporting and yellow card reporting are low and vary between Trusts, professionals and clinical areas/specialities • The Electronic Pharmacist Intervention Clinical System (EPICS) software to capture pharmacist interventions is not in use in all Trusts. • Although Datix is used to report adverse incidents (AIs) and serious adverse incidents (SAIs), and can be used to help identify medicines safety risks, there are currently no tools, for example, global trigger tool/ medication safety thermometer tool.

Provider	What best practice should be delivered	Gaps in delivery of best practice
General Practice	• A software system is in place to allow the recording of medicines incidents by GPs in their general practice (e.g. Datix) and to analyse medicines incidents. • All ADRs are reported via the yellow card scheme through the GP IT clinical system. • Tools are available to identify medication safety risks.	• The rates of medicines incident reporting are low. • The rates of yellow card reporting are low. • There are currently no approved tools for example global trigger tool/medication safety thermometer tool.
Community pharmacy	• A software system is in place to allow the recording of medicines incidents by community pharmacists in their pharmacy practice (e.g. Datix) and to analyse medicines incidents. • Community pharmacists actively report ADRs via the yellow card scheme and can do so through their pharmacy IT system.	• The rates of medicines incident reporting are low. • The rates of yellow card reporting are low.
Social Care	• Systems are in place to report ADRs and incident reporting systems for medicines. • Medication incidents are reported from all registered facilities to RQIA.	• The rates of incident and yellow card reporting are low.
Patients	• Systems are in place to allow patients to report medication incidents. • Patients report ADRs via the yellow card scheme.	• Patients are not currently encouraged to report medication incidents. • The rates of yellow card reporting are low.

Actions needed to address the gaps

- An open and fair culture to encourage timely reporting of medicines incidents and ADRs should be established across the HSC.
- A regional programme should be launched to increase yellow card reporting by health care professionals and patients with consideration of introducing contractual requirements to support implementation.
- A regional system should be introduced to allow electronic reporting, monitoring and analysis of medicines incidents by GPs, Community Pharmacies and Social Care Workers.
- A regional system should be introduced to identify and review incident data, identify and develop learning and explore new ways of how to deliver learning and share knowledge. See NICE Guideline NG5 recommendation 1.1
- Formal links should be established with other UK countries with respect to medication incident reporting and learning.
- Process reviews along with engineering and technological solutions should be developed which aim to minimise system failures that underpin medication errors.
- The use of Institute for Healthcare Improvement (IHI) methodology and other improvement science tools should be increased to improve medicines safety.
- A Never Event approach should be introduced as recommended in the Donaldson report for medication errors.

Quality Theme – Effectiveness

Standard 7 – Access to Medicines you Need

Patients have appropriate, equitable and timely access to quality assured, evidence-based and cost-effective medicines.

Why is the standard needed?

Improved access to medicines has contributed to an increase in life expectancy, helping people to stay healthy for longer and many previously debilitating or fatal conditions are now prevented or managed, often on a long term basis, through regular medicines use. The population of Northern Ireland uses a high volume of medicines per head of population. Robust systems are in place to ensure that medicines are prescribed to patients across the region in line with evidence and best practices in a cost effective manner. Furthermore, regional and local procurement practices in Trusts ensure the availability of quality assured medicines in hospitals. Equally, community pharmacies comply with professional standards for the sale and supply of medicines in the community and go to great lengths to ensure that patients have access to the medicines they have been prescribed, whether these are one-off prescriptions or ongoing medicines for long-term conditions. However, Northern Ireland is part of a wider UK and global medicines market and shortages can and do arise within the medicines supply chain which are frequently beyond their control. The consistent delivery of safe, high quality and cost effective prescribing and procurement is essential to facilitate continued access to medicines for the population. For new medicines, a regional managed entry process exists which aims to ensure timely and equitable access for patients to those medicines for which there is an evidence base on efficacy and cost-effectiveness. However, there is a perception that there are differences in access across the region and compared to other UK countries particularly in respect to cancer and specialist medicines.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• Hospital pharmacies ensure timely access to safe, quality assured medicines so as to avoid delays in administration. • All Health and Social Care Professionals are aware of the HSCB Regional Managed Entry [72] process which supports timely and appropriate access to new medicines for which there is an evidence base on efficacy and cost-effectiveness. • Timely and appropriate access to new medicines for patients for which there is an evidence base on efficacy and cost-effectiveness. • Compliance with regional guidelines for managing medicines shortages in hospitals. • All Individual Funding Request (IFR) applications subject to regionally consistent clinical input and peer review. • Improved support regarding access to unlicensed or off-label medicines in areas of unmet medical need, thus enhancing the landscape for developing, licensing and procuring innovative medicines.	• The funding mechanisms and the process of applying for funding for new, unlicensed and specialist medicines is not well understood. • Unlicensed and off-label medicines are not part of the established regional IFR process. • There is inconsistency across Trusts regarding Non-NICE medicines approval however work is progressing on the implementation of the DHSSPS IFR consultation recommendations.

72 http://niformulary.hscni.net/ManagedEntry/Pages/default.aspx

Provider	What best practice should be delivered	Gaps in delivery of best practice
General Practice	• All Health and Social Care Professionals are aware of the HSCB Regional Managed Entry process which supports timely and appropriate access to new medicines for which there is an evidence base on efficacy and cost-effectiveness.. • Compliance with regional guidelines for managing medicines shortages in primary care.	• The funding mechanisms for new, unlicensed and specialist medicines is not well understood. • There are no regional guidelines for managing medicines shortages in primary care.
Community pharmacy	• All community pharmacists are aware of the HSCB Regional Managed Entry process which supports timely and appropriate access to new medicines for which there is an evidence base on efficacy and cost-effectiveness. • Community pharmacies ensure timely access to safe, quality assured medicines so as to avoid delays in administration However if there are shortages outwith their control, they cannot be held accountable. • Compliance with regional guidelines for managing medicines shortages in primary care. • All patients have their repeat medicines dispensed on time to avoid clinical consequences.	• The funding mechanisms for new, unlicensed and specialist medicines is not well understood. • There are no regional guidelines for managing medicines shortages in primary care.
Patients	• Patients are aware of the HSCB Regional Managed Entry process which supports timely and appropriate access to new medicines for which there is an evidence base on efficacy and cost-effectiveness. • Timely and appropriate access to new medicines for patients for which there is an evidence base on efficacy and cost-effectiveness.	• There is public perception of variance in the managed entry of new, unlicensed and specialist medicines.

Actions needed to address the gaps

- Regional guidance should be developed to improve public and healthcare professional awareness and understanding of the processes for managed entry and access to new, unlicensed and specialist medicines in Northern Ireland. This should include accessible, accurate and up to date information for the public to view and include a schematic that shows how to access medicines in the HSC.

- Regional guidelines on handling medicines shortages in primary care should be developed. This would include the provision of advice by community pharmacists to prescribers of stock shortages and making recommendations for alternative products. If shortages arise within the medicines supply chain which are outwith the control of community pharmacists, they cannot be held to account.

- The recommendations of the DHSSPS IFR consultation should be implemented.

Standard 8 - Clinical and Cost Effective Use of Medicines and Reduced Waste

Within organisations a culture exists promoting a shared responsibility for the appropriate, clinical and cost effective use of medicines supported by systems for avoiding unnecessary waste.

Why is the standard needed?

Within HSC organisations it is important that systems for the procurement, prescribing, ordering and supply of prescribed medicines provide cost effective use of medicines providing optimal health outcomes, safety and avoiding waste.

A regional focus on evidence based and cost effective prescribing has resulted in significant improvements in the quality of prescribing in recent years with evidence of change in terms of drug costs, volumes and levels of compliance with the Northern Ireland Formulary. Advertising campaigns have sought to raise public awareness of the need to reduce medicines waste by only re-ordering repeat medicines that are needed and highlighting actions for community pharmacies, GP practices and care homes. However, evidence shows that around 11% of UK households have one or more medicines that are no longer being used[73] and estimates, based upon a study conducted by the University of York, put the cost of wasted medicines in Northern Ireland at £18m per year[74]. The highest levels of wasted medicines are associated with repeat medicines that are ordered, prescribed, dispensed, collected by the patient/carer but never used and subsequently wasted. Waste in nursing and residential homes is recognised as a particular challenge.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• Prescribing is informed by the Northern Ireland Formulary. • All Trusts have policies promoting the use of patient's own drugs (PODs) where possible on admission to hospital.	• Prescribing data by clinical indication in secondary care is not available. • There are differences between Trusts in how the process of using PODs is adopted.

73 Woolf, M. Residual medicines: a report on OPCS Omnibus Survey data

74 Evaluation of the Scale, Causes and Costs of Waste Medicines, University of London and York 2010

Provider	What best practice should be delivered	Gaps in delivery of best practice
General Practice	• Prescribing is informed by the Northern Ireland Formulary. • HSC Board medicines management advisors, prescribing support pharmacists and practice-based pharmacists support effective prescribing in GP practices. • Repeat prescribing policies and processes aim to restrict over-ordering and reduce errors in ordering.	• The Northern Ireland Formulary is not linked to GP ICT systems. • Not all GP surgeries have prescribing support. • The current repeat dispensing service is paper based, inefficient and underused. • Unwanted items previously prescribed may be re-ordered in error.
Community pharmacy	• Systems are in place to check that items ordered on repeat prescription are required before supply is made. • Medicines waste returned to pharmacies for disposal is safely handled and levels of waste are monitored. • Pharmacies follow HSC Board guidance relating to ordering and collection of medicines.	• There is no requirement for pharmacies not to dispense prescribed items and unwanted items ordered in error may still be supplied. • The level of waste returned for disposal is not monitored. • Full compliance with the HSC Board guidance relating to ordering and collection of medicines is not assured.
Social Care	• Systems are in place to manage the ordering of prescribed medicines to ensure adequate supplies and prevent wastage. The RQIA encourages and promotes good stock control.	• Stock control is an ongoing problem. • Over ordering and waste returned for disposal from nursing and residential homes is not monitored.
Patients	• Systems are in place to allow patients to order their medicines when needed and prevent inappropriate ordering.	• Inappropriate ordering (over ordering, ordering unwanted items and under ordering) may still occur.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Other	• An ongoing regional medicines waste advertising campaign which seeks to influence patient behaviour and prescription ordering processes in GPs, Community Pharmacies and care homes. This should also encourage patients to bring their medicines into hospital with them to avoid unnecessary waste	

Actions needed to address the gaps

- A regional prescribing database should be available for secondary care with the Dictionary of Medicines and Devices (DM&D) as the dictionary to enable merging with primary care data.
- Prescribers should have access to an electronic Northern Ireland Formulary which is linked to GP ICT systems to inform prescribing.
- Consistent prescribing compliance with the Northern Ireland Formulary should be achieved.
- Levels of waste returned from pharmacies and care homes should be monitored and the impact of interventions on waste reduction measurement.
- Consideration should be given to a role for minimising medicines waste to be included in GP and community pharmacy contracts.
- The repeat dispensing service should be reviewed and re-launched in electronic form.
- To influence patient behaviour regarding medicines waste, the medicines waste advertising campaign should be ongoing.
- New approaches to minimising wasted medicines should be explored including collaboration with the pharmaceutical and technology industry.

Standard 9 – Clinical Medication Review

Clinical medication reviews are carried out with the patient and occur on a regular basis, at least annually.

Why is the standard needed?

The importance of medication reviews is recognised and a number of health policies and service frameworks recommend regular reviews for specific patient groups including: older patients, people with diabetes, respiratory disease and cardiovascular disease.

Medication reviews in this context are clinical reviews conducted with the patient and with full access to patient medication records. They are not medicines reconciliation checks, medicines use reviews (MURs), Manage Your Medicines service reviews or desk top patient medication record checks.

Currently medication reviews may occur at various stages in the patient journey carried out by a range of healthcare professionals with varying levels of clinical autonomy and expertise in medicines. There is a level of inconsistency in approach in terms of what the review involves, the optimal time and frequency for completion and who is best to conduct it.

An increasing challenge for medication reviews is the prevalence of multi-morbidities and polypharmacy as the population ages. Another issue is that patients may have medicines prescribed concomitantly by a number of different doctors and non-medical prescribers involved in their care.

These issues reinforce the need for a robust regional approach to clinical medication reviews.

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• 95% of people admitted to hospital receive a clinical medication review during their stay which is documented. • Clinical medication reviews to optimise medicines use in outpatient clinics for example diabetes, anti-coagulant and rheumatology.	• There is inconsistency in clinical medication reviews carried out in secondary care as the IMM service is currently only available for 50% of beds and there is variance in the quality of delivery of the service between Trusts.

Provider	What best practice should be delivered	Gaps in delivery of best practice
General Practice	• Within the core GMS contract is an expectation that patients on chronic medication have an annual clinical medication review. The appropriate frequency should be tailored to the individual and their care plan and may need to be carried out more frequently than annually • High risk patients are prioritised for 'regular' medication reviews as agreed in patient's care plans.	• Detailed clinical medication reviews are not being undertaken with patients on a consistent basis. • There is no regionally agreed best practice approach to clinical medication reviews resulting in duplication between reviews offered in secondary care, primary care and community pharmacy.
Community pharmacy	• Suitably trained Pharmacist Independent Prescribers (PIPs) with remote access to patient records from general practice have a role in the provision of clinical medication reviews.	• There is no defined role or service for community pharmacy in the provision of clinical medication reviews. • The number of PIPs working in community pharmacy is currently low.
Social Care	• Consultant pharmacist led care in intermediate care, nursing and residential homes supporting appropriate polypharmacy through clinical medication reviews. • GP Local Enhanced Service (LES) 2014/15 PIPs conduct clinical medication reviews of registered patients in nursing and residential homes.	• There is currently no agreed regional service available to provide clinical medication reviews for older people in intermediate care, nursing and residential homes settings.
Patients	• Patients are aware of what a full clinical medication review involves, when it should be carried out and by whom. • Clinical medication reviews should be carried out in a setting and time convenient to the patient where possible.	• Lack of understanding of what a full clinical medication review involves and when it is required.

Actions needed to address the gaps

- A regional model for clinical medication reviews should be developed which describes what should be included in the review, when it should be conducted and by whom. See NICE Guideline NG5 recommendation 1.4, medication review
- In primary care the frequency of clinical medication reviews for patients should be agreed within individual care plans and the requirement for completion of reviews included in GP contracts.
- In Trusts the availability of the IMM service should be increased and the service delivered to a consistent quality involving a clinical medication review conducted by a pharmacist.
- Within multi-disciplinary teams in primary care, secondary care and as outreach from Trusts, pharmacists should conduct clinical medication reviews and a role should be developed for community pharmacists
- The clinical medication review standard should be included as a generic standard in all service frameworks relating to patients with long term conditions, multi-morbidity and polypharmacy.

Standard 10 – Administration

Following an initial check that the direction to administer a medicine is appropriate, patients who have their medicines administered receive them on time and as prescribed.

Why is the standard needed?

A review of all medication incidents reported to the National Reporting and Learning System (NRLS) and England in Wales between 1st January 2005 and 31st December 2010 was undertaken. Incidents involving medicine administration (50%) and prescribing (18%) were the process steps with the largest number of reports. Omitted and delayed medicine (16%) and wrong dose (15%) represented the largest error categories[75]. A Rapid Response Report from the National Patient Safety Agency on 'Reducing harm from omitted and delayed medicines in hospital' highlighted that medicine doses are often omitted or delayed in hospital for a variety of reasons[76]. This can lead to serious harm or death for some critical conditions, for example patients with sepsis or pulmonary embolism where there is a delay/omission of intravenous medicines[77]. Parkinson's UK - Get it On Time campaign[78] outlines the importance of people getting their Parkinson's medication on time, every time in hospitals and care homes. A GAIN audit carried out in 2013 - The Importance of Timing in Parkinsons Medication[79] found that 59% of patients did not receive their medication on time during their hospital stay. A study which investigated the prevalence of medication errors in care homes in the UK found that 22.3% of 256 residents were observed to receive an administration error. The commonest administration errors were omissions because the drug was not available, so omissions need to be monitored and ordering, particularly of "as required" medicines, needs to be improved[80]. In a 2011 study of medicine administration errors in older persons in hospital wards in the UK, the number and severity of medication administration errors was found to be higher than previous studies. During 65 medicine rounds 38.4% of doses were administered incorrectly[81]. In domiciliary care settings nurses and care workers are involved in activities which range from administration to prompting patients to take their medicines. More older people are being cared for in their own homes often with complex and multiple medicines regimens and there is the need for regional best practices that support role clarification, accredited training and support systems for staff.

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75 Cousins DH, Gerrett D, Warner B. A review of medication incidents reported to the National Reporting and Learning System in England and Wales over 6 years. Br J Clin Pharmacol; 2012 Oct;74(4):597-604

76 National Patient Safety Agency. Patient Safety Observatory Report 4: Safety in doses; 2007.

77 National Patient Safety Agency. Rapid Response Report, 2010.

78 http://www.parkinsons.org.uk/content/get-it-time-campaign

79 http://www.gain-ni.org/images/Uploads/Audit/GAIN_-_FINAL_GIOT_REPORT_-_19_April_2013.pdf

80 Alldred DP, Barber N, Carpenter J, Dean-Franklin B, Dickinson R, Garfield S, Jesson B, Lim R, Raynor DK, Savage I, Standage C Wadsworth P, Woloshynowych M, Zermansky AG. Care homes use of medicines study (CHUMS). Report to the Patient safety {Portfolio, department of Health). 2009.

81 Kelly J and Wright D. Medicine administration errors and their severity in secondary care older persons' ward: a multi-centre observational study J Clin Nursing. 2011

Provider	What best practice should be delivered	Gaps in delivery of best practice
Hospital	• All patients should receive their medicines on time following a check that the direction to administer is appropriate and other related factors taken into consideration for example insulin dose close to meal time and meals are not delayed. • Patients self-administer their own medicines, where the risks have been assessed and the competence of the patient to self-administer is confirmed. • 'One-stop' dispensing[82] and the use of patient bedside medicines lockers to improve access and reduce medicines administration errors. The move from a 'trolley-based' system for administering medicines to a 'one-stop' dispensing system using patient's own drugs and custom-designed patient bedside medicine lockers has resulted in safer and faster medicine administration rounds[83] [84].	• Doses of medication are being omitted and delayed as shown in an audit carried out in the five Trusts in Northern Ireland in 2013.12.7% of doses were omitted and delayed. (NB however work is ongoing to ascertain how many were true omissions/failure to record). • Self-administration occurs to varying degrees in Northern Ireland hospitals. • One-stop dispensing occurs in varying degrees in Northern Ireland hospitals.

82 'One-stop' dispensing refers to the practice of combining inpatient and discharge dispensing into a single supply labelled for discharge. Patients are encouraged to bring their own medicines into hospital on admission and medicines are assessed by pharmacy as suitable for use are used for the patient during their hospital stay. A 28-day supply is given of any medicines deemed unsuitable for us, when the quantity of a particular medicine is depleted and when new medicines are commenced http://www.hospitalpharmacyeurope.com/featured-articles/one-stop-dispensing-and-discharge-prescription-time

83 Anon. Giving medicines from patient lockers reduces errors. Pharmaceut J 2002;268:274

84 Hogg et al. Do patient bedside medicine lockers result in a safer and faster medicine administration round? Eur J Hosp Pharm, July 2012 http://ejhp.bmj.com/content/19/6/525.abstract

Provider	What best practice should be delivered	Gaps in delivery of best practice
Community Pharmacy	• All patients required to take their medicines under supervision are treated in a confidential, non-judgmental manner in a private area within the pharmacy. • Community pharmacists helping to facilitate administration through new systems or additional support provided to care homes. • In domiciliary care community pharmacists supporting self administration of medicines through the provision of a variety of medicines adherence support solutions.	• Patients requiring medicines to be taken under supervision may not always feel that they are treated in a confidential, non-judgemental manner. • There is a limited evidence base for support systems for care homes and domiciliary care and no common regional approach to identifying and assessing non adherence and to the provision of solutions. However Medicines Adherence Support Service (MASS) pilot has been carried out and is currently being evaluated.
Social care	• All residents in care homes who have their medicines administered should receive their medicines on time following a check that the direction to administer is appropriate. • Patients self-administer their own medicines, where the risks have been assessed and the competence of the patient to self-administer is confirmed. • Community nursing core services associated with medicines administration of high risk and specialist medicines as well as other medicines such as vaccines in patients own home. • Domiciliary care workers are appropriately trained and supported to contribute to medicines optimisation.	• Evidence of administration errors in care homes due to omissions. • The roles of nurses and domiciliary care workers in medicines optimisation need to be reviewed and clarified.
Patients	• All patients living at home with predictable conditions are supported to self-administer their medicines and to remain independent for as long as possible.	• There are limited solutions available for supporting independence with medicines taking.

Actions needed to address the gaps

- In secondary care an ePrescribing & Medicines Administration (EPMA) system and the computerisation of records and processes should be introduced, linked to general practice and community pharmacy (see standard 1).
- An increase in the number of wards in hospital providing a 'one-stop' dispensing service should be considered.
- There should be an appropriate skill mix within clinical settings to ensure safe administration of 'critical' medicines.
- Self-administration schemes should be rolled out in secondary care and intermediate care where the risks have been assessed and the competence of the patient to self-administer is confirmed.
- Community pharmacies providing a substitution treatment service should have a private area where supervised administration can be undertaken which serves to normalise the process for patients.
- Consideration should be given as to how community pharmacists could provide additional support in relation to administration to patients living both in their own home and in a care home environment.
- The roles of nurses and care staff in medicines optimisation in domiciliary care settings should be reviewed, clarified and agreed regionally with accredited training and competency based assessments for care staff.
- There should be a regionally agreed process to support community nursing teams and care staff to administer medicines on time.

Integrated Innovation and Change Programme

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SECTION 4

Integrated Innovation and Change Programme

Supporting Continuous Improvement and Innovation in Medicines Use

4.1 The Quality Standards have identified a number of gaps in medicines management systems which impact on the delivery of the Regional Medicines Optimisation Model. Many of the actions needed to address these gaps require regional systems which may involve an element of whole system change with interdependencies across the HSC.

4.2 Traditionally a range of organisations have had active programmes of research and service development relevant to medicines optimisation with funding coming from a variety of sources.

4.3 The ultimate success of these programmes is for their outputs to inform practice throughout the HSC through changes to medicines policy or commissioned services. However, this does not always occur and in many instances outputs are not recognised or valued by commissioners and policy makers or practices are not successfully translated across the HSC leaving fragmented or disjointed services. Outputs need to be demonstrably transferrable across the wider HSC and monitored to ensure the programmes continue to be a success following roll-out.

4.4 A new strategic approach to pharmaceutical innovation is proposed to support and drive continuous improvement through the development and implementation of best practice in medicines optimisation in Northern Ireland exploiting new funding opportunities whilst using existing funding streams and resources efficiently and following the core values and principles of Personal and Public Involvement (PPI).

4.5 This will require a dedicated oversight group to drive the development and implementation of evidence based best practice associated with each medicines quality standard.

4.6 The strategic approach has four components:

- a regional action plan for medicines optimisation;
- a medicines optimisation innovation centre;
- a medicines optimisation network; and
- a regional database to monitor improvement.

Regional Action Plan for Medicines Optimisation

4.7 The Regional Action Plan for medicines optimisation will prioritise activities in a regional change programme of research, service development and translation with clear outputs and timelines for developing, testing and implementing solutions.

4.8 Methodology to develop the plan will include:

- a baseline assessment of all activities underway or in development across the HSC relating to each quality standard;
- stratification of the activities to identify those capable of informing regional versus local best practice;
- agreement with commissioners of the priority and timescales related to the regional activities; and
- analysis of the regional activities to identify the different actions needed, timeframes and costs as follows:

Table 9: Regional Action Plan Analysis of Activities

Type of Activity	Action needed	Timeframe and costs
Activities involving best practices that are or have the potential to be regionally commissioned through existing services or contractual agreements and performance managed thereafter.	• Promote the best practice regionally to all relevant providers and set quality expectations • Amend contractual agreements and/or job descriptions of service providers to include responsibility for delivery • Manage performance	• Immediate to Short term. • No cost.

Type of Activity	Action needed	Timeframe and costs
Activities involving best practices that are available in some but not all areas regionally which need support to scale up and roll out.	• Develop a business case for scale up and roll out • Utilise change management principles to implement consistently across HSC • Amend contractual agreements and/or job descriptions to include responsibility for delivery • Manage performance	• Medium term • Costs associated with regional roll out
Activities addressing gaps in best practice which involve the development, feasibility testing and evaluation of new solutions.	• Agree a prioritised innovation programme of research and service development to develop and test new solutions • Engage the Medicines Optimisation Innovation Centre to manage the programme • Consider the evidence base and type of solution needed • Test and evaluate the solution within the HSC • Develop a business case for scale up and roll out • Utilise change management principles to implement consistently across HSC • Amend contractual agreements and/or job descriptions to include responsibility for delivery • Manage performance	• Longer term • Costs associated with R&D and pilots for service development.

4.9 Methodology to deliver the plan will include:

- an agreement across HSC organisations to adopt regional best practices;
- a system for the timely translation of best practice across the HSC including support for organisations and staff involved in change, utilising evidence based change methodology;
- a prioritised innovation programme of research and service development to develop and test new solutions;
- an agreed process for involving patients in research and service development in medicines optimisation;
- a training and development plan for staff involved in new medicines optimisation roles; and
- a financial plan outlining revenue and capital investment, invest to save approaches and the utilisation of HSC, UK and EU funding streams and resources to deliver the work plan objectives.

Medicines Optimisation and Innovation Centre

4.10 An element of the regional action plan will involve projects seeking new solutions, to address gaps in best practices for the quality standards, which are developed and tested within the HSC prior to commissioning for scale up and implementation regionally. These projects will be undertaken in collaboration with the Medicines Optimisation and Innovation Centre (MOIC).

4.11 The MOIC centre provides a locus for developing a systematic approach to finding and testing solutions for the HSC with the following functions.

- Project manage an innovation programme of research and service development projects.
- Develop, test and evaluate solutions to pre-commissioning stage.
- Support successful translation into HSC service delivery and commissioning.
- Help projects to access and utilise available funding streams.
- Provide a regional centre of expertise for research and service development in medicines optimisation and post-implementation review of service delivery.
- Build local expertise and competence in developing and translating research into practice.
- Facilitate a continuous cycle of improvement within the HSC in the area of medicines optimisation.

4.12 The centre also has wider benefits combining pharmaceutical and R&D skills with technology and business acumen to:

- provide evidence based solutions for medicines optimisation which could be developed commercially, marketed and sold to other countries with the HSC as a beneficiary;
- promote Northern Ireland as a leading area for medicines optimisation research and development and strengthen Northern Ireland's 4 star EU reference status bid;
- attract inward investment into a Northern Ireland Medicines Optimisation Innovation Fund/ Programme; and
- increase collaborative work with other established research networks in UK, Europe and internationally.

Medicines Optimisation Network

4.13 The work of the MOIC will lead to the development of a medicines optimisation network linking the HSC with other health and life science networks and innovation centres in Northern Ireland, UK and internationally. It will also support knowledge sharing both within the HSC and with wider networks and the development of collaborative working partnerships and joint working arrangements between participants that may include the following.

- Commissioning organisations (HSC Board, Trusts, PHA, BSO)
- Policy (DHSSPS)
- Patients and their representative bodies
- Independent contractors (GPs and community pharmacists)
- Independent Domiciliary Care Providers
- Academia (UU and QUB)
- Pharmaceutical and Technology Industries
- Voluntary sector
- Charities
- Expert(s) with research skills
- NIMDTA, NICPLD, NIPEC
- Other Innovation Centres and translational research groups
- Health and Social Care professionals
- Experts from across the UK and international

Regional Database to Monitor Improvement

4.14 To allow commissioners and policy leads to monitor progress and enable comparisons regionally and with other UK countries a new regional database is proposed. This will largely bring together existing data related to medicines use from different sources across the region to monitor trends, enable benchmarking and help drive quality improvements. It will also provide an understanding of how well patients are supported across the region to use their medicines safely and effectively to improve health outcomes. Outcome measurements include:

- patient/client satisfaction;
- medicines safety incident reporting;
- cost effective use of medicines;
- impact on acute health services; and
- achievement of expected therapeutic outcomes.

4.15 Methodology to develop a regional database to monitor improvements will include:

- agreement of core outcome measurements for medicines optimisation in Northern Ireland;
- alignment with a Medicines Optimisation dashboard based on NHS England's dashboard which was developed in collaboration with Clinical Commissioning Groups, Trusts and the pharmaceutical industry; and
- the inclusion of questions relating to patient's experience of medicines in relevant Northern Ireland Health Surveys.

4.16 Implementation of the Medicines Optimisation Quality Framework will be monitored by DHSSPS through existing arrangements for HSC commissioning plans.

4.17 The Medicines Optimisation Quality Framework will be reviewed in 2021.

SECTION 5

Summary of Recommendations

Table 10: Recommendations

1. A Regional Model for Medicines Optimisation should be introduced which outlines what patients can expect when medicines are included in their treatment as they access services in health and social care settings.

2. The model should be delivered by a multi-disciplinary medicines optimisation workforce trained and competent in medicines optimisation, with the involvement of pharmacists in all settings.

3. The medicines optimisation workforce should deliver regional services and roles which are commissioned and coordinated across all HSC organisations and related agencies involved in the prescribing, dispensing and administration of medicines.

4. The services and roles should aim to consistently deliver regional best practices in compliance with new Quality Standards for Medicines Optimisation.

5. Regional best practices should always be co-designed with patients, following the principles of Personal and Public Involvement (PPI).

6. An innovation and change programme should be implemented, linked to HSC commissioning plans, to support the development, testing and scaling up of technology and service solutions to deliver consistent best practices related to the Quality Standards.

7. Regional systems should be implemented supporting HSC connectivity, electronic transmission of prescriptions and access to the Electronic Care Record, prescribing support, Northern Ireland Formulary and enhanced data analysis.

8. Within the HSC a regional organisational infrastructure for medicines optimisation should be maintained that incorporates, the Medicines Governance Team, Pharmacy and Medicines Management Team, Regional Pharmaceutical Procurement Service, Medicines Information Service, Medicines Optimisation Innovation Centre (MOIC).

9. A new regional database for medicines optimisation should be developed to monitor progress and enable comparisons regionally and with other UK countries.

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ANNEX A

History of Medicines Management in Northern Ireland 2000 - 2014

1. Medicines are the most common medical intervention within our population and at any one time 70% of the population[85] is taking prescribed or over the counter medicines to treat or prevent ill-health.

2. From a financial aspect, HSC medicines expenditure equates to £550m/annum in Northern Ireland, representing 14% of the total HSC budget and is the second largest cost after salaries. This does not take into account private transactions.

3. Social deprivation is linked with health and social care needs and levels of need for medicines. In comparison with other UK countries the volume and cost of medicines used per head of population in Northern Ireland is historically high, as detailed in Figures 3 and 4 and Table 11.

Number of items prescribed per head of population in the UK from 2007-2013

Figure 3: Source – NI Audit Office Primary Care Prescribing Report 2014

85 Office of National Statistics Health Statistics 1997.

Prescribing cost per head of population

Figure 4: Source – NI Audit Office Primary Care Prescribing Report 2014

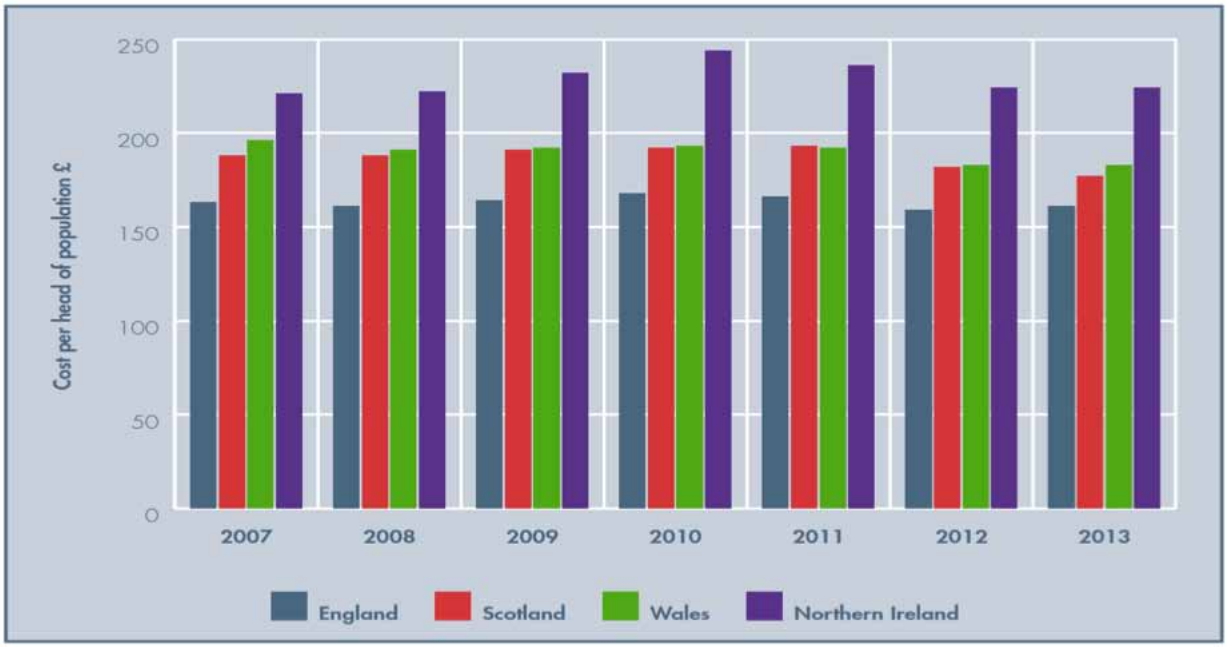

Table 11: Source - Business Services Organisation – Prescription Cost Analysis Reports

		2007	2010	2013
	NI	£221.09	£243.94	£223.54
	England	£162.95	£167.82	£160.12
	Scotland	£187.92	£192.25	£183.73
	Wales	£196.37	£193.05	£182.96

4. The 2014 NI Audit Office Primary Care Prescribing Report[86] highlighted that the volume of items prescribed per head of population per annum has been higher in Northern Ireland than in England and Scotland from 2007 and primary care prescribing costs have been consistently the highest here compared with the other regions in the UK from 2007 to 2013. However, it should be noted that the analysis does not consider the differences in data definitions and prescribing arrangements between the four countries so care is required on interpretation.

86 http://www.niauditoffice.gov.uk/primary_care_prescribing-2.pdf

5. High prescribing costs were first highlighted in 2000 when the limited outcome of the Comprehensive Spending Review required the Department to review spend against all budget areas, including the medicines budget.

6. In response, the Department established a Pharmaceutical Services Improvement Plan (PSIP) which for the first time considered a whole system approach encompassing both primary and secondary care.

7. This work identified and challenged all parts of the medicines journey from procurement through to prescribing, supply and utilisation introducing the concept of "Medicines Management"[87] [88] to HSC practice.

8. Professor John Appleby's Review in 2005 helped inform the next phase of PSIP. The report highlighted the need for new mechanisms to tackle high prescribing costs and to encourage greater use of generic drugs[89].

9. In response the existing PSIP programme was augmented with a new Pharmaceutical Clinical Effectiveness (PCE) Programme comprising a number of initiatives designed to work together to optimise medicines management which delivered savings across the HSC during the period from 2005/06 to 2007/08. Savings of £54m were made against a community drugs budget of approximately £387m. Re-engineering of pharmacy services in secondary care demonstrated savings as described in paragraph 16.

10. The PCE programme was extended into the 2008/09 - 2010/11 period and several new initiatives were added to provide a regional focus to medicines management establishing an infrastructure within the HSC through operational models, systems and policies to deliver:
    a. clinical and cost effective procurement;
    b. clinical and cost effective prescribing;
    c. behavioural change by engaging healthcare professionals in decision making;
    d. Integrated Medicines Management within the HSC; and
    e. extension of the secondary care medicines governance team which was established in 2002 to primary care.

87 Medicines management has been defined as "encompassing the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care.

88 Audit Commission (2001) A Spoonful of Sugar – Medicines Management in NHS Hospitals.

89 https://www.dhsspsni.gov.uk/publications/appleby-report

11. In the 2014 NI Audit Office Primary Care Prescribing Report it was noted that in the three year period following the introduction of PCE significant efficiencies had been made and the rate of growth in expenditure on drugs was reduced to less than 5 per cent per annum.

12. Responsibility for the prescribing budget was transferred from DHSSPS to the HSC Board in July 2010 and an annual PCE programme was established which continues today[90].

13. In the four year period from 2010/11 to 2013/14 the PCE programme has delivered a total of £132.2m against a target of £122m, an overachievement of approximately £10m.

14. Although the prescribing budget transferred to the HSC Board in 2010 the Department retained a role in pharmaceutical innovation, leading a regional 'Innovation in Medicines Management Programme' based on an 'invest to save' ethos which continues today. The Innovation Programme has overseen a range of medicines optimisation projects within the HSC including the development of the Northern Ireland Medicines Formulary.

15. The PCE and Innovation programmes have resulted in a range of best practices for medicines management as listed in Table 12, many of which are now embedded within HSC systems, services and patient pathways whilst others are suitable for regional roll out.

90 HSC Board's Pharmaceutical Clinical Effectiveness Programme 2014/15 http://www.hscboard.hscni.net/medicinesmanagement/NMP%20-%20Pharmacist%20Prescribing/03%20Pharmaceutical%20Clinical%20Effectiveness%202014-15.pdf

Table 12: Examples of regional best practice in medicines management

Procurement	The rational selection and therapeutic tendering of medicines, in secondary care, in line with NICE guidance and emerging evidence using the Safe and Therapeutic Evaluation of Pharmaceutical Product Selection (STEPSelect)* model[91] [92]
Selection	Northern Ireland Medicines Formulary[93]*
Prescribing	Prescribing Policies • Generic medicines (Generics leaflet)* (Medicines unsuitable for Generic Prescribing)* • Identified therapeutic classes of medicines* (Anticoagulants) (Antipsychotics) (Controlled Drugs) (Diabetes) (Lithium) (Opioid Substance) • Specialist medicines (Interface Pharmacist Network Specialist Medicines, red/amber drugs)* (Trust interface arrangements for patients in the community, eg mental health) • NI Wound Care Formulary* • Prescribing guidance for safe and evidence based prescribing (NICE)[Y] • Antimicrobial guidelines[94] for primary care (Primary Care Management of Infection Guidelines)* and secondary care • Independent Pharmacist, Nurse and other Non-Medical Prescribers (DHSSPS Non-Medical Prescribing)*
Supply	• Extended supplies on hospital discharge (PCE Programme)* • Repeat Dispensing (Repeat Dispensing Guidance)* • Minor Ailments scheme (Minor Ailments)*

* regional initiatives

Y UK-wide guidance

91 Scott MG ,McElnay JC Janknegt R et al Safe Therapeutic Economic Pharmaceutical Selection (STEPSelect) :development .introduction and use in Northern Ireland European Journal of Hospital Pharmacy Practice 2010 ;16:81-3

92 Scott MG Pharmaceutical Clinical Effectiveness Programme (PCEP) –STEPSelect (Safe Therapeutic Economic Pharmaceutical Selection) British Journal of Pharmaceutical Procurement 2012; 3(1):23-6

93 The Formulary provides guidance on first and second line drug choices and covers the majority of prescribing choices and is focused on non-specialist prescribing choices in Northern Ireland. Whilst the Formulary will aim to standardise practice and ensure a level of consistency, it is recognised that individual patients may require medicines which lie outside such guidance.

94 Antimicrobial Guidelines for Primary Care can be accessed in digital format, including through smartphone apps and in secondary care settings, antimicrobial prescribing guidelines are accessible on Trusts' websites, and in some Trusts are also available to download as an app.

Adherence	• NI Single Assessment Tool* (NISAT) • Targeted Medicines Use Reviews (MURs) (Guidance for conducting Medicines Use Reviews)* • Managing Your Medicines Service (Managing Your Medicines)*
Safe transitions of care and Medicines Reconciliation	• The Integrated Medicines Management Service NI clinical pharmacy standards* • Regional Guidelines for the Supply of 'Take Home Medication' from Northern Ireland Emergency Departments* • Regional Guidelines for http://www.gain-ni.org/images/Uploads/Guidelines/Immediate-Discharge-secondary-into-primary.pdf*
Appropriate polypharmacy and optimal outcomes in the elderly	• Pharmaceutical Care Model for Older People within intermediate care, residential and nursing homes[95] [96] [a] • Consultant led Pharmacist clinical medication reviews in nursing homes[97] [a] • Application of PINCER[98] • Application of STOPP/START tool[99]
Governance	• Medicines Governance Networks in Primary and Secondary Care Medicines Governance*
Cost effectiveness	• Pharmaceutical Clinical Effectiveness (PCE) programme (PCE Programme)*
Medicines Information Services	• Regional Medicines and Poisons Information Service* http://www.belfasttrust.hscni.net/Pharmacy.htm

* regional initiatives

a Local Pilot

95 Darcy C, Miller R, Friel A, Scott M. Consultant pharmacist case management of elderly patients in intermediate care. British Geriatrics Society for better health in old age, Book of Abstracts, Spring Meeting 2014; p78 http://www.bgs.org.uk/pdf_cms/admin_archive/2014_spring_abstracts.pdf

96 Miller R, Darcy C, Friel A, Scott M, Toner S. The introduction of a new consultant pharmacist case management service on the care of elderly patients in the intermediate care setting. Int J of Phar Prac, 2014; 22 (Suppl 2): 106-107. Available at: http://onlinelibrary.wiley.com/doi/10.1111/ijpp.12146/pdf

97 McKee H A, Scott M G ,Cuthbertson J and Miller R. Do consultant led pharmacist medication reviews lead to improved prescribing? British Geriatrics Society Autumn Meeting 2014 Page 26 http://www.bgs.org.uk/pdf_cms/admin_archive/2014_autumn_abstracts.pdf

98 Avery et al: A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. Lancet 2012

99 Gallagher et al: STOPP (Screening Tool of Older Person's Prescriptions) and START (Screening Tool to Alert doctors to Right Treatment). Consensus validation. Int J Clin Pharmacol Ther. 2008 Feb; 46(2):72-83

Integrated Medicines Management Service (IMM)

16. One example of best practice is the Integrated Medicines Management Service (IMM) which has strategically re-engineered clinical pharmacy services in HSC Trusts. By targeting the work of pharmacists and pharmacy technicians on admission, during the patient's inpatient journey and at discharge, the service has demonstrated significant improvements in patient care validated by two randomised controlled trials. These included reduced length of stay, lower re-admission rates, reduced medication errors and increased medicines appropriateness and revealed that each £1 invested equated to £5-8 in non cash-releasing efficiencies[100] [101]. It was demonstrated that the IMM programme of care was transferable to routine hospital care in two hospital sites in NI supporting the case for roll out of IMM as routine clinical practice in all NI Trusts by 2008[102]. A more recent study which applied risk predictive algorithms to a sample of patients who received IMM throughout their hospital stay has shown a correlation between the number of ward-based clinical pharmacy services with a reduction in risk-adjusted mortality index (RAMI)[103] [104].

17. Many best practices work synergistically to drive whole system improvements in the use of medicines. For example, innovative methodology for medicines selection has resulted in prescribers within the HSC referring to a Northern Ireland Medicines Formulary. This along with a regional generic prescribing policy has helped support the effective utilisation of medicines resources in line with clinical guidance for the benefit of patients. Prescription data analysis relating to the period April-June 2013 shows a high level of prescribing compliance (83%) in primary care with Northern Ireland Formulary recommendations and a 68% generic dispensing rate. Generic prescribing policies are also in place in secondary care with generic supply from pharmacy, where appropriate.

18. In community pharmacy the MUR Service aims to improve patients' knowledge, adherence and use of medicines and vulnerable or at risk patients are further supported through the Managing Your Medicines service.

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100 Scullin et al. An Innovative approach to integrated medicines management. Journal of evaluation in clinical practice. Vol 13, issue 5. Oct 2007: 781-788.

101 Burnett et al. Effects of an integrated medicines management programme on medication appropriateness in hospitalised patients. American journal of health-system pharmacy. May 1 2009 vol 66, no.9: 854-859

102 Scullin C Hogg A Scott MG et al Integrated Medicines Management-can routine implementation improve quality? Journal of Clinical Evaluation 2012 ;18(4) :807-15

103 Feras et al. Enhanced clinical pharmacy service targeting tools: risk-predictive algorithms. Journal of Evaluation in Clinical Practice. Vol 21, issue 2. April 2015: 187-197

104 RAMI is a predictive tool which was developed to calculate the risk of death during inpatient stay based on a range of variables – age, gender, diagnosis-related group, diagnosis and specific co-morbidities within the population being investigated.

19. These are among the initiatives that helped Northern Ireland to be formally identified as a reference site within the European Innovation Partnership in Active and Healthy Aging (EIP-AHA) in April 2013 and awarded three stars for the level of innovation, scalability and outcomes demonstrated in medicines management[105]. This recognises Northern Ireland as one of the leading regions in Europe in addressing the health and social care needs of the older population through innovation in medicines management.

105 European Innovation Programme- https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/rs_catalogue.pdf

ANNEX B

Moving to Medicines Optimisation – The Challenges and Need for Change

1. It is clear that a significant amount of work has been undertaken to improve how medicines are managed within the HSC Service. However, Northern Ireland has the fastest growing population in the UK, a rising number of older people with increasing multi-morbidities and a health seeking culture in which people use more medicines with higher associated costs per head per annum than other UK countries. The Regulation and Quality Improvement Authority (RQIA) carried out a Review of Medicines Optimisation in Primary Care in 2015 and concluded that more work needs to be done to achieve optimal medicines optimisation processes, leading to better, measurable outcomes for patients. There are potentially significant challenges ahead which require a renewed focus on using medicines to gain the right outcomes for patients at the right cost for the HSC.

Increasing Need

2. Global innovation in medicines development and improved access to medicines with a good evidence base, for example NICE Guidance[106] have contributed to an increase in life expectancy helping people to stay healthy for longer and many previously debilitating or fatal conditions are now prevented or managed, often on a long term basis, through regular medicines use.

3. Medicines use increases with age and 45% of medicines prescribed in the UK are for older people aged over 65 years and 36% of people aged 75 years and over take four or more prescribed medicines[107].

4. Each year community pharmacies in Northern Ireland dispense in excess of 38 million prescription items, for medicines costing £375m. In addition, some £175m of medicines are dispensed in the hospital setting.

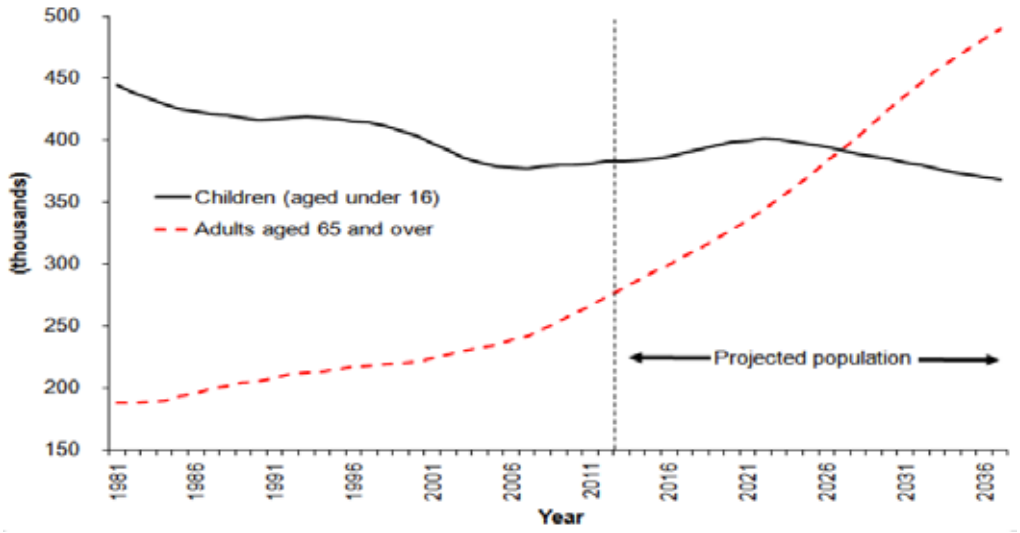
106 https://www.nice.org.uk/guidance

107 Department of Health (2001). Medicines and Older People. Implementing medicines-related aspects of the NSF for Older People. Department of Health. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008020

5. Within Northern Ireland the future need for medicines is expected to increase as the population ages and the prevalence of chronic disease increases. Northern Ireland has the fastest growing population in the UK. Currently there are approximately 1.8m people living in Northern Ireland, a figure which is expected to rise to 1.918m by 2022. In 2012, it was estimated that 15% of the population were aged 65 and over. This figure is expected to rise by 26% by 2022 and those aged 85 years and over will increase by 50%[108].

Children aged under 16 and adults aged 65 and over, actual and projected, 1981-2037 (non-zero y-axis)

Figure 5: Source – Northern Ireland Statistics and Research Agency, Statistical Report 2012



6. A report from Public Health Ireland predicts that between 2007 and 2020 the number of adults living with long term health conditions (LTC) in Northern Ireland will rise by 30%[109].

108 Northern Ireland Statistics and Research Agency, Statistical Report 2012 NISRA 2012 Based Population Projections

109 Institute of Public Health in Ireland, 2010 -"Making Chronic Conditions Count"

Table 13: Source – Institute of Public Health - "Making Chronic Conditions Count"

	2007		2015		2020	
	No.	% of population	No.	% of population	No.	% of population
Hypertension	395,529	28.7	448,011	30.3	481,867	31.7
CHD	75,158	5.4	87,848	5.9	97,255	6.4
Stroke	32,941	2.4	38,405	2.6	42,457	2.8
Diabetes (Type 1 & 2)	67,262	5.3	82,970	6.0	94,219	6.6

7. Low health literacy alongside cultural and structural factors have a significant influence on lifestyle decisions. These decisions such as unhealthy diets , smoking and harmful misuse of alcohol also contribute to the overall prevalence of disease in Northern Ireland. Rates of admission to hospital due to alcohol continue to rise year on year and national data indicates that around 70% of weekend emergency department attendances are alcohol-related[110]. From the Northern Ireland health survey 2014/15 - 60% of adults measured were either overweight or obese and 7% of children aged 2-15 years were assessed as being obese. Loss to the local economy as a result of obesity is estimated at £400 m, £100m of these costs being direct healthcare costs[111].

8. As well as the impact on prescribing budgets a rising need for medicines will place increased pressure on primary and secondary care services and community pharmacies. Increased use of medicines by a larger older population will also impact on social care services.

110 http://www.publichealth.hscni.net/sites/default/files/Drug%20and%20Alcohol%20Commissioning%20Framework%20Consultation%20Document.pdf

111 The Cost of Overweight and Obesity on the Island of Ireland – Safefood, November 2011)

Patient Engagement

9. In NI, the involvement of users and carers is a statutory duty for all those employed in statutory HSC organisations[112]. Donaldson highlighted that we are trailing behind with patients and families having a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world. It is crucial that Personal and Public Involvement (PPI) is supported by all involved in decisions at all levels of care; including at a strategic level and that the values that underpin all PPI work which include dignity and respect, inclusivity, equality and diversity, collaboration and partnership, transparency and openness are promoted. The value and importance of involving individuals in decisions about their care is recognised in the King's Fund paper[113] and in national guidance from NICE [NICE Clinical Guideline 76 which now overlaps with NICE Guideline NG5 Medicines optimisation] although full implementation of its recommendations will require change in existing service models. For example, consultations with patients may need to be longer to provide time to prescribers to listen to any concerns patients may have, provide better information about newly prescribed medicines empowering patients to make informed decisions, anticipated treatment outcomes and to consider patient choice, benefits and acceptability. Furthermore, sufficient time will be needed for regular medication and adherence reviews and patients taking multiple or high risk medicines will require regular scheduled specialist clinical reviews. Patients living with their health condition(s) are often 'experts by experience' and communication with patients about their experience helps inform decisions regarding their medication at review.

Non Adherence

10. The volume and costs of prescribed medicines are increasing but there is evidence that between a half and a third of medicines prescribed for long term conditions are not taken as recommended[114].

11. This is known as non-adherence and can involve people taking either more or less medicines than prescribed or not taking them at all. The factors which contribute to non-adherence fall into two overlapping categories.

    - **Intentional** where the individual decides not to follow the treatment recommendations perhaps because of concerns about the value or effectiveness of medicines, their side-effects, and the inconvenience of taking the drugs at the prescribed times and frequency. Also, patients with a mental health illness for example, schizophrenia, may have altered thinking and beliefs about medicines and their illness which may affect adherence.

112 www.publichealth.hscni.net/sites/default/files/PPI%20Strategy%20-%20March%202012_0.pdf

113 http://www.kingsfund.org.uk/sites/files/kf/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf

114 Horne R, Weinman J, Barber N, Elliott R, Morgan M. Concordance, adherence and compliance in medicine-taking. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D. 2005.

- **Unintentional** where the individual wants to follow the treatment recommendations but is prevented from doing so by practical barriers which include cognitive problems, poor organisational skills, polypharmacy and difficulty accessing medicines[115].

12. There are many layers to non-adherence and whatever the cause(s), non-adherence represents a health loss for the individual and an economic loss for society. Consequences include; reduced quality of life; deterioration of health; and unplanned admissions to hospital as people fail to gain the optimal outcomes from their medicines.

Generic Medicines

13. Government policy promotes the use of generic medicines, where appropriate. However, patients concerns regarding inconsistency in the medicines they are supplied with has been highlighted in the Patient Client Council Report 2011[116]. For example, variations in size, colour and shape of their medicines which are made by a range of manufacturers. This is particularly confusing for the elderly who may be on multiple medications leading to an inability to manage their medicines appropriately, risking their independence and impacting on the help they need from carers and families. Lack of support and unexplained changes to how a medication looks can result in patients not taking their medicines. Community pharmacists are well placed to provide advice if the presentation changes but all health and social care professionals and patients should be aware that the presentation of medicines can change and that there is a system to support patients when this occurs.

Medicines Related Harm

14. All medicines are associated with a level of risk and each year millions of people worldwide are hospitalised due to potentially avoidable, medicine-related factors. Medicines used in combination and patients with multiple co-morbidities who are taking multiple medicines are at increased risk. The constant repeating of medicines without regular medication reviews leaves patients susceptible to harm from medicines which they may not need to be taking. Additionally an individual's social circumstances can significantly affect the level of harm related to medicines use. On average, around 3-6% of hospital admissions are due to the adverse effects of medicines[117] [118] [119] and this can increase up to almost 30% in elderly

115 Steinman MA and Hanlon JT. Managing Medications in Clinically Complex Elders "There's Got to Be a Happy Medium". Journal of the American Medical Association. 2010; 304(14):1592-1601. doi: 10.1001/jama.2010.1482

116 http://www.patientclientcouncil.hscni.net/uploads/research/People%E2%80%99s_views_about_prescription_charging_and_products_available_on_prescription_-_June_2011.pdf

117 Lazarou J, Pomeranz BH, Corey PN. Incidence of adverse drug reactions in hospitalized patients: a meta-analysis of prospective studies. JAMA 1998; 279:1200-5.

118 Pirmohamed et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. BMJ 2004;329:15-9

119 Roughead EE. The nature and extent of drug-related hospitalisations in Australia. J Qual Clin Pract 1999;19:19-22

people who are taking more medicines and are more susceptible to their adverse effects[120]. In Northern Ireland, positive steps taken to reduce harm related to medicines include the work of multidisciplinary medicines governance committees in HSC Trusts, the implementation of National Patient Safety Agency (NPSA) alerts and the HSCB/PHA management of serious adverse incidents (SAIs) through the Quality, Safety and Experience (QSE) multidisciplinary group and the Safety, Quality and Alert Team (SQAT). More recently to improve safety, there has been a standardisation of adult medicines kardexes (process for prescribing and recording administration of medicines to patients in hospital).

15. UK evidence shows that one in 15 hospital admissions are medication related, with two-thirds of these being preventable[121]. Evidence also shows that some medicines are associated with a higher risk of harm than others with four groups of drugs accounting for 50% of preventable drug related admissions to hospital[122]. A review carried out of medication incidents reported to the National Reporting and Learning System in England and Wales over a 6 year period showed that the top 5 medicines where the clinical outcome was death or severe harm were opioids, antibiotics, warfarin, low molecular weight heparins and insulin[123]. In Northern Ireland, examples of high risk medicines are available on a poster for GPs and community pharmacies however there is no agreed system for highlighting high risk and specialist medicines on patient records and ECR.

16. Another cause of harm is medication errors which can occur at any stage of the medicines process from prescription, to dispensing to the patient taking the medication. A report for the General Medical Council in 2012 investigating the prevalence of prescribing errors in general practice found that one in 20 prescriptions contained an error with a higher prevalence associated with prescriptions for the elderly and those taking 10 or more medications[124]. Prescribing errors in hospital in-patients are a common occurrence affecting 7% of medication orders, 2% of patient days and 50% of hospital admissions[125]. The NPSA estimated that medication errors in 2007 cost £770m due to the cost of admissions for adverse drug reactions and the cost of harm due to medicines during inpatient stay[126].

120 Chan M, Nicklason F, Vial JH. Adverse drug events as a cause of hospital admission in the elderly.Intern Med J 200; May-Jun;31(4):199-205

121 Garfield S, Barber N, Walley P, Willson A, Eliasson L. Quality of medication use in primary care--mapping the problem, working to a solution: a systematic review of the literature. BMC Medicine 2009; 7:50.

122 Which drugs cause preventable admissions to hospital? A systematic review. www.ncbi.nlm.nih.gov/pubmed/16803468

123 Cousins DH, Gerrett D, Warner B. A review of medication incidents reported to the National Reporting and Learning System in England and Wales over 6 years. Br J Clin Pharmacol; 2012 Oct;74(4):597-604

124 http://www.gmc-uk.org/Investigating_the_prevalence_and_causes_of_prescribing_errors_in_general_practice___The_PRACtICe_study_Reoprt_May_2012_48605085.pdf

125 Lewis PJ, Dornan T, Taylor D, Tully MP, Wass V, Ashcroft DM. Prevalence, incidence and nature of prescribing errors in hospital inpatients: a systematic review. Drug Saf 2009; 32(5):379-389.

126 NPSA safety in doses:medication safety incidents in the NHS 2007

17. When patients transfer between HSC settings there is a greater risk of medication error and evidence shows that 30% to 70% of patients have an error or unintentional change to their medicines when their care is transferred[127]. In a study carried out in Northern Ireland, it was shown that 33% of patients post discharge had medication related problems[128].

Polypharmacy

18. Polypharmacy, the concurrent use of multiple medications by one individual, is becoming increasingly common. UK data highlight that of those patients with two clinical conditions, 20.8% were receiving four to nine medicines, and 10.1% receiving ten or more medicines; in those patients with six or more co-morbidities, these values were 47.7% and 41.7 %, respectively, and increasing with age[129].

19. The 2013 Kings Fund report on Polypharmacy and Medicines Optimisation[130] proposes that polypharmacy can be classified as appropriate or problematic recognising that it has the potential to be beneficial for some patients, but also harmful if poorly managed. The value of a co-ordinated, multidisciplinary approach to managing polypharmacy has been recognised by other UK countries and the Scottish Government has issued specific guidance on polypharmacy in the elderly.[131]

20. Patients are finding it increasingly difficult to manage the volume of medicines they are prescribed. In particular, older people are most likely to be prescribed multiple medications for multi morbidities (different diseases) and polypharmacy is a growing challenge for individuals, carers and social care workers trying to manage complicated medicines regimens at home. Multi-compartment compliance aids/Monitored dosage systems (MDS) are often used to support patients to manage their medicines and are currently perceived as the only solution for the elderly and those with dementia in particular. However, there are many other ways in which patients can be helped to take their medicines safely, or carers supported to administer medicines correctly, and alternative interventions should be considered as outlined in the Royal Pharmaceutical Society guidance, The Better Use of Multi-compartment Compliance Aids[132].

21. Polypharmacy is also a challenge for prescribers. Prescribing is largely based on single disease evidence-based guidance which does not generally take account of multi-morbidity, now the

127 Campbell et al. A systematic review of the effectiveness and cost-effectiveness of interventions aimed at preventing medication error (medicines reconciliation) at hospital admission. The University of Sheffield, School of Health and Related Research (ScHARR), Sep 2007

128 Brookes K Scott MG McConnell JB The benefits of a hospital based community liaison pharmacist. Pharmacy World and Science 2000; 22(2): 33-8

129 Payne RA, et al. Prevalence of polypharmacy in a Scottish primary care population. Eur J Clin Pharm 2014; in press.

130 The Kings Fund 2013 Polypharmacy and Medicines Optimisation - Making it Safe and Sound

131 Scottish Government 'Polypharmacy Guidance' October 2012

132 http://www.rpharms.com/support-pdfs/rps-mca-july-2013.pdf

norm in those over 65 years[133]. Also, prescribing decisions may be made by different medical and non-medical prescribers involved in the individual's care resulting in combinations of medicines which may not work effectively together and increase the risks of medicines related harm. Deprescribing i.e. the process of tapering, reducing or stopping medication which may be causing harm, may no longer be providing benefit or may be considered inappropriate should be a planned process for patients on multiple medications. There are barriers to deprescribing so guidance and the use of tools such as STOPP/START could help facilitate the process.

Specific Patient Groups

22. Difficulties arise across interfaces when specific patients for example mental health patients who live in the community require secondary care services. The primary/secondary care interface and responsibilities of the various professionals can make it difficult for patients to receive the medication they require. For patients with Parkinson's disease where it is crucial that they get the right medication at the right time, there is a clear need for a consistent service when they move across interfaces and between different healthcare professionals. Those with life-long conditions for example Inflammatory Bowel Disease which most commonly presents in patient's teenage years/early twenties need access to multidisciplinary teams working collaboratively with them and each other and is key to ensuring optimisation of their medicines.

23. Better knowledge and understanding of rare diseases among healthcare professionals is essential to ensure that patients receive a timely and accurate diagnosis. Delays in diagnosis of rare diseases can lead to patients not receiving timely and appropriate medication for their condition. Additionally, misdiagnoses can mean that patients may receive inappropriate treatment and lack of support. A multidisciplinary approach to accurate and safe care plans and shared decision making regarding treatment choices is necessary to delivering effective care to these patients.

133 Barnett K, Mercer SW, Norbury M et al. Epidemiology of multimorbidity and implications for healthcare, research, and medical education: a cross sectional study. The Lancet 2012:380:37-43

Access to Information

24. Access to good quality information about medicines is essential to enable optimal management of clinical conditions. However, there is a vast amount of information on the internet regarding medicines, some of which is reliable and relevant in the UK and some is not. There are some credible websites and proposed plans for the development of a patient portal on the NIDirect website to help direct patients to appropriate information about medicines and how to use this information are welcomed.

Over Use and Misuse of Medicines

25. Increased access to medicines via prescription, internet and over the counter sale introduces new risks. The New Strategic Direction for Alcohol and Drugs Phase 2 highlighted the emerging issue of the misuse of prescription drugs and over-the-counter drugs with benzodiazepines reported as one of the main drugs of misuse[134] in Northern Ireland. Although there has been some success in tackling benzodiazepine use, other challenges with regards to potential for abuse remain with commonly prescribed medicines including opiate painkillers and pregabalin.

26. A Scottish literature review explored the links between poverty, social exclusion and problematic drug use. It supported the view that the extent of drug problems is strongly associated with a range of social and economic inequalities and is complex[135]. A study which looked at the influence of socioeconomic deprivation on multimorbidity at different ages found that higher rates of drug misuse correlated with deprivation across all age groups, but particularly in those under 45 years of age[136].

27. Inappropriate and overuse of antimicrobial medicines is a particular concern and the consequences are that common infections will be harder to treat as the incidence of antimicrobial resistance and healthcare acquired infections increases presenting a major public health challenge[137]. Increasing healthcare professional, patient and public awareness and changing behaviour by applying behavioural science may help address this issue. A recent literature review and behavioural analysis carried out by the Department of Health and Public Health England proposes a range of behavioural science interventions that could be tested in practice[138].

134 DHSSPS (2011) New Strategic Direction for Alcohol and Drugs, Phase 2 2011-2016

135 Drugs and poverty:A literature review. Scottish drugs forum report, March 2007

136 McLean G et al. The influence of socioeconomic deprivation on multimorbidity at different ages: a cross-sectional study. Br J Gen Pract. Jul 2014; 64(624): e440-e447

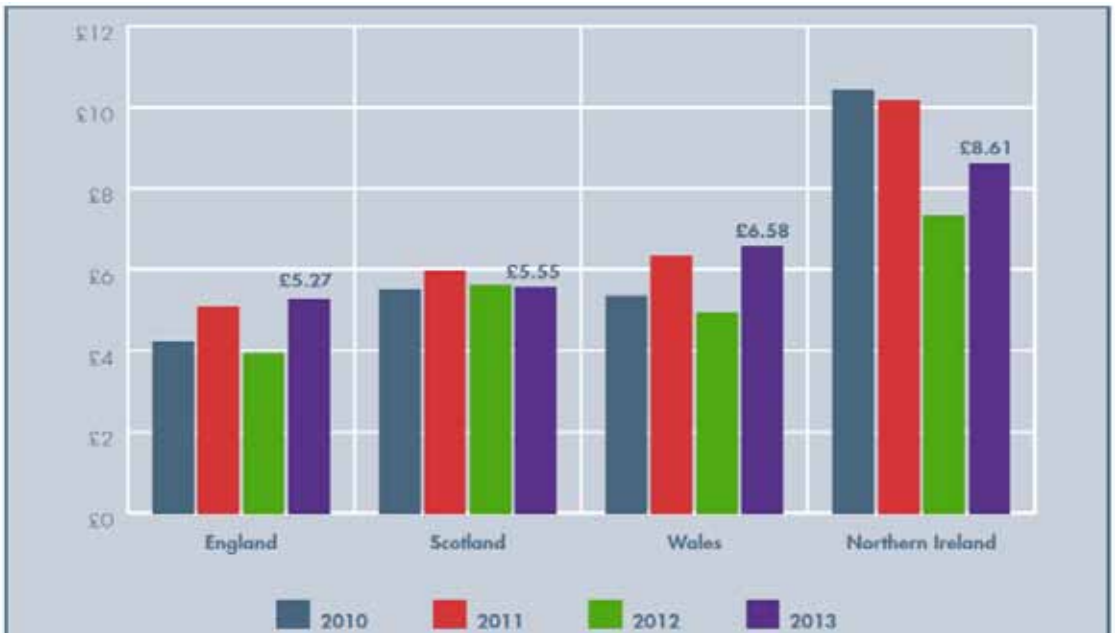
137 DHSSPS Strategy for tackling antimicrobial resistance (STAR) 2012-2017

138 Behaviour change and antibiotic prescribing in healthcare settings, literature review and behavioural analysis. February 2015 https://www.gov.uk/government/publications/antibiotic-prescribing-and-behaviour-change-in-healthcare-settings

28. Antidepressant use in Northern Ireland is high compared to other countries in Western Europe. In comparison to other countries in the UK, Northern Ireland had higher antidepressant costs per head of population from 2010 to 2013.

The cost of anti-depressant prescribing per head of population in the UK over the 4 year period to 2013

Figure 6: NI Audit Office Primary Care Prescribing Report 2014



29. Better access to services, for example counselling, stress and anxiety management is crucial if we are to see a reduction in the use of medicines to manage some mental health conditions. Choice and Medication[139] is a good example of where people can access information regarding alternatives to medicines and when necessary and appropriate, information regarding their medicines to manage their condition.

Waste

30. Wasted medicines are a significant problem in Northern Ireland with large quantities of unused medicines regularly returned to community pharmacies for safe disposal. These medicines are either ordered but no longer required or no longer prescribed for a particular condition. Returned medicines to community pharmacies cannot be re-used and are destroyed because their safety and effectiveness cannot be guaranteed. Not all unused medicines are returned

139 www.choiceandmedication.org/hscni/

to pharmacies and many are kept in patients' homes, sometimes well past their expiry date, or are incorrectly added to household waste. In hospital, medicines that are no longer required are returned to the hospital pharmacy for safe disposal or, where appropriate, recycled and reused to minimise waste. It is difficult to measure the exact value of medicines wasted. Based on research findings elsewhere in the UK the value of medicines wasted in Northern Ireland is estimated to be around £18m per annum[140] although as yet there is no way of accurately validating this figure.

Reform of Health and Social Care Services

31. Ongoing HSC reform supporting care closer to home will mean that in future more people will receive care at home rather than in residential care or hospital. For many people care at home will require support with managing and taking multiple medicines. This will require changing roles for social care workers and an increasing demand for pharmaceutical care in the community and primary care to support safe and effective medicines use[141].

32. As new services develop creating new interfaces for example acute care at home and rapid response respiratory services, issues of prescribing and supply need to be addressed. Drug specific shared care agreements are available already for specialist medicines through the 'Interface Pharmacist Network Specialist Medicines' but are not yet available for non specific prescribing and supply in such new settings.

33. Another issue is the increasing use of third party homecare services. A homecare service in this context is defined as the delivery of medicines and where necessary, associated care, which is initiated by the hospital prescriber, direct to the patient's home with their consent. This is a growing market and the volume and costs of medicines supplied through homecare services in Northern Ireland has increased from £6m in 2008 to almost £22m in 2014. Homecare services bring both benefits and risks for patients and new challenges for the provision of pharmaceutical care by HSC Trusts. A review of homecare medicines supply in England in 2011[142] included having stable contractual arrangements which would enable Trusts to adapt easily and safely to changes in homecare providers and through a quality framework have clear lines of responsibility for dispensing, delivery to patients and nursing care provision when required. Better use of technology could track expenditure and interface with electronic care

140 Evaluation of the Scale, Causes and Costs of Waste Medicines, University of London and York 2010

141 Pharmaceutical Care is defined as "A patient-centred practice in which the practitioner assumes responsibility for a patient's medicines-related needs and is held accountable for this commitment". Cipolle RJ, Strand LM, Morley PC. Pharmaceutical care practice: the clinicians guide. 2nd ed. New York:McGraw-Hill; 2004.

142 Homecare medicines – towards a vision for the future, DH 2011

records would allow information to be available in real time. Communication of the service to all healthcare professionals involved in a patient's care is essential. A regional assessment of the optimal approach to homecare medicines is needed to ensure quality, good governance, accountability and effective use of resources.

34. HSC reform will also support new integrated models of care as exemplified by Integrated Care Partnerships (ICPs). ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors, as well as service users and carers to design and coordinate local HSC services. These collaborative networks present new opportunities for the integration and co-ordination of care for frail older people and those with long term conditions. ICPs are tasked with focussing on four key aspects for delivery of integrated care; Risk Stratification, Information Sharing, Care Planning and Evaluation (RICE). All 17 ICPs in Northern Ireland are currently delivering person centred proactive care management for a risk stratified cohort of patients through collaborative multidisciplinary working. A more co-ordinated and person centred approach to medicines management has been an important aspect of this work. There are also a number of local ICP service improvements which involve improved integration of community pharmacy services as part of the care pathway. The structure of ICPs which has community pharmacists embedded at a local level to promote the development of collaborative relationships is an effective platform for the delivery of improved medicines management and associated patient outcomes.

35. More recently the Northern Ireland General Practice Committee (NIGPC) has developed a network of GP Federations with the vision of supporting primary care and working at the scale needed to realise the ambitions of Transforming Your Care.

36. In future, patients are likely to have a number of health and social care professionals involved in their overall care at the same time. This will include an increasing number of non-medical prescribers (DHSSPS non-medical prescribing) using existing skills and knowledge to ensure better patient access to advice about medicines, assessment of their condition and help patients receive appropriate medication without delay alongside helping reduce demand on GPs and medical staff in hospitals.

37. The Donaldson Report, Transforming Your Care, Living with Long Term Conditions Framework[143] and the RQIA Review of Medicines Optimisation in Primary Care all recognise the increased role that pharmacists (in particular community pharmacists) have to play in raising a patient's quality of care and improving their health outcomes. The Community Pharmacy Future Project[144] shows that patients derive considerable benefits in terms of health outcomes and quality of life when they receive additional support and advice from community pharmacists alongside the supply of their normal medication. The profession could be further utilised in this setting by using their clinical skills, working in partnership with patients and other health and social care professionals to contribute significantly to medicines optimisation.

38. A recent Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP)[145] Joint Statement supports the inclusion of practice based pharmacists within primary care teams to improve patient care. They state that there is considerable evidence to support the benefit of this role and the RPS and RCGP will work together to promote the uptake of practice based pharmacists.

39. As new models of care develop it will be necessary to establish a clear understanding of roles and responsibilities for medicines optimisation for health and social care professionals within the patient's care. This will require clarification of existing roles and the development of new roles within integrated secondary care, general practice and community pharmacy linking to social care supporting safe, appropriate and effective medicines use throughout the patient journey. This is a patient centred model in which multidisciplinary professionals will work collaboratively and share information to meet the needs of patients.

Variance

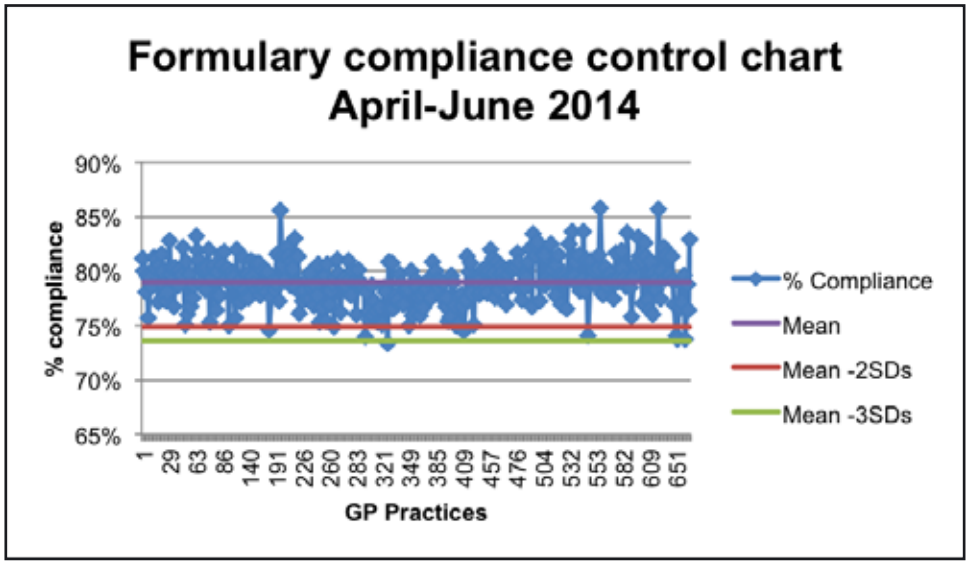
40. There is variation in how medicines are used and managed across the HSC. For example there are differences in; the uptake of NICE approved medicines and implementation of NICE guidance; delivery of the IMM Service and service provision across seven day working within HSC Trusts. The introduction of the Northern Ireland Formulary is supporting a reduction in variance in prescribing in general practice as demonstrated in Figure 7.

143 https://www.dhsspsni.gov.uk/publications/living-long-term-conditions-policy-framework

144 http://www.communitypharmacyfuture.org.uk/pages/sitesearch.cfm

145 http://www.rpharms.com/promoting-pharmacy-pdfs/rcgp-joint-statement-for-pharmacists-in-gp-surgeries-version-2.pdf

Figure 7: % compliance with the Northern Ireland Formulary, quarter 2, 2014



41. A King's Fund report in 2011 concluded that there are wide variations in the quality of care in general practice stating that the delivery of high-quality care requires effective team working for which the skill-mix needs to evolve, so that the GP should no longer be expected to operate as the sole reactive care giver, but should be empowered to take on a more expert advisory role, working closely with other professionals[146].

42. There is a growing awareness of the risks of variance in the quality of service delivery within the health service as exemplified by the Francis Report 2013 which emphasised the need to put patients first at all times and that they must be protected from avoidable harm and the Berwick Report 2013 which recommends 4 guiding principles for improving patient safety including:

- place the quality and safety of patient care above all other aims for the NHS;
- engage, empower and hear patients and carers throughout the entire system and at all times;
- foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work; and
- insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge.

146 Improving the quality of care in general practice. Report of an independent inquiry commissioned by the King's Fund, 2011. http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice

43. Whilst it is important that variance in practice is reduced where appropriate across the HSC advances in personalised or precision medicines will introduce an approach which is used for disease treatment and prevention that takes into account individual variability in genes, environment, and lifestyle for each person. As we move towards an era of personalised or precision medicine it is clear that more choice and variability will be required to select the most appropriate medicine for a specific patient.

Evidence Based Decision Making

44. Evidence-based medicine (EBM) is the cornerstone of modern medical practice. Defined as the conscientious, explicit, and judicious use of current best evidence, in combination with the physician's clinical expertise and the preferences of the patient in making decisions about the care of individual patients[147], EBM relates to all aspects of medical practice including the prescribing of medicines.

45. With over 13,000 medicines with Marketing Authorisations in the UK[148], prescribers need to be able to keep up to date with the evidence base in order to select the most appropriate, safe, clinically effective and cost effective medicines for their patients.

46. Scientific advances in drug development mean that the clinical use of medicines is becoming more complex and increasing sophistication inevitably leads to higher costs both for the medications themselves and for the clinical management process (e.g. increased monitoring).

47. Not only does this pose challenges in terms of resource implications but it requires increasing diligence as to the appropriateness of the introduction of new medicines. In Northern Ireland, systems exist through NICE (DHSSPS NICE guidance)[149] and the Scottish Medicines Consortium to adjudicate the utility of new medications allied to their provision within the NHS through managed entry arrangements (HSC Board Managed Entry).

48. There is already clear evidence of where the pressures are, for example in the areas of cancer, biologics and mental health and these will continue to be significantly resource intense areas. Similarly, the growth in long term preventative medicine e.g. use of statins and an escalating trend in treatments for lifestyle related disease such as anti-obesity medicines has major cost implications for the pharmacy elements of the health and care system.

147 Dawes M, Summerskill W, Glasziou P, et al. Second International Conference of Evidence-Based Health Care Teachers and Developers. Sicily statement on evidence-based practice. BMC Med Educ. 2005;5(1):1.

148 This figure includes different strengths of the same medicine and generics. Source – Medicines and Healthcare Products Regulatory Agency

149 https://www.dhsspsni.gov.uk/articles/nice-clinical-guidelines

49. In addition, the evidence base for medicines management practices will continue to expand in the coming years. For example, the NICE Guideline NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes was published in March 2015 and other NICE clinical guidelines and quality standards are under development relating to medicines optimisation, domiciliary care, managing medicines in care homes, older people with long term conditions and multi-morbidities.

50. These guidelines and standards are useful and will inform best practice in Northern Ireland but their timely implementation and consistent incorporation into existing services and roles will have to be monitored and managed.

Improvements in Communication, Technology, Data Management

51. The ECR and ongoing ICT development programme will facilitate better sharing of information between healthcare professionals and enable advances such as electronic prescribing. There needs to be 'one source of truth' regarding documentation of patient's medications which can be accessed by the patient and shared by all healthcare professionals. Patients' views need to be taken into consideration when decisions are being made regarding the level of clinical data being shared. The growing use of health analytics (which analyses large, complex data sets with sophisticated software) will help clinicians and managers to utilise various information sources to identify and target interactions of patients with the highest risk. This will further necessitate role clarification among health and social care professionals and standardised approaches to medicines management.

52. However, tracking activities in secondary care requires improvements in informatics and data management systems to provide the level of whole system monitoring of medicines use and service delivery needed to support improved quality and governance across the HSC and allow comparison with other UK countries.

53. Further advances in technology, robotics and tele-health will enable the automation of routine processes and self-monitoring by patients and allow health and social care professionals more time to focus on clinical care and optimising health outcomes. To maximise the benefit of these advances for patient outcomes their integration into patient care plans needs to be planned and managed.

Prevention and Alternatives to Medicines

54. This Framework deliberately focuses on improving the use of medicines. However, it is recognised that over time the aim of health policy is to reduce the population's need for medicines. Current Government strategies like Making Life Better[150] and Making it Better through Pharmacy in the Community[151] support this, encouraging people to be more aware of healthier lifestyle choices and supporting prevention through initiatives to help address the underlying causes of disease. In modern healthcare there is a heavy reliance on medicines and the system needs to change to adopt a more holistic approach where medicines are not seen as the only solution available. This issue is highlighted in the Patient and Client Council's Pain Report[152].

Summary

55. In summary, the future will bring new challenges as the number of older people rises, demand for medicines grows, advances in medicine, therapeutics and technology accelerate and the evidence base for decision making expands.

56. In this era of economic, demographic and technological challenge, optimal use of medicines will help secure better quality, patient outcomes and value from medicines.

150 Making Life Better 2013-2023 https://www.dhsspsni.gov.uk/articles/making-life-better-strategic-framework-public-health

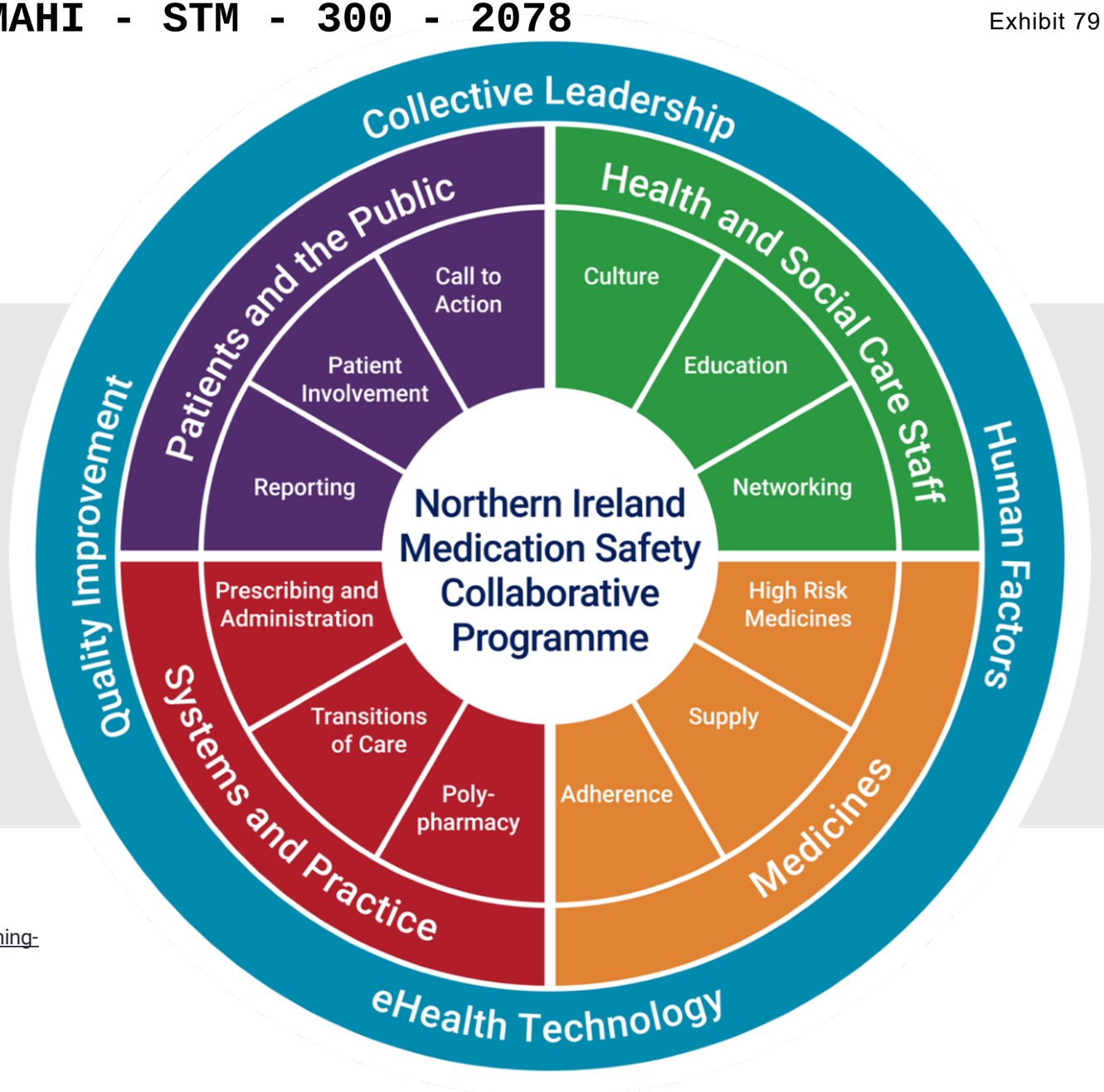
151 Making it Better through Pharmacy in the Community 2015-2019 https://www.dhsspsni.gov.uk/publications/making-it-better-through-pharmacy-community

152 http://www.patientclientcouncil.hscni.net/uploads/research/Pain_Report_-_Final_HARDCOPY_VERSION.pdf

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

Transforming medication safety in Northern Ireland

Aligning our medication safety priorities to the World Health Organization Third Global Patient Safety Challenge 'Medication Without Harm'



This document has been produced in an interactive electronic book format and therefore this downloadable PDF version will not contain the links to additional information. Access to it can be found at https://view.pagetiger.com/Transforming-medication-safety-in-Northern-Ireland

Foreword

Safety matters with medication. Medicines are the most commonly used medical intervention in Northern Ireland, and at any one time 70% of our people take prescribed or over the counter medicines to treat or prevent ill health.

In Northern Ireland, we are fortunate to benefit from effective systems for the safe prescribing, dispensing and administration that have developed over many years. Despite this, the prevalence and burden of medication harm remains too high, and avoidable harm related to medicines occurs too often.

We want medication safety to be a priority for everyone receiving and providing care within our health and social care service. The World Health Organization's (WHO) third Global Patient Safety Challenge 'Medication Without Harm' provides us with the opportunity to re-energise our approach to ensuring the safe use of medicines in Northern Ireland. Our response sets out what we commit to do over the next five years to improve safe practices with medicines and support a medication safety culture within our population. Our commitments have been informed and shaped by those who receive and deliver safe and effective care across Northern Ireland, and we thank all of you for your contributions.

Achieving the WHO target of reducing severe, avoidable medication-related harm by a further 50% over the next five years will be challenging. Our response seeks to harness the energy and impetus provided by the Challenge to tackle some of our known 'wicked problems' through strong collective leadership, increasing public engagement, and new approaches to delivering transformational change. In short, we seek to build a new social movement. Join us on this journey.

Our aim is to build on existing successes and to progress from 'a good position' to one that is 'great'.

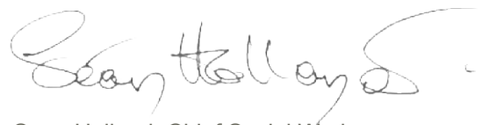
WHO Campaign video →

Dr Michael McBride, Chief Medical Officer

Cathy Harrison, Chief Pharmaceutical Officer

Charlotte McArdle, Chief Nursing Officer

Jenny Keane, Chief Allied Health Professions Officer



Sean Holland, Chief Social Worker

Simon Reid, Chief Dentall Officer

The Need for Safer Use of Medicines in Northern Ireland

Ensuring that medicines are used safely is challenging. The medicines use process is highly complex, with multiple steps involved: from the decision to initiate treatment to ordering, prescribing, dispensing, administration and monitoring.

Each step is associated with a potential risk of harm and our health service has good systems in place to identify and mitigate risk and ensure patient safety.

However 'to err is human', and both health care workers and patients will make mistakes, often as a result of poorly designed systems, tasks and processes. All medication errors are potentially avoidable and can therefore be greatly reduced or even prevented.

MAHI - STM - 300 - 2080

Every year in Northern Ireland it is estimated that...

11.7 Million
Medication errors occur

Acute Care	3.1 Million
Primary Care Includes Care Homes	8.6 Million

41.9 Million prescription items
are issued in primary care

- **1.7 Million** prescribing errors
- **1.4 Million** dispensing errors

4 in 10 adults are dispensed **5** or more prescription items

9 in 10 patients aged **75 and over** are dispensed **5** or more prescription items

800 non-elective hospital admissions are due to avoidable medication related adverse events

Avoidable medication errors:

- Cost the HSC **£1.9 Million**
- Consume **5,500 Bed Days**
- Cause **20 Deaths**
- Contribute to **54 Inpatient Deaths**

2.4 Million
Inpatient prescription items issued in secondary care

212,000
Prescribing errors in secondary care

14.2 Million
Doses of medication administered in secondary care

0 10 20

2.6 Million
Administration errors in secondary care

Four drug groups account for **more than half** of preventable drug-related hospital admissions:

- Antiplatelets
- Diuretics
- NSAIDs
- Anticoagulants

HOSPITAL

2,000 inpatients
experience an avoidable adverse event due to medications

What people said...

Half of people
prescribed medication felt fully involved in decisions about the best medication for them

9 in 10
inpatients understood instructions on how to take their medication

The methodology applied to calculate the prevalence and burden of medication errors in Northern Ireland was informed by the 2018 research study, Prevalence and Economic Burden of Medication Errors in The NHS in England. Rapid evidence synthesis and economic analysis of the prevalence and burden of medication error in the UK. Policy Research Unit in Economic Evaluation of Health and Care Interventions. Universities of Sheffield and York.

The 3rd WHO Global Patient Safety Challenge ‘Medication Without Harm’

Global Patient Safety Challenges focus on patient safety burdens that pose a significant risk to global health.

Previous Challenges ‘Clean Care is Safer Care’ and ‘Safe Surgery Saves Lives’ sought to gain a worldwide commitment to action to reduce health care associated infection and risk associated with surgery respectively, and have delivered real and lasting improvements thanks to strong and rapid commitment from governments, health system leaders, professionals and civic society.

Building on the success of previous Challenges, the WHO launched their third Global Patient Safety Challenge ‘Medication Without Harm’ in March 2017. The Challenge focuses on improving medication safety by strengthening the systems for reducing medication errors and avoidable medication related harm.

The goal of the third Global Patient Safety Challenge on Medication Safety is to gain worldwide commitment and action to reduce severe, avoidable medication-related harm by 50% in the next five years, specifically by addressing harm resulting from errors or unsafe practices due to weaknesses in health systems.

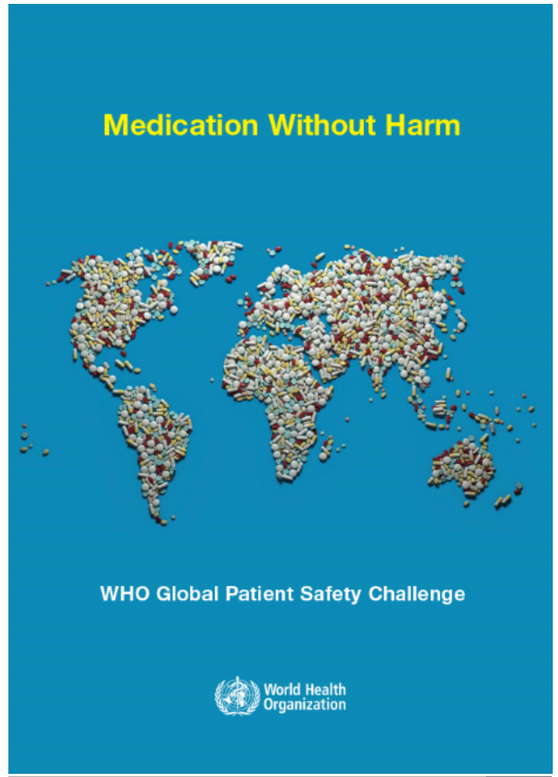
The requirements of the Challenge are for countries to:

1. Target three priority areas:

   - High-risk situations
   - Polypharmacy
   - Transitions of care

2. Design specific programmes of action for improving safety in each of four domains in which medications can cause inadvertent harm:

   - Health care professionals’ behaviour
   - Systems and practices of medication
   - Medicines
   - Patients and the public



WHO’s Global Patient Safety Challenge: Medication Without Harm brochures →

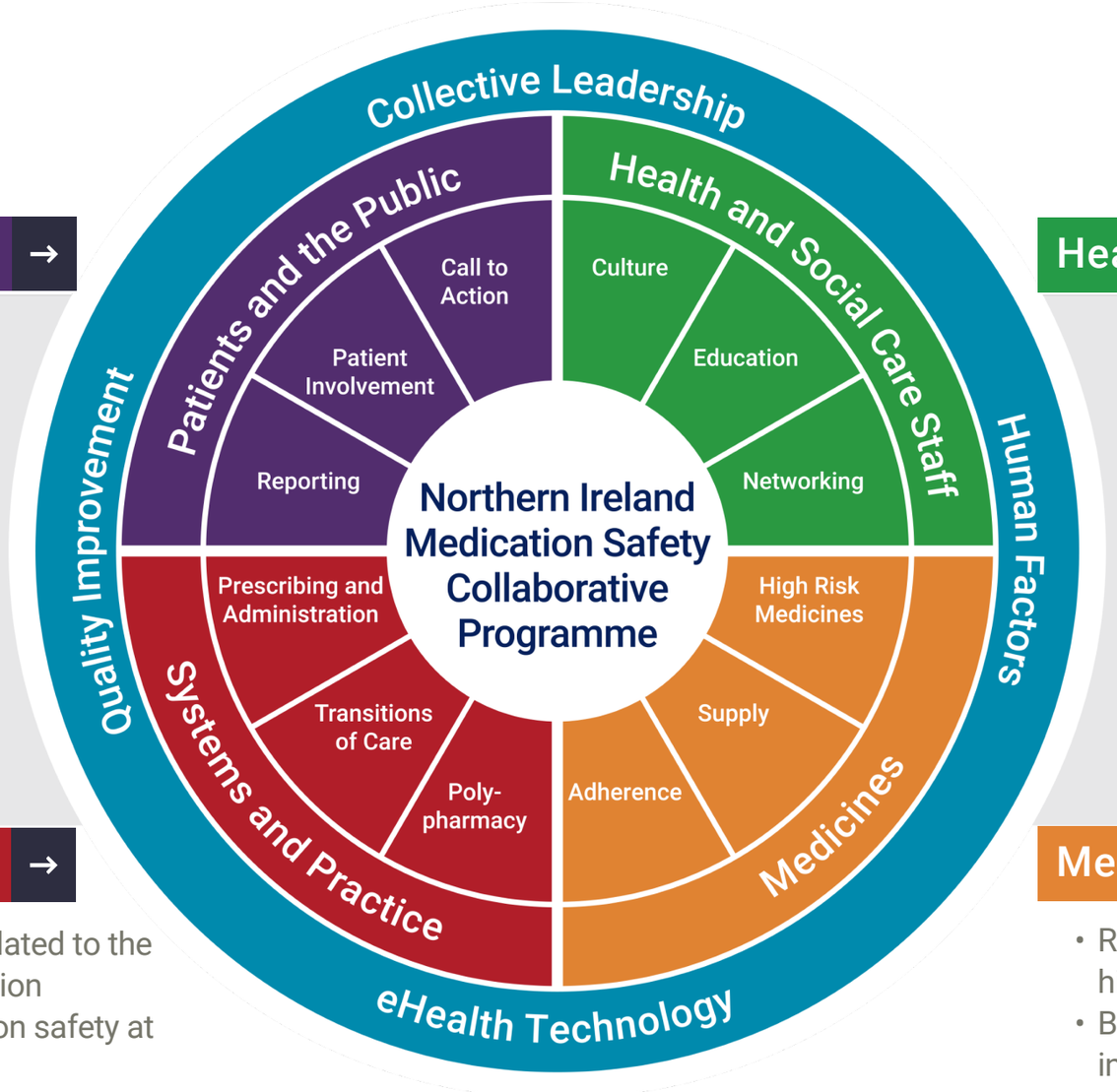
The Northern Ireland Response to the WHO Challenge 'Medication Without Harm'

Patients and the Public →

- Increase public awareness of the importance of using medication safely
- Support people to be more involved in decisions about their medication
- Help patients to report issues and concerns about their medication

Systems and Practice →

- Introduce systems to help reduce harm related to the prescribing and administration of medication
- Introduce a standard system for medication safety at transitions of care
- Take action to ensure that patients are taking the right medication for optimal benefit



Health and Social Care Staff →

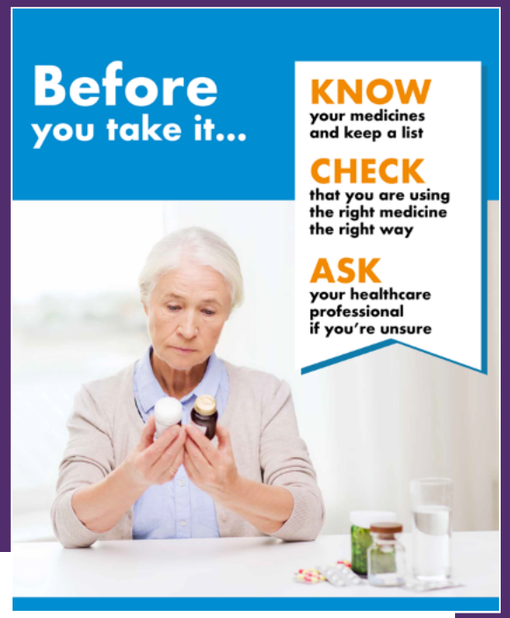
- Raise awareness among health and social care staff that medication safety is everyone's responsibility
- Ensure health and social care staff have the skills to be medication safety wise
- Facilitate new ways of connecting staff to share and spread best practice

Medicines →

- Reduce the burden of avoidable harm from high-risk medicines
- Build good practice in medication safety into the supply of all medicines
- Support improvements in adherence to medication

Patients and the Public

"Patients and the public are not always medication-wise. They are too often made to be passive recipients of medicines and not informed and empowered to play their part in making the process of medication safer." WHO



AIMS

1 Increase public awareness of the importance of using medication safely

What do we want to achieve?

We want people to take an active role in the management of their medication and move away from a passive culture where people do not feel able to ask questions of their health care professional and feel they must '*do as the doctor says*'.

This will require us to encourage and help people to be more curious about their medication. They should know what medication they are using and how to use it safely. People should feel able to ask their health care professionals questions about their medicines. Raising awareness that medication safety is important also empowers people to 'speak up' and prevent a potential medication error and harm from occurring.

Our commitments

We will deliver a public 'call to action' based on the WHO 'Know, Check, Ask' campaign. This campaign will be repeated annually to encourage a long term cultural change so that being *'medication safety wise'* becomes the social norm.

We will work with schools and education partners to help equip our children and young people with the knowledge and skills they need to be medication safety wise throughout life.

WHO Know, Check, Ask Campaign →

AIMS

2 Support people to be more involved in decisions about their medication

Our commitments

We will work with health and social care providers, patient groups, community and voluntary organisations to support patients, families or caregivers to use the WHO '5 Moments for Medication Safety' tool.

What do we want to achieve?

We want to help people to ask their health care professional questions about their medication, treatment and care plan. This will assist them to manage their medication safely and enable them to get the best intended outcomes.

The '5 Moments for Medication Safety' patient engagement tool provides patients, families or caregivers with information about what types of questions they can ask a health care professional.

The '5 Moments' are when medication is started, when they are taking it and when medications are; added, reviewed and stopped.

The tool aims to engage and empower patients to be involved in their own care and when decisions are made about their medicines. It can be used in collaboration with any health care professional during any of these 'moments', and helps patients to record valuable information that will support them to manage their medication safely.

MEDICATION WITHOUT HARM
Global Patient Safety Challenge

World Health Organization

5 Moments for Medication Safety

WHO '5 Moments' app →

Starting a medication

- What is the name of this medication and what is it for?
- What are the risks and possible side-effects?

Taking my medication

- When should I take this medication and how much should I take each time?
- What should I do if I have side-effects?

Adding a medication

- Do I really need any other medication?
- Can this medication interact with my other medications?

Reviewing my medication

- How long should I take each medication?
- Am I taking any medications I no longer need?

Stopping my medication

- When should I stop each medication?
- If I have to stop my medication due to an unwanted effect, where should I report this?

AIMS

3 Help patients to report issues and concerns about their medication

What do we want to achieve?

We want people to feel able and confident to report problems with their medication early and so help reduce avoidable harm.

Reporting problems that have occurred or had the potential to cause harm ('*near misses*') with medicines is essential for patient safety. It can help to identify previously unknown issues with the medication itself, and highlight potential areas for improvement in prescribing, dispensing and administration processes.

Reporting issues helps the health care system to better understand medication safety risks and to learn from mistakes by taking action that can help keep patients safe in future.

Our commitments

We will work with health and social care providers, patient groups, community and voluntary organisations to raise public awareness of the benefits of reporting medication issues, and support patients and carers to report any issues and concerns by addressing barriers to reporting.

Northern Ireland has the lowest rate of adverse drug reaction reporting by members of the public within the United Kingdom

Medicines and Healthcare products Regulatory Agency (MHRA)

Health and Social Care Staff

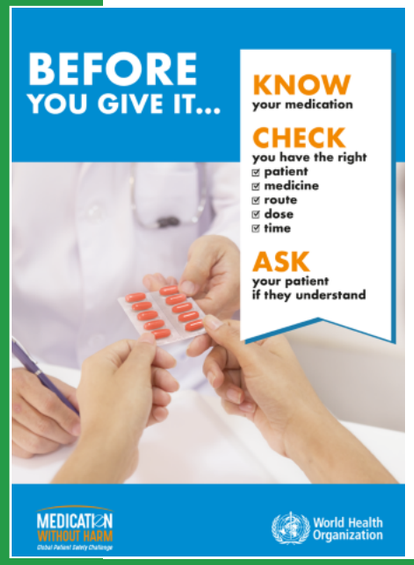
"Health care professionals sometimes prescribe and administer medicines in ways and circumstances that increase the risk of harm to patients."

WHO

AIMS

1

Raise awareness among health and social care staff that medication safety is everyone's responsibility



What do we want to achieve?

We want all health and social care staff to recognise their roles and responsibilities to ensure that medicines are used safely.

In addition to those that prescribe, administer or dispense medication, many other staff groups are directly or indirectly involved in the medication use process. This includes healthcare assistants, social and domiciliary care workers, porters and medical secretaries who interact directly with patients and their medication.

All of these staff need to be aware of their own responsibilities and that ensuring medication safety is part of their role. These responsibilities also include reporting and learning from incidents where harm has occurred or potential risks are identified, as well as *learning from excellence* and celebrating when things go right.

A culture of medication safety across health and social care is essential to ensuring patient safety.

Our commitments

We will involve our health and social care staff in the delivery of WHO's 'Know Check Ask' Campaign so that before a medication is prescribed, dispensed or administered by them they:

- **Know** 'the medication'

- Have **Checked** if they have the right patient, medicine, route, dose and time

- **Ask** the patient or carer if they understand.

We will encourage and support our health and social care staff to report and learn from medication related adverse effects and incidents, including 'near misses'.

We will work with the other UK countries to explore the development of a multi-disciplinary medication safety competency framework for health and social care staff to identify their medication safety learning and development needs for current and future roles.

WHO Know, Check, Ask Campaign →

AIMS

2 Ensure health and social care staff have the skills to be medication safety wise

What do we want to achieve?

We want health and social care staff that work together to learn together in a consistent way about medication safety and to develop self and situational awareness skills that will help them to navigate uncertain and complex scenarios.

Medication safety education is already incorporated within undergraduate and postgraduate training for medical, nursing and pharmacy professionals. Moving towards an integrated approach will better reflect how staff work together after qualification.

Education programmes will need to continually evolve to equip staff with the skills needed to respond to future technological advances that will change how medicines are managed.

Our commitments

We will work with universities, postgraduate training providers and professional bodies to incorporate the principles of the revised WHO Medication Safety Curriculum Guide and Human Factors training within multi-disciplinary medication safety programmes that are responsive to future needs.

AIMS

3 Facilitate new ways of connecting staff to share and spread best practice

What do we want to achieve?

We want to harness the energy and ideas of our health and social care staff and help them to come together to develop, test and implement solutions for known problems.

Nurturing a medication safety learning and improvement culture is essential for improvement, and is enabled by providing people with the opportunity to meet physically or virtually to share and learn together.

There are already many examples of initiatives and networks within the health and social care system that apply the '*all teach, all learn*' philosophy to support the safer use of medicines which could be further developed and spread to other areas via greater collaboration and engagement.

Our commitments

We will encourage networks that enable people to learn and work together to improve medication safety across the health and social care system, building upon existing communication platforms and structures.

We will hold an annual Northern Ireland medication safety conference that brings practitioners together to share best practice and learn from each other.

We will encourage health and social care staff to showcase examples of exemplar practice through participation in UK, ROI and international safety events.

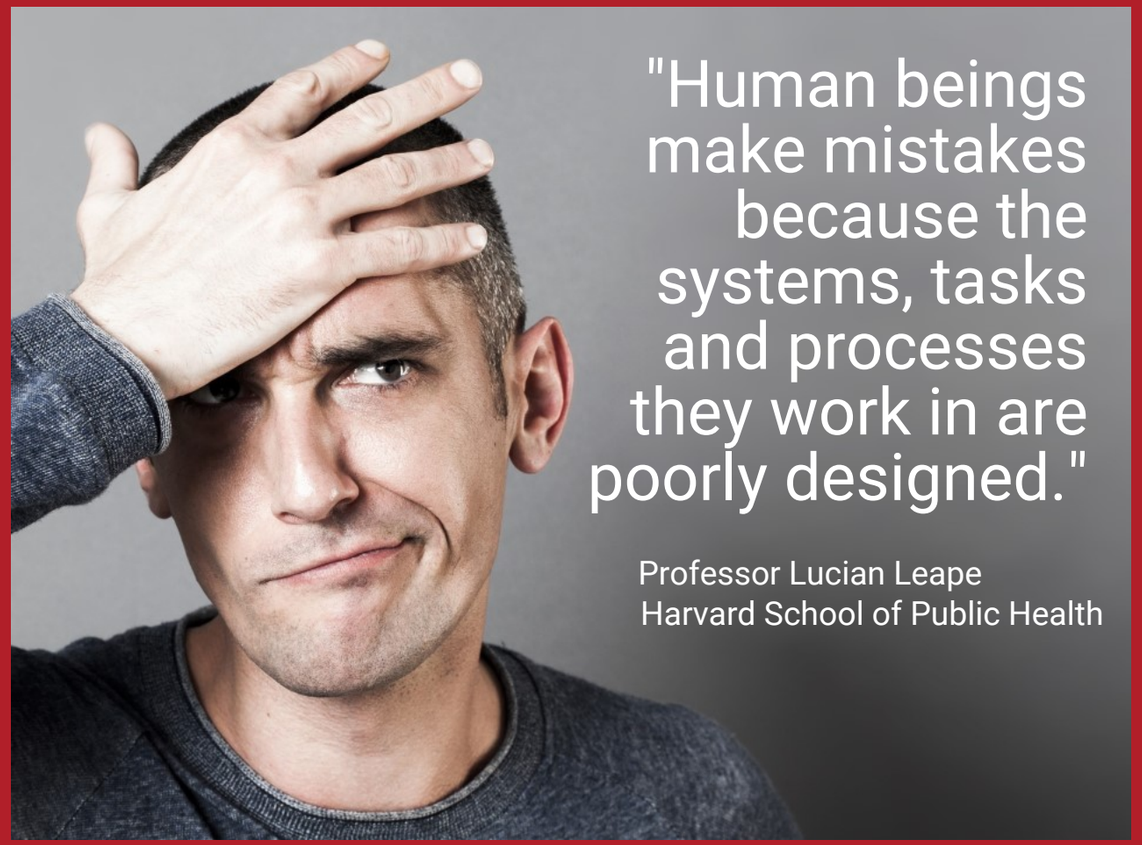
"Networks are primarily innovative creative places, they are useful for rapid learning and development and for amplifying members' effectiveness."

The Health Foundation

Systems and Practice

“Systems and practices of medication are complex and often dysfunctional, and can be made more resilient to risk and harm if they are well understood and designed.”

WHO



The Hierarchy of Intervention Effectiveness

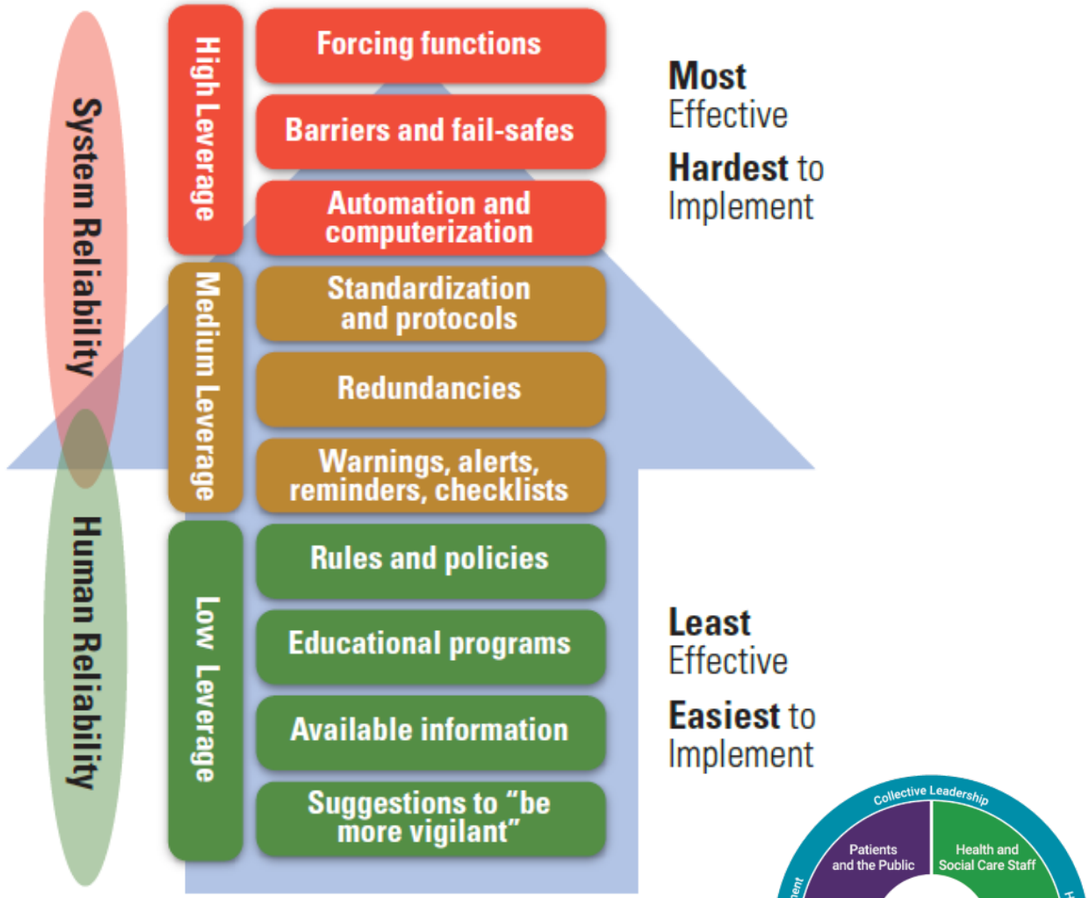


Image copyrighted to the Institute for Safe Medication Practices (ISMP)

AIMS

1

High Risk Situations

Introduce systems to help reduce harm related to the prescribing and administration of medication

What do we want to achieve?

We want to support safer prescribing and administration practices across the HSC to help staff to '*get it right first time'.*

We want to do this through standardisation of practice, improved access to protocols and guidelines, and better communication between teams.

Our commitments

We will support safer prescribing and administration of medication by introducing Electronic Prescribing and Medicines Administration (EPMA) and Closed Loop Medicines Administration (CLMA) systems in our hospitals, and prescribing decision support and risk identification systems in general practice.

We will undertake a targeted improvement programme to reduce the number of inappropriate omitted doses within our hospitals and care homes.

We will extend the standardisation of our secondary care prescription and administration documentation (Kardex) to our care home settings.

AIMS

2 Safer Transitions of Care

Introduce a standard system for medication safety at transitions of care

What do we want to achieve?

We want to adopt a co-ordinated approach across Northern Ireland that will help to ensure that medicines reconciliation is deliverable and sustainable for all patients.

Many prescribing incidents in Northern Ireland are attributable to systems failures during transitions of care in a complex health and social care system involving many different care providers.

Communication failures between providers can lead to unintended harm and unnecessary readmissions to hospital. This harm is largely preventable with effective and consistent medicines reconciliation.

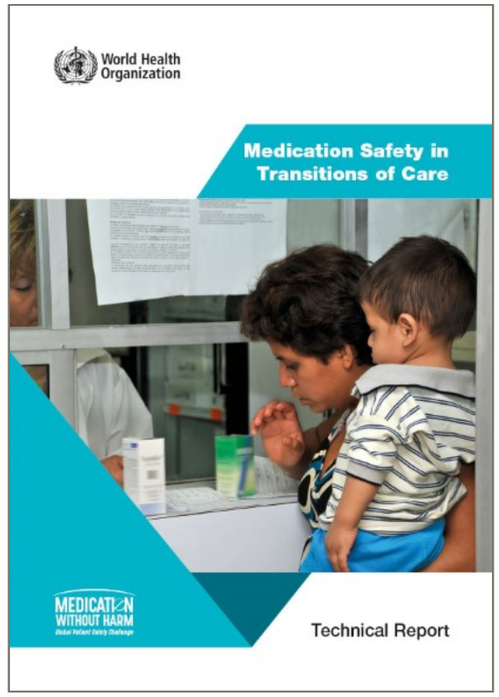
Northern Ireland has established systems that can deliver medicines reconciliation in primary and secondary care. The challenge is to ensure that we have a reliable system whereby every patient, every time, has their medication reconciled when transferring between care settings.

Our commitments

We will develop a co-ordinated Northern Ireland approach to ensure safer transitions of care between care providers, through the consistent delivery of medicines reconciliation that is aligned to the National Institute of Clinical Excellence recommendations.

"Meeting the complex challenge of reducing medication-related harm arising at transitions requires long-term leadership commitment, coordination and collaboration, formulation of goals and strategies and investment in resources."

WHO Technical Report Medication Safety in Transitions of Care



A Patient's Journey video →

Image reprinted from the World Health Organization's The High 5s project Implementation Guide. Assuring Medication Accuracy at Transitions in Care. Medicines Reconciliation.

AIMS

3

Polypharmacy

Take action to ensure that patients are taking the right medication for optimal benefit

What do we want to achieve?

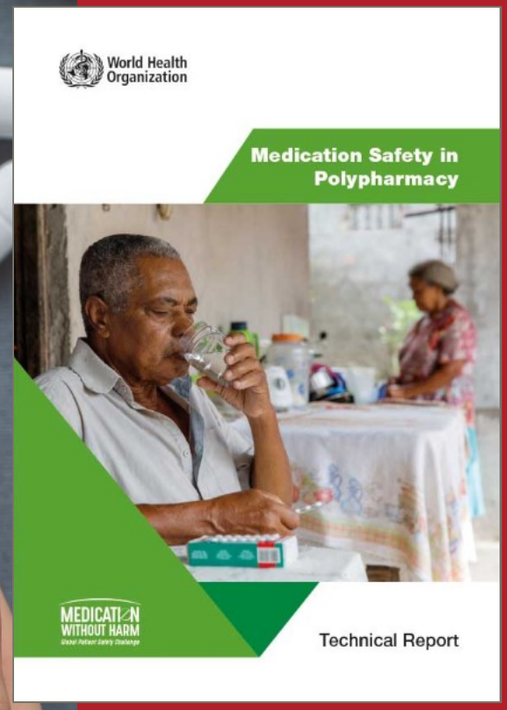
We want to build on our existing examples of best practice and reduce harm from inappropriate polypharmacy by adopting a robust and consistent approach to medication review across care settings.

The prevalence of polypharmacy in Northern Ireland continues to increase, with our ageing population suffering from increasing frailty and multiple long-term conditions. Polypharmacy can be appropriate, based on clinical evidence and patient characteristics, or inappropriate, due to the irrational prescribing of too many medicines.

Inappropriate polypharmacy can cause significant harm to patients from increased adverse effects, interactions between medicines, and medication errors, particularly at transitions of care.

Our commitments

We will work to reduce inappropriate polypharmacy by ensuring that all patients who are most at risk from harm receive at least an annual medication review.



32% of patients receiving 5 or more medicines have prescribing or monitoring errors. This increases to 47% in patients receiving 10 or more medicines.

11% of unplanned hospital admissions are attributable to harm from medicines, and over 70% of these being due to older people on multiple medicines.

"Ensuring medication safety in polypharmacy is one of the key challenges for medication safety today."

WHO

Medicines

“Medicines are sometimes complex and can be puzzling in their names, or packaging and sometimes lack sufficient or clear information. Confusing ‘look-alike sound-alike’ medicine names and / or labelling and packaging are frequent sources of error and medication-related harm that can be addressed.”

WHO

AIMS

1 Reduce the burden of avoidable harm from high-risk medicines

What do we want to achieve?

We want to ensure the safer use of medicines where published evidence and our incident reporting data shows are associated with a risk of significant harm if used incorrectly. Causes of error are frequently multifactorial and may involve a range of health and social care staff, patients and carers. They are complex to solve and require multiple approaches and innovative thinking to address inherent risks.

Our commitments

We will undertake a targeted improvement programme with the aim of reducing preventable harm associated with the following groups of high-risk medicines.

- Anticoagulants
- Insulin
- Opioids
- NSAIDs

HSC High Risk Medicines Poster →

AIMS

2 Build good practice in medication safety into the supply of all medicines

What do we want to achieve?

We want to enhance our medication supply processes to reduce the risk of preventable harm involving high risk medicines, look-alike sound-alike Medicines and omissions or delays relating to supply chain issues and shortages. Effective use of technology should be used to support safe supply of medication.

Patients and their carers should receive appropriate advice and support to help them gain the best outcomes from their treatment and avoid harm. Health and social care staff should provide patients with appropriate reassurance of continued efficacy after changes to brand or presentation of their medication.

Our commitments

We will develop strategies that will prevent incidents involving look-alike sound-alike medicines.

We will support better identification and management of medicines supply chain issues and shortages.

We will use risk stratification tools in primary and secondary care to ensure that patients taking high risk medicines receive the advice and support they need to reduce the risk of harm.

We will work with the MHRA and Pharmaceutical Industry to identify and manage existing and emerging medication risks.

We will work to introduce digital solutions including the electronic transfer of prescriptions in primary care.

MAHI - STM - 300 - 2095

3 Support improvements in adherence to medication

What do we want to achieve?

We want all of our health and social care staff to work with patients to reduce non-adherence to prescribed medication. Reasons for non-adherence may include an individual's own concerns and beliefs about their medication, low health literacy or physical, cognitive or visual barriers, and challenges accessing services. Supporting patients to take the right medicine at the right time is the final step in ensuring the safe use of medicines, and can prevent significant harm and sub-optimal clinical outcomes.

Northern Ireland has led the way in the development of many examples of best practice, such as the Medicines Optimisation in Older People (MOOP) model. We want to build on these successes so that people across Northern Ireland are supported at every contact with a health and social care provider to agree the best way for them to use their medicines in a safe and effective way.

Our commitments

We will develop, test and implement integrated models of care that support patients to take their medicines as recommended by their healthcare professional.

Ten days after starting a medicine, almost a third of patients are already non-adherent - of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent.

Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.

Delivering Our Commitments

Our commitments are ambitious, and are intended to reinvigorate our approach to medication safety while building on past successes. Successful implementation will require a whole system approach, which embraces multi-professional leadership and ownership across the HSC. A new approach is needed to support this, where:

- Collective leadership empowers people to lead in all areas at all levels, enabled to take responsibility for ensuring medicines are used safely.
- Our health and social care staff have the confidence and skills to deliver and lead quality improvement initiatives, and utilise Human Factors principles to improve patient safety.
- Transformation at scale and pace is facilitated by eHealth technologies, including digitalisation of our clinical processes.

These enablers will allow us to build on the collaborative approach utilised in the development of this response, and support the sustained, system-wide transformation that is required to meet the WHO goal of a 50% reduction in severe avoidable medication-related harm over the next five years.

To achieve this, our aim is that a Medicines Safety Collaborative for Northern Ireland will be established during 2020, jointly led by the HSC Board and the HSC Quality Improvement Hub. This will work with multi-disciplinary partners across the system to implement our commitments by fully utilising the expertise and experience of staff, including our HSC Medicines Governance Team and Medicines Optimisation Innovation Centre.

MOIC video →

HSCQI Inspire • Connect • Improve

HSC Health and Social Care Board

Medicines Governance Team

moic Medicines Optimisation Innovation Centre

HEALTH AND WELLBEING 2026

DELIVERING TOGETHER

12 Month Progress Report October 2017

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

SECTION 1: CONTEXT AND AMBITION

1. 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***[1]. *Delivering Together* was based on the report of the Expert Panel, led by Professor Rafael Bengoa, *Systems, not Structures: Changing Health and Social Care*[2] which was published on the same day.

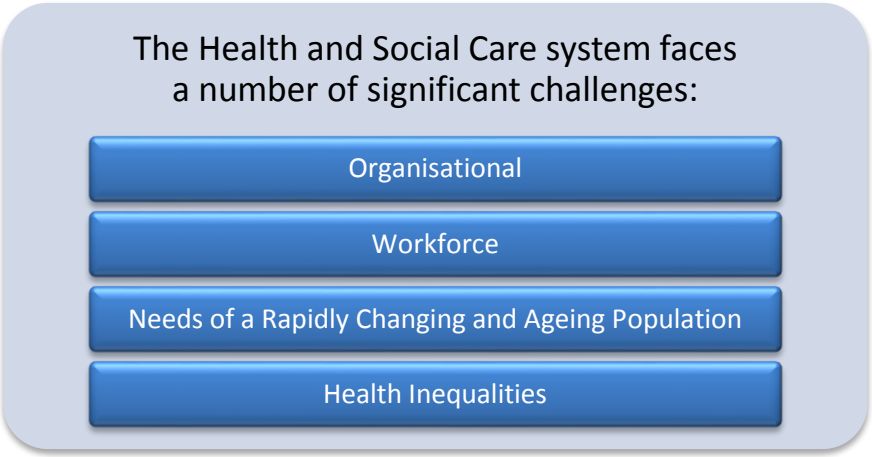
2. This vision for the future also drew on the findings of previously commissioned reports including *Transforming Your Care*[3] and Sir Liam Donaldson's report *The Right Time, The Right Place*[4]. The direction of travel in *Delivering Together* secured universal buy-in at political, system and service user level and is now the single roadmap for radical health and social care transformation.

3. It seeks to radically reform the way services are designed and delivered with a focus on person centred care rather than the current emphasis on buildings and structures. The aim of this report is to demonstrate the progress on the commitments in *Delivering Together* one year into the programme.

The Case for Change

4. *Delivering Together* set out a clear and unassailable case for change. The inability to meet the extraordinary demands and pressures created by an ageing population; the stark differential in health and social care outcomes between the most and least deprived areas; the current service delivery model being no longer fit for purpose and the challenges in attracting and retaining staff to prop up an outdated system means that transformation is not an option, it is an imperative.

[1] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[2] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report
[3] http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf
[4] https://www.health-ni.gov.uk/publications/right-time-right-place



5. It is clear that we have a 20th century model seeking to deliver services for a 21st century population and that the current delivery models continue to have an increasingly negative impact on the quality and experience of care, constraining the ability of Trusts and the wider system to transform itself.

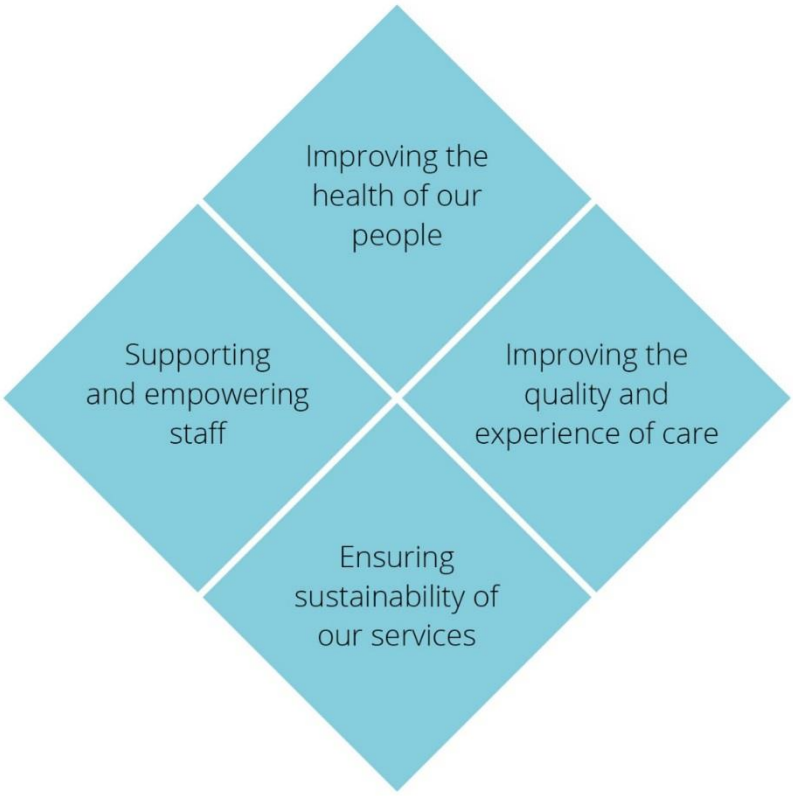
The Ambition

6. *Delivering Together* is driven by the Northern Ireland Executive's draft Programme for Government and sets out an ambition to support people to lead long, healthy and active lives.

7. The model of person-centred care in *Delivering Together* focusses on prevention, early intervention and supporting independence and wellbeing. This enables the emphasis of health and social care services to move from the treatment of periods of acute illness and reactive crisis approaches, towards a more holistic approach to health and social care where people are supported to stay healthy, well and safe in the first place.

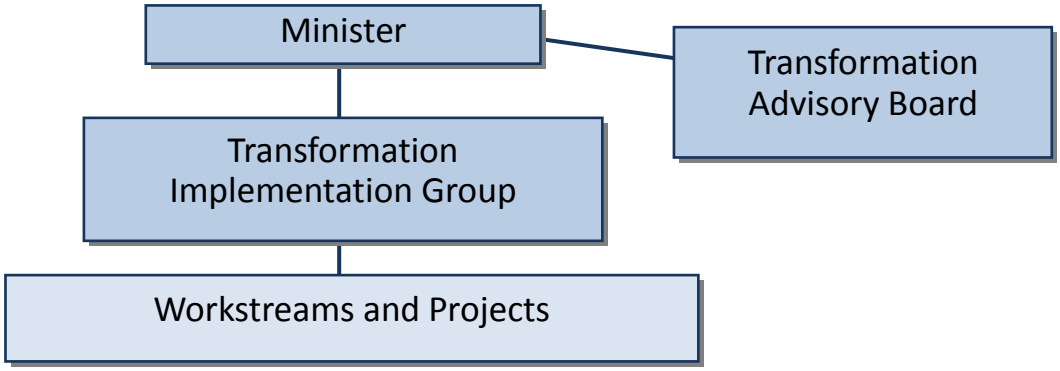
8. When care is needed, people will have access to safe, high quality care and are treated with dignity, respect and compassion. Staff will be empowered and supported to do what they do best while services will be efficient and sustainable for the future.

9. Underpinning this ambition are four key aims, namely:



SECTION 2: LEADING & GOVERNING THE CHANGE

10. The requirement for a transformation oversight structure with membership drawn from within and outwith the HSC was an explicit commitment of *Delivering Together.* In November 2016, a Transformation Implementation Group was established to provide leadership in driving forward transformation. A Transformation Advisory Board was also formed to provide strategic advice to the Minister on the direction of reform.



Transformation Advisory Board

11. The Transformation Advisory Board (TAB) is chaired by the Health Minister, and members include Professor Bengoa, Chair of the Expert Panel, along with trade union, service user and community and voluntary sector representatives, and the Permanent Secretary of the Department of Health. Full details of membership is included at Appendix 1.

12. The TAB met once in February 2017. Due to the current political position, no further meetings of the TAB have been possible, however senior Departmental Officials continue to engage with members.

Transformation Implementation Group

13. A Transformation Implementation Group (TIG) is chaired by the Permanent Secretary of the Department of Health and comprises senior leaders from the Department of Health, HSC and Trust Chief Executives, along with a consultant

surgeon and a General Practitioner. Since its establishment, this group has met fortnightly.

14. An opportunity is taken at the start of each TIG meeting to showcase a local project or innovative practice that is strategically aligned and underpins transformation across the HSC. To facilitate this, TIG meetings are held in different venues across the HSC. The notes and actions from TIG meetings are regularly published on the Department's website at: https://www.health-ni.gov.uk/publications/transformation-implementation-group-tig-meetings-notes-and-action-points

15. The TIG provides strategic leadership and oversight to the design, development and implementation of transformation, working across the traditional organisational boundaries to lead and manage the change agenda. Details of membership is included at Appendix 1.

16. TIG continues to draw on Professor Bengoa's extensive knowledge of health systems and health reform, along with his awareness of the specific challenges facing the health and social care system in Northern Ireland. Importantly, this also brings an element of continuity to the transformation process following the completion of the Expert Panel report.

Workstreams

17. In taking forward the changes, a number of priority actions have been initiated under the leadership of TIG. In some instances, workstreams were established and in others, work was already ongoing. Taking this work forward at an operational level draws largely on colleagues across the HSC, and indeed beyond, who bring skills, knowledge and experience from a wide range of backgrounds.

18. Partnership working and co-production remain key tenets of the way change is developed and implemented moving forward. The people who use services and those that deliver them need to be involved in the decisions that are made about the design of services.

19. The work undertaken so far has sought to adopt a more inclusive and transparent approach, as illustrated, for example, by the work to reshape stroke services and the design of a Community Development Framework.

20. Important activities which will enable and support transformation continue to happen outside of the formal programme arrangements, with staff in many different disciplines working together to come up with innovative practices and models of care that make a real difference to patients.

SECTION 3: PROGRESS AGAINST OUR AMBITIONS

21. To support people to lead long, healthy and active lives, the focus of health and social care services, and how and where those services are delivered, needs to change. This will be challenging, and will take sustained and incremental effort over the next ten years. This section sets out the progress made towards our stated aims.

22. *Delivering Together* also set out a range of priority actions for the initial 12 month period to make a positive and ambitious start towards the stabilisation, reconfiguration and transformation of the health and social care system. Appendix 2 provides an update on these actions.

23. Reforming a complex health and social care system does not happen overnight. Much of the work that has been undertaken so far is the kind of necessary preparatory and enabling work that is not immediately visible. It has been critically important to build these foundations and engage with the people who use services, and those who provide them, to ensure that the changes improve outcomes for the population, and are sustainable in the long term.

Changing our models of care

Building capacity in communities and in prevention

To reduce inequalities and ensure the next generation is healthy and well. This includes a focus on working with communities to support them to develop their strengths and use their assets to tackle the determinant of health and social wellbeing. Alongside this, link social care more strongly with improving and safeguarding the wellbeing of individuals, families and communities.

24. A workstream has been established to design and implement a **Community Development Framework,** to provide the community and voluntary sector with the tools, training, and standards it needs to help grow the sector to meet the future demands associated with transformed HSC services. In partnership with HSC staff, the voluntary and community sector, and service users, the workstream will finalise the framework early in 2018.

25. Through the implementation of the **Healthy Child, Healthy Future programme** parents are being supported to make healthy choices, which promotes the health and wellbeing of their children and families. Whilst progress has been made, due to workforce capacity issues the programme remains to be fully delivered.

26. The **Making Life Better programme** continues to set the strategic direction for improving population health and addressing inequalities in health. The emphasis has been on working collaboratively to address the factors that impact on health and wellbeing and health inequalities to create the conditions for individuals, families and communities to take greater control over their lives, and be enabled and supported to lead healthy lives. There is already a great deal of work underway, including the **Healthier Lives Programme** led by the Public Health Agency (PHA).

27. In relation to **Family Support Hubs,** progress has been made with building further connections to other Hub arrangements, and those involved believe there is increased likelihood of better outcomes for children and families. Subject to funding, the Hubs will be further enhanced and expanded.

28. A number of projects have been concluded within the **Early Intervention Transformation Programme,** and four new projects have been agreed. Work includes equipping parents with the skills to ensure children have the best start in life, supporting families earlier, and a focus on the development of the children's workforce, including teachers, social workers, doctors, nurses and police officers. A Gateway Review has commenced.

29. Considerable work continues on the development of the **Looked After Children Strategy**, and an implementation plan has been developed. A series of workshops are ongoing looking at issues relevant to looked after children, and a range of innovative proposals are being developed to meet the aims of the strategy. It is hoped the Looked After Children Strategy will go out to public consultation in the autumn of 2017. Alongside this, consultation on the **Adoption and Children Bill** has concluded and analysis is ongoing.

30. The implementation of the **Improving and Safeguarding Social Wellbeing Strategy** continues to make progress, with all five HSC Trusts having established a Local Engagement Partnership. A framework for social work/care and social wellbeing, co-produced with people who use services and social workers, has been developed and was launched at the Moving Forward Together Leadership Event in June 2017. A draft Evaluation Framework has been developed to measure the impact of strategy. In addition, an Innovation Overview Report highlighting the innovations funded between 2012 and 2016 has recently been published.

Enhancing support in primary care

Providing more support in primary care to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems. The future model of primary care will be based on multi-disciplinary teams embedded around general practice.

31. A workstream has been established to take forward the development and implementation of **multi-disciplinary teams in primary care**. Alongside the core membership of the workstream group – which includes a service user, a GP, Trust staff and professionals from the Health and Social Care Board (HSCB) and PHA – members of the group have been meeting with a wide range of partners. A service user reference group has also been established.

32. In its first phase of work, the group has been reviewing existing models of primary care multi-disciplinary working, from a range of countries and reviewing existing best practice here in Northern Ireland, including a workshop with a wide range of stakeholders. The group has also undertaken research to understand demand and pressures in GP and nursing services.

33. There has been close working with a number of other workstreams, for instance, to consider how primary care multi-disciplinary teams can link better with the community sector. Drawing on all this work, the group expect to have a draft set of principles to underpin a primary care multi-disciplinary model by the New Year, alongside a plan setting out the immediate next steps to start developing the model on the ground.

34. Alongside this work, by March 2017, named **District Nurses and Health Visitors for each GP practice** were in place, and there was an increase in the number of **GP training places** from 85 to 97, in August 2017.

35. Having a pharmacist as part of the primary care team improves the quality and safety of prescribing and supports value for money in medicines prescribing. It relieves work pressure on GPs, freeing up their time for patients with more complex medical needs. **Practice Based Pharmacists** (PBPs) started to take up post in September 2016, it was further expanded in January 2017, and

continues to grow. By August 2017, 296 (88%) of the GP practices in a GP Federation had access to a PBP, and it is expected this will increase to 100% by March 2018. By April 2021, nearly 300 PBPs are expected to be in place.

36. In line with the increasing focus on multi-disciplinary and inter-professional working set out in the draft HSC Workforce Strategy, two key programmes have commenced. In January 2017, the first cohort of **Physician Associate** students started a post-graduate programme with Ulster University, which will include placements in primary care.

37. The new **Advanced Nurse Practitioner** (ANP) programme (also with Ulster University) began in September 2017, and this includes a cohort for primary care who will be supported and facilitated in their clinical practice by the Down GP Federation. The development of the ANP role in primary care is being piloted as a potential nursing workforce solution to increase capacity in primary care services and support the GP workforce in delivering effective primary care services.

38. The development of a new framework for **Community Pharmacy** has begun, with a Memorandum of Understanding signed in January 2017, and the design of services and cost investigation completed by June 2017. Concluding this work is dependent on budget and consideration by an incoming Minister.

Reforming our community and hospital services

Reforming community and hospital services so that they are organised to provide care where and when it is needed. Within this, it is inevitable that the role of our hospitals will fundamentally change as they focus on delivering the highest quality of specialist and acute care.

39. A public consultation on the **Criteria for Reconfiguring Health and Social Care Services** was concluded in February 2017, and the report is awaiting consideration by an incoming Minister.

40. A workstream has been established to undertake **Service Reconfiguration Reviews**, and under this umbrella, significant progress has been made:

- **Elective Care Centres** – A clinically led group was established in March 2017 and has been working to collect and analyse evidence that will inform the development of elective care surgery centres. This group is due to deliver its report in autumn 2017.

- **Stroke** – The pre-consultation on the reshaping of stroke services concluded in September 2017. Working closely with *Chest, Heart & Stroke* and the *Stroke Association*, widespread engagement took place with stroke survivors, their families, carers, charities and other key stakeholders to listen to views, concerns and ideas on how to reshape stroke services. The findings will inform the design of a new model, and it is hoped this will be published for formal public consultation early in 2018.

- **Diabetes** – Progress has been made with the implementation of the Diabetes Strategic Framework, which was published in November 2016. NI Diabetes Network has since been established, and a number key workstreams are underway (including footcare pathway and structured diabetes education). Workplans for 2017/18 for these areas have been agreed and are currently being progressed.

- **Imaging** – Public consultation on a future model for Imaging commenced in October 2017. Preliminary work continues on the review's recommendations.

- **Paediatrics** – The paediatric strategies were published in November 2016, and a paediatric network has been initiated and is being led by the PHA. Planned completion for network design is January 2018.

- **Pathology** – Consultation on the proposals for the modernisation of pathology services was completed earlier in February 2017 and the HSCB is working with the Pathology Network to finalise the proposals.

- **Breast Assessment Services** – A review of Breast Assessment services is underway. Criteria for assessing service options for future service models of care have been proposed. A range of engagement activities have taken place including meetings with major cancer charities, surveys with 500 patients, public meetings and patient focus groups. The HSCB is currently working on final proposals for a new model of care.

- **Ambulance Services** – The report of the Demand and Capacity Review on Field Operations and Control Room Operations has been approved, and the NI Ambulance Services (NIAS) is currently developing an action plan for implementing the findings of the review.

41. The **Elective Care Plan**, to address the issue of long waiting lists, was published in February 2017. Work is ongoing to monitor progress. However, investment is required to take forward the commitments in the Plan.

42. Progress has been made across the region on the development of the **Acute Care at Home service** with patients receiving treatment at their own home as an alternative to an admission to hospital. These services are providing complex integrated care in peoples own homes, and depends on strong local joined up working across providers. As well as an expansion in geographical coverage, Acute or Enhanced care at home services have seen an increase in the number of referrals over the last year. This service will continue to be expanded over coming years.

43. In relation to the **Reform of Adult Social Care and Support**, an Expert Advisory Panel established to identify reform proposals has completed its work, which is to be considered by an incoming Minister, prior to publication and public consultation. As part of this work, the Panel engaged with carers and their representative organisations, and support for carers will continue to be a key focus of this reform agenda as this work moves forward. Work is underway to identify opportunities to continue engagement and to plan for the forthcoming consultation.

44. Achieving parity of esteem for mental health continues to be a priority, while investment is dependent on funding. In particular, work has progressed on establishing a **Regional Mental Trauma Service** to address the unmet mental health need of trauma associated with the legacy of the conflict in Northern Ireland. A Partnership Board and Implementation Group have been put in place to take forward this service, and recruitment of staff to manage trauma caseload across the Trusts is underway. A paper setting out the options for the future **development of perinatal services**, including proposals for a specialised Mother and Baby Unit, is ready for consideration by an incoming Minister.

Organising ourselves to deliver

Organising ourselves to ensure that the administrative and management structures make it easier for staff to look after the public, patients and clients. Embracing new models of care has the potential for harnessing the strengths of different parts of our systems, working and delivering together across traditional boundaries.

45. Within the broad framework defined by previous Ministers, including confirmation that the Health and Social Care Board will close, progress has been made in terms of developing future models for performance and financial management.

46. Proposals for the future role and function of the PHA have been developed and these are currently being considered. Work is now underway to identify the future operating model post closure of the HSCB, for consideration by an incoming Minister. It is critical that any changes permanent or transitional are made in the context of supporting new models of service delivery and the broader transformation agenda.

Enabling Sustainable Transformation

Partnership Working

The health and social care system belongs to all of us and everyone must be treated with respect, listened to and supported to work as real partners within the health and social care system, including the adoption of creative and innovative ways to **maximise partnership working and involvement**.

47. Partnership working is a key tenet of the way change is developed and implemented moving forward. A **Co-production Working Group,** led by the Chief Nursing Officer and involving people with a vast range of relevant experience, are developing a co-production guide to support partnership working across health and social care. This will be published in the coming months.

48. Work continues on the development and procurement of a **Real Time User Feedback System** which would be of benefit to all those who both use and deliver services, and training to support the continued rollout of the Q2020 Attributes Framework is ongoing.

Improving Quality and Safety

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

49. The initial design work for a **Regional Improvement System,** which will enable the health and social care system to take a strong position on quality improvement, was completed by February 2017. A regional workshop to further develop the model was held in June 2017 and a small number of significant areas of practice have been identified which would enable a test of scale and spread. These will be taken forward in Phase 1 (July 2017-March 2018).

Investing in our workforce

To ensure we have **the people and the skills needed** to support sustainable models of care, taking account of increasing demand, informed by robust information and analysis, and mapped to configuration of services and increased focus on primary care.

50. Work is well advanced on the development of a **Health and Social Care workforce strategy.** This will include areas such as retention and recruitment, opportunities for introducing new job roles and upskilling initiatives. It will also focus on ensuring that health and social care is a rewarding and fulfilling place to work and train.

51. Membership of the Workforce Strategy Steering Group, which is leading the development of the strategy, is wide ranging and includes Trusts, primary care, professionals and trade union side. This collaborative approach will be continued into the implementation of the strategy.

52. In line with the commitment to develop proposals through co-production, three initial 'engage' events were held in January 2017, with over 200 attending. This was followed by a programme of focus groups, open to all HSC workers. The draft Strategy is currently under consideration by the Transformation Implementation Group, in readiness for an incoming Minister.

53. In addition, **the Nursing and Midwifery Task Group,** was established in December 2016. It is chaired by Sir Richard Barnett, and as well as HSC representation, its membership includes the Royal College of Nursing, the Royal College of Midwifery and Ulster University. It aims to maximise the contributions of nursing and midwifery to improving outcomes for the population, and is conducting a series of workshops across NI to co-produce potential actions. It is due to report in March 2018.

Leadership and Culture

If we are to develop a culture of quality improvement and partnership working, it must be underpinned by a **new approach to collective and system leadership.** All those working in health and social care will feel able to effect change and improvement in care.

54. The HSC-wide Collective Leadership Strategy was launched in October 2017 setting out an approach for the creation of a culture of high quality, continually improving, compassionate care and support.

55. The development of the strategy embodied a partnership approach. The work was led by a core group with a wide membership, including HSC, DoH, Trade Union Side, a GP, a service user, and a representative from the voluntary and community sector, and there was engagement events with over 400 people from across different levels, professions and experiences.

56. The implementation and embedding of the strategy across the HSC system is now being mobilised.

eHealth and Care

Making better use of technology and data is essential if we are to move to a model focussed on service users, on improving the health and wellbeing of the population and getting beyond organisational and professional silos.

57. Work continues towards a **new patient portal,** which will allow people living with dementia and their carers to have secure on-line access to their own health and care information, with a delivery date now set for the summer of 2018.

58. There has been an increase in the number of community pharmacies with access to **Northern Ireland Electronic Care Record** (NIECR), with the rollout of this continuing to take place during 2017. A proposal for rollout of access to NIECR for all pharmacies is expected to be agreed by March 2018. Work is

ongoing to develop an optometry specific view within NIECR, and a pilot is expected to commence early in 2018.

59. The development of a more consolidated and common patient and user record remains a priority. The **Electronic Health Care Record (EHCR)** programme has been rebranded as the **Encompass Programme**. Evidence indicates that investment in a digital record-in-common will dramatically contribute to improving the health and wellbeing of the community including user experience, quality, safety and ultimately, health outcomes. An initial review of the Outline Business Case has been completed by both Department of Health and Department of Finance, and there continues to be significant engagement with HSC professionals on early design.

SECTION 4: LOOKING AHEAD

60. The new models of care will see citizens interact with the HSC system in a different way. This can only happen with the understanding, commitment and involvement of the population, which will require an ongoing and open public debate, and strong political leadership.

61. Whilst progress can continue to be made in bringing forward proposals for change, difficult decisions will be required, as set out by the Executive and the then Minister upon the launch of *Delivering Together*. The nature of these decisions and their impact on the population warrants Ministerial consideration.

62. The financial position remains challenging and this is not anticipated to change. The Executive agreed that transformation cannot happen without investment. It is inevitable that the pace of transformation will be impacted by the level of funding available.

63. Under the funding arrangement provided for by the confidence and supply agreement, £200m will be made available for transformation. A further £50m will be invested in mental health services over 5 years. It is important that this funding is invested in initiatives which will enable and deliver transformation, ensuring our models and systems are fit for the future, rather than addressing current pressures.

64. The pace and scale of change is dependent on a range of internal and external factors. The Transformation Implementation Group continues to plan, prioritise and sequence actions to ensure that momentum is maintained and impact is maximised.

APPENDIX 1

MEMBERS OF THE TRANSFORMATION ADVISORY BOARD:

- Minister of Health (Chair)
- Richard Pengelly (DoH Permanent Secretary and Chair of the Transformation Implementation Group)
- Rafael Bengoa (Chair of Expert Panel)
- Mairead McAlinden (Expert Panel member)
- Seamus McAleavey (Voluntary and Community sector representative)
- Brian O'Hagan (Co-chair of the regional PPI forum)
- Maria Somerville (Person with caring experience)
- John Patrick Clayton (Trade Union representative)

MEMBERS OF THE TRANSFORMATION IMPLEMENTATION GROUP:

- Richard Pengelly (Permanent Secretary, DoH; Chair)
- Deborah McNeilly (Deputy Secretary, DoH)
- Jackie Johnston (Acting Deputy Secretary, DoH)
- Michael McBride (Chief Medical Officer)
- Sean Holland (Chief Social Services Officer, DoH)
- Charlotte McArdle (Chief Nursing Officer, DoH)
- David Gordon (Director of Communications, DoH)
- Valerie Watts (Chief Executive, HSCB and Interim Chief Executive, PHA)
- Martin Dillon (Chief Executive, BHSCT)
- Tony Stevens (Chief Executive, NHSCT)
- Anne Kilgallen (Chief Executive, WHSCT)
- Francis Rice (Interim Chief Executive, SHSCT)
- Hugh McCaughey (Chief Executive, SEHSCT)
- Shane Devlin (Chief Executive, NIAS)
- Liam McIvor (Chief Executive, BSO)
- Alan Stout (General Practitioner)
- Mark Taylor (Consultant in General and Hepatobiliary Surgery, BHSCT)

APPENDIX 2

PERFORMANCE AGAINST DELIVERING TOGETHER ACTIONS

Key Deliverable		Target	Position
1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work the Health and Social Care Board, as well as the recommendations from the Expert Panel	January 2017	Elective Care Plan published February 2017
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by • increased GP training places; • continued investment in Practice Based Pharmacists; • ensuring every GP practice has a named District Nurse, Health Visitor and Social Worker to work with; • supporting the development of new roles such as Physician Associates and Advanced Nurse Practitioners; and • Further rollout of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies	March 2017	Research continues into potential models of multi-disciplinary teams in primary care with ongoing engagement with stakeholders. GP Training Places increased August 2017. 88% GP practices in a Federation had access to a Practice Based Pharmacist by August 2017, and investment and expansion continues. Named District Nurses and Health Visitors for each GP practice were in place March 2017. Work ongoing with regard to Social Workers. Physician Associates programme commenced January 2017; Advanced Nurse Practitioner programme commenced September 2017. The online triage system, AskMyGP, continued to be rolled out and piloted by 20 practices. Consultation proposals on GP Federations under development.
3	Bring forward proposals relating to the extension of placement options for **Looked After Children**.	October 2017	A series of alternative placement options for looked after children have been developed through co-production discussions, led by the

Key Deliverable		Target	Position
			HSCB and South Eastern HSC Trust. These are undergoing further testing with wide range of stakeholders and will thereafter be finalised for Ministerial consideration.
4	Following the completion and evaluation of a pilot project, roll out access to the electronic care record (NIECR) to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists**.	October 2017	There has been an increase in the number of community pharmacies with access to Northern Ireland Electronic Care Record (NIECR) and rollout continues. Work is ongoing to develop an optometry specific view within NIECR and pilot is expected to commence in first quarter of 2018.
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	November 2016	The development of a new framework has commenced. A Memorandum of Understanding was signed January 2017.
6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	November 2016	Consultation on criteria for service reconfiguration completed February 2017, and report drafted for consideration by incoming Minister. Programme of service reconfiguration reviews underway.
7	Following extensive review and engagement, launch a public consultation on proposals to modernise and transform **Pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future.	November 2016	Consultation on the proposals was completed in February 2017 and the Health and Social Care Board (HSCB) is working with the Pathology Network to finalise the proposals.
	Move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups.	November 2016	Diabetes Strategic Framework published November 2016. NI Diabetes Network has since been established, and a number key workstreams are underway (including footcare pathway and structured diabetes education). Workplans for 2017/18 for these areas have been agreed and are currently being progressed.
	Launch and commence implementation of the **Paediatric**	November	The paediatric strategies were published in November 2016, and a

Key Deliverable		Target	Position
	Strategies (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families.	2016	paediatric network has been initiated and is being led by the PHA.
	Launch a public consultation on proposals to develop sustainable **Stroke** services and further improve the standard of treatment and care provided to stroke patients.	February 2017	The pre consultation on the reshaping of stroke services concluded in September 2017, working closely with clinicians, stroke survivors and voluntary groups. Formal public consultation on more detailed proposals for change expected in early 2018.
	Following a recent review, launch a public consultation on the configuration of **Imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice.	February 2017	Public consultation launched October 2017.
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres**.	October 2017	A clinically led group has been established to collect and analyse the data and evidence for future models, and use this to bring forward proposals. The group is due to report in autumn 2017.
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	March 2017	A broad structural framework was set out in January 2017, work on detailed operating model design is ongoing.
10	Identify current **innovative HSC projects** at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.	April 2017	Programme of innovative projects agreed in August 2017. Implementation plans to be developed.
11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	November 2016	A series of engagements with staff and service users took place November 2016 to January 2017.
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	November 2016	Oversight structures (Transformation Advisory Board and Transformation Implementation Group) in place November 2016.

Key Deliverable		Target	Position
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the longer term sustainability of the adult social care system.	April 2017	The work of the Expert Advisory Panel Report on the Reform of Adult Care and Support is complete and its report will be considered by incoming Minister prior to public consultation.
14	Consult on proposals for, and complete design of a **new user feedback platform** open to all those who both use and deliver our services.	October 2017	A specification and business case is under development for the procurement of a Real Time User Feedback System.
15	Complete the initial design work for the **Improvement Institute**.	February 2017	Initial design work completed by February 2017. Small number of significant areas of practice identified to test scale and spread model during Phase 1 (July 2017-March 2018).
16	Develop a **Workforce Strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	May 2017	Work is ongoing with a wide range of stakeholders. A draft strategy nearing completion for consideration by TIG and incoming Minister.
17	Develop an **HSC-wide Leadership Strategy**, to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	May 2017	HSC Collective Leadership Strategy launched October 2017.
18	Expand the range of information and interaction available to citizens on-line and development of a **patient portal** for dementia patients.	October 2017	Work continues on identification of a preferred supplier with a delivery date now set for the summer of 2018.

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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HEALTH AND WELLBEING 2026

DELIVERING TOGETHER

Progress Report - May 2019

INDEX

SECTION 1: INTRODUCTION

1. *Health and Wellbeing 2026: Delivering Together*[1] provides a ten-year road map for the transformation of Health and Social Care (HSC) services in Northern Ireland. The first progress report, published in October 2017[2], outlined actions taken since its launch in October 2016.

2. This update builds on that position, and outlines the extensive, transformative work which has been undertaken to date.

3. Transformation of HSC services is a complex long-term ambition dependent on a wide range of enablers, many of which will be covered later in this report. The two most critical factors influencing the scale and pace of change remain to be political leadership and additional investment. It is a matter of record that some three months after the launch of *Delivering Together* the local Assembly and Executive was dissolved. Whilst this is regrettable *Delivering Together* set out a clear direction of travel and an initial action plan which has allowed significant progress across a broad range of critical areas.

4. At the launch of *Delivering Together*, the Northern Ireland Executive agreed that transformation could only be realised if additional money was made available, over and above the amount required to deliver existing HSC services.

5. The budget for 2019/20 does not provide sufficient funding to meet current demand. In short, the budget as it currently stands is insufficient to meet rising pressures across hospital, general practitioner (GP) practices, social care and mental health services, or to systematically tackle the growing waiting list backlog.

6. This is far from ideal in terms of the planning and management of services. Financial difficulties will also continue to intensify in coming years as demand increases. This is due to an ageing population with greater and more complex needs, increasing costs for goods and services, and growing expertise and innovation which means an increased range of services.

7. That said, as result of the Confidence and Supply agreement announced in June 2017, additional non–recurrent funding of £200m was made available to kick start transformation over the two year period beginning 2018/19.

8. In 2018/19, £100m was allocated to the following priority areas, with up to:
   - £30m to help tackle elective care waiting lists;
   - £15m to support services in primary care;
   - £15m to support development of our workforce;
   - £30m to help reform hospital and community services;
   - £5m to help build capacity in communities and prevention;
   - £5m to enable the transformation process.

1. https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
2. https://www.health-ni.gov.uk/publications/delivering-together-progress-report-october-2017

9. Whilst it is recognised that this short-term, non-recurrent investment limits HSC's ability to make the long-term changes needed to sustain services for future generations, it has provided much needed seed-funding and has helped make a real difference to those who work for, and those who use, HSC services.

10. The investment profile for 2019/20 funding is currently under development and will build on the positive start made in 2018/19.

SECTION 2: AMBITION

11. The vision for HSC transformation, *Health and Wellbeing 2026: Delivering Together*, was based upon the report of an expert panel, led by professor Rafael Bengoa, entitled, *Systems, not Structures: Changing Health and Social Care*[3], and was published on the same day.

12. *Delivering Together* seeks to radically reform the way HSC care services are designed and delivered in Northern Ireland, with a focus on person-centred care, rather than on buildings and structures.

13. It also sets out a clear and unassailable case for change which includes; the current system's inability to meet the extraordinary demands and pressures created by an ageing population, the stark differential in health and social care outcomes between the most and least deprived areas, the current service delivery model being no longer fit for purpose, and the challenges in attracting and retaining staff to prop up an outdated system.

14. *Delivering Together* is aligned with the aspirations set out within the Northern Ireland Executive's draft Programme for Government, with the ambition to support people to lead long, healthy and active lives.

15. Four key aims underpin this ambition:
    - Improving the health of our people;
    - Supporting and empowering staff;
    - Improving the quality and experience of care;
    - Ensuring the sustainability of our services.

3. https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

SECTION 3: LEADING & SUPPORTING CHANGE

16. Established in November 2016, the Transformation Implementation Group (TIG) continues to provide strategic leadership in driving forward the transformation agenda. It is chaired by the permanent secretary of the Department of Health and comprises senior leaders from across HSC.

17. In addition to this, a Transformation Advisory Board (TAB), whose purpose is to advise a minister, continues to liaise with Departmental officials to support the delivery of transformation. Full details of current membership of both groups is included at Appendix 1.

18. A Transformation Programme has been established to support delivery of the commitments made in *Delivering Together*. This programme is managed by the Department of Health, with extensive engagement and partnership across HSC. It is also working to understand the approaches to, and share learning from HSC developments across the rest of the UK and beyond.

SECTION 4: PROGRESS AGAINST OUR AMBITIONS

19. *Delivering Together* committed to transforming the whole HSC, as one system, by:

- **Building capacity in communities and in prevention;**
- **Providing more support in primary care;**
- **Reforming our community and hospital services;**
- **Organising ourselves to deliver.**

20. The remainder of this report outlines progress to date.

BUILDING CAPACITY IN COMMUNITIES AND IN PREVENTION:

Significant work is underway with communities to create the environment that helps support them to develop their strengths, and to use their assets to tackle the underlying social determinants of health and wellbeing.

SUPPORTING FAMILIES

21. A programme of work is currently underway to reform the services which support some of the most vulnerable families and children here. This work includes a regional roll-out of a new social work model, *Signs of Safety*, which saw 1,727 social workers trained in 2018/19.

22. This new way of working aims to empower families to build on their own strengths, and to put arrangements in place to support the wellbeing of the family, and to safeguard children.

23. A trial project aimed at preventing children from being taken into care on a repeated basis is well advanced. Additionally intensive support and diversionary activities are being provided to children and young people to help prevent the breakdown of foster care placements. A new approach to foster care recruitment has also been introduced.

24. A joint care and justice campus is also planned between the Departments of Health and Justice aimed at providing young people in secure accommodation with a more consistent model of care, focused on meeting their needs and diverting them from the justice system. For those 16 and 17-year-olds who present as homeless a pilot project is underway to test a new housing solution.

25. Support is also being provided for families with troubled adolescents, young fathers in prison and those with drug and alcohol problems.

26. Looked after Children are also being supported with their educational needs through the promotion of the Looked after Children Champion role which aims to raise educational outcomes at Key Stage 2 in conjunction with the Department of Education.

27. The *Getting Ready for Baby* initiative has also proved successful, increasing the numbers of mothers initiating breast feeding within the programme by 75%, as well as increasing the numbers of children accessing a three-year-old plus review.

28. Work continues to build upon the success of the *Early Intervention Transformation Programme (EITP)*, including *Family Support Hubs* working to better understand the needs of families, particularly those who are hard-to-reach, with the aim of offering early support before the need for statutory service involvement.

29. Another key initiative in the work to reduce inequalities, and to ensure that the next generation is healthy and well, is the *Family Nurse Partnership*, which is currently working to improve outcomes for first-time teenage mothers and their children.

30. On top of intensive and structured home visiting, this initiative teams specially-trained family nurses with teenage mothers, from early pregnancy until their child is two-years-old. To date 10 new family nurses have been recruited, which has provided 230 additional places on the programme for teenage mums. Evaluation of the programme to date has shown that this model plays a significant role in breaking the cycle of intergenerational disadvantage, deprivation and exposure to multiple other adverse childhood experiences.

31. *The Infant Mental Health Framework* aims to support those working with children up to three-years-old, and in critical need of support, to increase their mental health knowledge and skills. New teams to support this work have been established in both the Belfast and South Eastern Health and Social Care Trusts, to increase the capacity of parents to address the needs of their children in their first 1,000 days.

32. This extensive programme of work will be supported by the development and introduction of new strategies, including a new, *Looked after Children Strategy,* and a new, *Family and Parenting Support Strategy*.

33. A comprehensive review of the assessment framework used in connection with children and families by Social Services and their partner agencies has also begun, as well as work on delivery of the *Improving and Safeguarding Social Wellbeing Strategy*, which is supporting greater involvement through local engagement partnerships, and putting improvement at the heart of social work.

PREVENTION

34. *Delivering Together* outlines the need to move beyond simply managing illness, ensuring that our HSC services supports people to stay well; physically, mentally and emotionally. The introduction of an *HIV Prevention Clinic* is just one initiative which aims to do just that.

35. Opened in July 2018 at the Belfast Health and Social Care Trust, the pilot clinic has already seen 375 patients across 128 clinics, including a number of high risk individuals, who were not previously regularly engaging with services. The clinic aims to prevent new cases of HIV in high risk populations, with these services in high demand at present.

36. A new health outreach for people experiencing homelessness, the Inclusion Health Hub, began taking clients in February 2019, with the aim of improving access to healthcare for a population who experience severe health inequalities and barriers to accessing healthcare. The Homeless Nursing Team offers GP, dental, nursing and podiatry support, with three GP outreach sessions held each week. Patients can drop-in to be seen, or can be referred. To date, the service has successfully registered 60 new patients with a further 19 patients having been seen as temporary residents.

37. *Healthy Places* is a new cross-cutting programme which aims to improve health, reduce inequalities, and improve wellbeing and wider social outcomes. The programme is initially being taken forward in three pilot sites of Ballycastle, Lisnaskea, and in Belfast, the Ardoyne and Greater Ballysillan area, with a focus on testing new ways of working in a more co-ordinated way across statutory and non-statutory bodies for the benefit of the community.

38. A programme of community engagement is well underway in each area, and assets and resources are being fully mapped. The next stage will be aligning delivery and resources to address the identified needs. The idea is to take the learning from these three places and, if the approach is successful, scale and spread the programme to other areas in due course.

39. Integral to the *Healthy Places* initiative, is the work that is also underway to look at the establishment of a regional networking forum to explore and promote best practice with a strong focus on interface with local government.

SUPPORTING COMMUNITIES

40. As part of ongoing work to build capacity in our communities, a programme of initiatives has been established to support and improve the quality and safety of people living in nursing and residential care homes in Northern Ireland.

41. A peer support system has been established in an effort to enhance understanding of working with older people and to make care homes an attractive and rewarding place to work. 12 peer workers have already been recruited to deliver a training programme to care home staff.

42. A Nursing Home Workforce Seminar was held in March 2019, with representatives from health departments across the UK and Ireland, together with local expertise, to share their knowledge of issues relating to the care home workforce. Work is also underway to enhance engagement with service providers.

43. *Intermediate care at home* is another way in which work is ongoing to build capacity in communities. As a result of Transformation Funding, *intermediate care at home* has been enhanced to provide patients, usually older people, with the care they need after leaving hospital, or when they are at risk of being sent to hospital.

44. This service is provided to people in different places, for example, in a community hospital, residential home, or in their own home with the aim of helping people avoid going into hospital unnecessarily, to be as independent as possible after a stay in hospital, and to prevent people from having to move into a residential home until they really need to. A variety of professionals offer this type of specialised care - from nurses and allied health professionals (AHP), to social workers - with capacity for this service increased in 2019.

45. *Delivering Together* outlined the requirement to bring forward a Community Development Framework which would provide the voluntary and community sector with the tools, training, and standards it needs to help grow the sector to meet the future demands associated with transformed HSC services. This work is progressing well in partnership with staff, the voluntary and community sector, and service users.

46. The Community Development and Health Network (CDHN) was recently appointed to build the capacity of the voluntary and community sector by, amongst other things, establishing and hosting a community development online portal, developing and delivering a community development curriculum informed by National Occupational Standards, and by building sustainable, resilient, collaborative communities through delivery of a community mentorship programme.

47. A mapping exercise of existing community development and health inequalities training is now also underway.

48. Also supporting local people is the *Community Resuscitation Programme* - supported by the Northern Ireland Ambulance Service - which aims to increase survival of cardiac arrest outside of hospital. In the last year work has been undertaken in schools and across councils to establish lifesaver groups, and to provide best practice for those who own an Automated External Defibrillator (AED). Members of the public have also been trained to perform CPR.

PROVIDING MORE SUPPORT IN PRIMARY CARE:

Significant work has been brought forward to allow more access to services within primary care.

PRIMARY CARE MULTI-DISCIPLINARY TEAMS

49. A new model for primary care multi-disciplinary teams has been developed which is seeing local GP practices focus not just on managing ill-health, but also on the physical, mental and social wellbeing of communities.

50. Practice-based physiotherapists, social workers and mental health practitioners, are now based in a number of GP practices. These new teams are being supported by increased investment in district nursing, health visiting, training, and access to appropriate specialist advice.

51. Enhanced teams are now been rolled out across Down, Derry/Londonderry and West Belfast GP Federation areas. These areas account for approximately 365,000 people who will potentially benefit from this new model of care.

52. Problems with muscles and joints are a significant part of a GPs workload with unacceptably long waiting lists for referral to more specialist services. To tackle this significant issue, practice-based physiotherapists are now working in GP practices across all three roll-out areas. This new approach aims to relieve GP workloads, reduce waiting times, and reduce the need for referrals by making these expert practitioners the first point of contact.

53. Research suggests that up to a fifth of GP time is spent on social issues that are not principally about health[4], with GPs not always best placed to address these issues which may be underlying ill health. Practice-based social workers have therefore been recruited and have started in practices in the Down area, with further roll-out planned. Assistant social workers have also been recruited and will take up posts shortly.

54. The third of the new practice-based roles is that of mental health practitioners. This new role will address another area of high demand, ensuring expert assessment, treatment and referral of those with mental health issues. Recruitment to these posts has recently started.

55. Data analysts have also been recruited to work across practices to help in the use of data to understand and identify opportunities for early intervention which may be social rather than medical, such as helping people to exercise more, or addressing loneliness. To support this approach, investment is being focussed to create capacity in local social prescribing initiatives.

4. A Very General Practice: How Much Time Do GPs Spend On Issues Other Than Health?; Citizens Advice; 2015.

56. To accommodate new teams an investment of over £2m has been made in practice premises.

57. An independent evaluation of the new multi-disciplinary team approach will be carried out to assess impact and inform further roll-out.

FURTHER EXPANDING THE MULTI-DISCIPLINARY TEAM

58. In addition to the model of primary care multi-disciplinary working outlined above, there are a number of other initiatives designed to improve patient care and support new ways of working. For instance, administrative staff in some GP practices are being training to expand their skills, and reduce the administrative burden on GPs, freeing their time to see patients and deal with other clinical tasks.

59. Two paramedics have been trained as community paramedics and are embedded within rural GP practices in border areas. Their enhanced training and skills has allowed them to undertake assessments of patients with chronic long-term conditions, as well as minor illnesses and injuries, including undertaking home visits.

60. A further significant development has been the introduction of the first locally trained, advanced nurse practitioners (ANPs) in primary care. ANPs are highly skilled, with the ability to diagnose a very wide range of patients and to offer significant support to GPs and wider multi-disciplinary team members.

61. Currently, five ANPs are completing their training working within multi-disciplinary teams across the Down area. This has allowed them to see and support over 15,000 patients. Training is now underway for a further 15 ANPs to support local people across Derry/Londonderry, Armagh, Dungannon, and East Belfast.

62. The District Nursing Framework, *24 Hour District Nursing Care No Matter Where You Live*, was launched in February 2018 with a focus on preventative and proactive care. Implementation is now underway, with a group established to oversee delivery.

63. Central to this framework is the development of a Neighbourhood District Nursing prototype model, which sees self-managing teams of district nurses working with a high degree of autonomy, and working closely with multi-disciplinary teams. Neighbourhood district nursing coaches and support staff have been recruited, with a new transformational district nursing model being tested in a number of areas including, Newcastle, Limavady, Moy, West Belfast and Ballycastle.

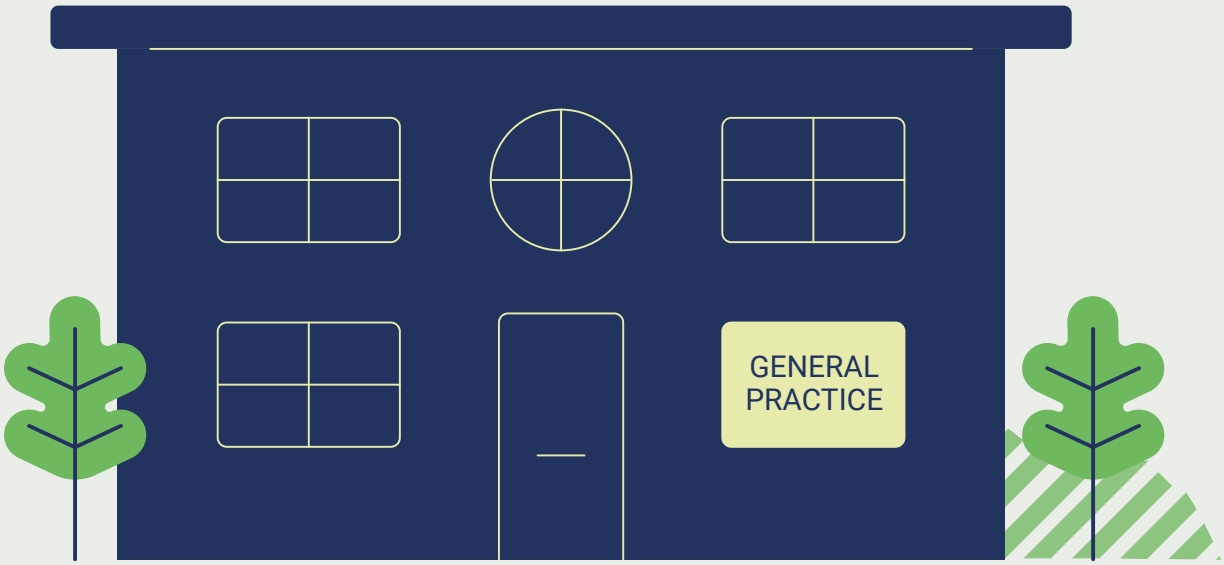
64. Practice-based pharmacists are also working as part of the teams in GP practices, with the aim of ensuring quality and safety of prescribing, whilst also supporting value for money, offering support to other members of the primary care team, and freeing up GP time to dedicate to patients with more complex needs. Every GP practice in Northern Ireland now has access to a practice-based pharmacist with, approximately 274 pharmacists to be based within local GP practices by the end of the summer.

65. Community pharmacy also plays a significant role in preventative and proactive care within communities, stemming the flow of patients to other parts of the health and social care system. Support has been provided to enable community pharmacies to enhance their clinical capability and capacity and support their transformation into health and well-being hubs.

66. *The Pharmacy First service for sore throats, colds and flu-like illness* was launched on 1st December 2018 and ran until 31st March 2019. The service aimed to displace activity, including consultations, advice and generating prescriptions for common winter conditions, from GPs to a community pharmacy based service. 21,715 consultations took place at 432 community pharmacies during the winter months.

67. The service was co-designed by the Health and Social Care Board and Community Pharmacy Northern Ireland, following a review of the current evidence base for the management of common winter conditions.

68. The Department of Health, along with the Health and Social Care Board is also committed to ensuring that the network of community pharmacies can continue to support the needs of local populations. Work is ongoing on a needs assessment for community pharmacy services in Northern Ireland.



WORKING AT SCALE

69. To support the reform in primary care, the 17 GP Federations in Northern Ireland have taken on a coordination role allowing initiatives like practice-based pharmacists and primary care multi-disciplinary teams to be rolled-out at scale.

70. GP Federations are also currently developing and rolling out new ways of working, including the development of crisis response teams to support practices facing particular challenges, and a *GP Hub Model*, to address pressures facing early evening, and GP out-of-hours, services.

REFORMING OUR COMMUNITY AND HOSPITAL SERVICES:

The role of our hospitals will fundamentally change as we focus on delivering the highest quality of specialist and acute care, outside of structural boundaries.

ELECTIVE CARE

71. An investment of £30m from the £100m Transformation Fund available in 2018/19 was allocated to the reduction of elective care waiting lists. Whilst not transformational in itself, this significant investment was made in the full understanding that immediate action was needed to reduce excessive waiting times – an issue that continues to attract significant criticism and remains a huge frustration for those accessing services.

72. As a result of this investment, by the end of February 2019, approximately 100,000 more patients had been diagnosed, assessed or treated. Whilst a positive outcome the funding has served only to slow the growth in elective care waiting times. Long-term investment over and above what is required to deliver existing services, is required to make sustainable change.

73. New ways of working are under development to meet patients' needs within GP practices rather than waiting to be seen in a hospital setting. As a result, eight nurse endoscopists are currently being trained to carry out endoscopy procedures.

74. A GP led vasectomy service has been established using non-scapel procedures for the first time locally. Since October 2018, over 642 procedures – which would otherwise have required a hospital referral – have now been carried out in GP practices in Belfast. The service will be further rolled out in 2019/20.

75. GPs are also delivering services for photo dermatology triage, gyneacology, muscular skeletal (pain), and enhanced minor surgery, with over 3,256 patients treated since December 2018.

76. Primary care optometrists are engaged in new initiatives to stem the flow of referrals into hospitals, managing non-sight threatening acute eye problems in the community and carrying out non-complex post-operative cataract reviews, in addition to offering community-based ocular hypertension reviews.

77. A priority in the transformation agenda is to enable improved access to elective care services by establishing regional centres, known as *Day Case Surgery Hubs*, to provide a dedicated resource for less complex planned surgery. This new approach will help ensure that patients do not go beyond clinically-indicated review dates, reducing the risk of harm, whilst simultaneously freeing capacity in secondary care. Whilst additional travel times to these centres may be inevitable waiting times will be greatly reduced.

78. The Department of Health/NISRA 2017 Health Survey indicated that 78% of those surveyed would be prepared to travel beyond the nearest acute hospital if treatment was available in a more timely manner. 82% of people surveyed thought that a journey time of up to one hour would be reasonable.

79. In December 2018 a significant step forward was made through the introduction of new prototype day case surgery hubs. Centres for the treatment of varicose veins are now up and running at Lagan Valley Hospital, and Omagh Hospital and Primary Care Complex. In the Mid-Ulster Hospital, Downe Hospital, and the South Tyrone Hospital, similar prototypes have been introduced for the treatment of cataracts.

80. This work will ultimately help to inform a regional model for Northern Ireland, which will be subject to public consultation.

81. The Department has announced plans of future additional hubs for a wide range of specialties including general surgery and endoscopy, urology, gynaecology, orthopaedics, ENT, paediatrics and neurology.

82. By December 2020, the Department of Health aims to transfer more than 100,000 day cases, 25,000 endoscopies and 8,000 paediatric procedures to this new model.

83. Whilst the work underway to address the waiting list crisis is positive, the Department of Health's Elective Care Plan[5] published in February 2017, was clear that transformation was required to sustainably improve elective care services and will require significant funding over a number of years, as part of broader investment in reform.

5. https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

REFORM OF ADULT SOCIAL CARE AND SUPPORT

84. The Expert Advisory Panel's report, *Power to People*, was published in December 2017. Whilst awaiting ministerial approval, work has been advanced to consider options and develop an action plan with input from a wide range of stakeholders, Citizens' Forum and Independent Expert Carers panel.

85. This work will ensure that the voice of carers is heard at all levels of the decision making process. Work is also underway with the voluntary and community sector to understand how this approach could be replicated to form a service user panel.

MENTAL HEALTH SERVICES

86. Supporting our mental health is a key priority in *Delivering Together*. As well as being a key focus in the work to develop primary care multi-disciplinary teams, there are a number of additional initiatives being taken forward through the introduction of mental health practitioners.

87. A *Multi-Agency Triage Team* (MATT) prototype has been operational from July 2018 and is due to run until March 2020. Supported by the Transformation Fund, this project involves two police officers, a mental health nurse and a paramedic working together to respond to people with mental health problems, aged 18 and over, who have accessed the 999 system.

88. The service currently operates on Friday and Saturday nights, between 7pm-7am, covering areas within the South Eastern Health and Social Care Trust. To date there have been over 150 referrals to this service.

89. A new pilot *Derry Community Crisis Intervention Service*, launched at the start of 2019, to support local people who are in crisis, reducing unnecessary transfers to emergency departments or to police custody. Similarly, a crisis de-escalation pilot commenced in Belfast in March 2019, to support local people and their families with weekend, out of hours support to those aged 18 and over, presenting in social and emotional crisis.

90. In addition to this, a Towards Zero Suicide Collaborative Board has been established in Northern Ireland as part of the *UK Zero Suicide Alliance*, and will be supported by the Institute of Healthcare Improvement, placing Northern Ireland in a strong position to benefit from learning and innovation from across the UK and Europe on this important issue.

91. Work has progressed on establishing a *Regional Trauma Network* to address the unmet mental health need of mental trauma. A partnership board and implementation group have been put in place to take forward this service, and recruitment of staff to manage trauma caseload across Trusts is underway.

92. Work has begun on developing a five year plan for mental health. A project board has been set up, with a stakeholder event held in November 2018 to initiate work. Further development of Children and Adolescent Mental Health Services (CAMHS) is included in this work, with the continued roll out of, *Working Together: A pathway for children and young people through CAMHS*, and training targeted to further support implementation, including GP training.

93. Work is also ongoing on future development of perinatal services, including specialist community perinatal teams.

ACUTE CARE AT HOME

94. Progress has also been made regionally on the development of the Acute Care at Home service, with more than 3,500 patients receiving treatment in their own home this year, as an alternative to hospital admission. This is an increase of approximately 10% on the previous year. Further roll-out is planned for 2019/20.

RECONFIGURING HEALTH AND SOCIAL CARE SERVICES

95. The consultation report on the criteria for reconfiguring health and social care services has been published. This is the outworking of the commitment within *Delivering Together* to consult on the seven reconfiguration criteria proposed in the Expert Panel Report.

96. The post consultation criteria will be adopted as policy within the Department of Health, in conducting upcoming service reviews as part of the Transformation Programme.

97. The criteria can be viewed at: www.health-ni.gov.uk/consultations/health-and-social-care-transformation-consultation-criteria-reconfiguring-health-and-social-care.

DAISY HILL PATHFINDER PROJECT

98. The *Daisy Hill Hospital Pathfinder Project* was established in response to increasing concerns about the future sustainability of Daisy Hill Hospital Emergency Department due to ongoing difficulties in securing senior medical cover, particularly in the out of hours period. This was against a backdrop of significant public concerns about the future of Daisy Hill Hospital.

99. The aim of the pathfinder was to develop a new model, through a co-production approach, to ensure safe and sustainable unscheduled care services to meet the needs of the Newry and Mourne population.

100. Implementation of this work is underway, with significant progress made in providing a stable Emergency Department workforce, stronger links with local GPs, enhanced services for the sickest patients, and improved patient flow.

101. A new Direct Assessment Unit opened in February 2019 and is taking referrals from GPs, the Northern Ireland Ambulance Service, and specialist services. The unit will allow quicker access to senior doctors, direct telephone discussion between clinicians and GPs, an increase in clinical assessments for adults with medical needs. Frail older people will also benefit from diagnosis, observation, treatment and rehabilitation in an appropriate area outside of the Emergency Department.

FERMANAGH AND WEST TYRONE PATHFINDER

102. In response to service pressures, a pathfinder has been established to undertake a review of the current service provision in the area.

103. An intensive period of community engagement has commenced which will be followed by a recalibration of the population health data, to inform the development of transformative service models designed to meet the specific needs of this population. The work will have both a hospital and community focus, with the ambition of establishing early pilots in spring 2019.

104. Professor Rafael Bengoa who led the expert panel and the development of *Systems not Structures* endorsed the direction of travel at a recent health summit.

RECONFIGURATION OF STROKE SERVICES

105. A public consultation on reshaping stroke services was launched on 26th March 2019, with plans to enhance existing provision to create specialised hyperacute stroke units offering 24/7 access to faster diagnosis and cutting edge treatments.

106. Currently, eight hospitals routinely provide thrombolysis to stroke patients, but despite the dedication of staff, most are struggling to consistently meet national best practice standards of care for stroke patients.

107. The central aim of the reconfiguration of stroke services is to significantly reduce disability and save more lives. The proposed new network of hyperacute stroke units will ensure that patients have access to the best possible care in regional centres of excellence no matter where they live, or what time they are admitted.

108. The reforms will address variance in the use of the clot busting, thrombolysis, and support greater access to thrombectomy, the groundbreaking procedure that removes a clot from the brain.

109. The consultation on Reshaping Stroke Care will run until 19th July 2019 and follows a pre-consultation in 2017. The consultation paper also outlines planned improvements in the treatment of transient ischemic attack (TIA), also known as mini-stroke, as well as improvements to community-based stroke care.

110. The consultation proposes extending the HEMS air ambulance service to coordinate with emergency road transport for patients with strokes and other conditions in remote rural areas to ensure they arrive at hospital for treatment as quickly as possible. The public consultation report is available at: www.health-ni.gov.uk/reshaping-stroke-care.

RECONFIGURATION OF DIABETES SERVICES

111. Significant progress has been made with the implementation of the Diabetes Strategic Framework and action plan, which was published in November 2016.

112. Particular progress has been made in improving access to technology, with over 33,000 prescriptions written for flash glucose monitors this year.

113. Progress has also been made in establishing a prevention programme for those at high risk of developing the condition. The new *Diabetes Prevention Programme* is aimed at people who have been identified as pre-diabetic. The programme is facilitated by health coaches who help participants change their lifestyle, diet and physical activity.

114. In addition, an education programme has now been established for each type of diabetes, as well as agreement and implementation of standardised protocols for the management of diabetes in all inpatient settings. Progress has also been made in the development of a comprehensive foot care pathway, focussed on preventing foot complications caused by diabetes and reducing the number of amputations.

PROVISION OF IMAGING SERVICES

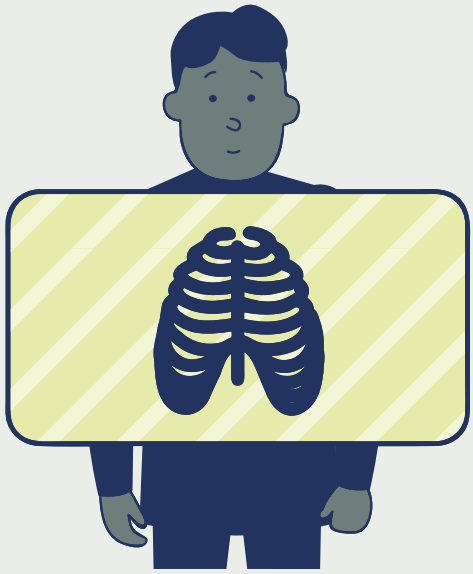
115. Imaging services are a critical component of the health service in terms of diagnosis, monitoring and treatment of diseases and conditions. In June 2018 the Strategic Framework for Imaging Services in Health and Social Care was published, with the aim of enhancing and modernising services over the next 10 years.[6]

116. As part of the framework a training scheme has been expanded to increase the number of radiology trainees, with the first cohort of these due to enter the workforce this summer. There has also been an expansion in the number of places on the undergraduate course for diagnostic radiographers.

6. www.health-ni.gov.uk/publications/strategic-framework-imaging-services-health-and-social-care

117. HSC Trusts are participating in a regional programme to achieve accreditation against the imaging quality and safety standards set by the Royal Colleges.

118. Work is ongoing to consider the future of picture archive and imaging systems. This will replace the three current imaging systems in use in Northern Ireland with a single regional service. It aims to improve patient safety through an improvement in patient diagnostic services and improved ability to share imaging information regionally.



IMPLEMENTATION OF PAEDIATRIC SERVICES

119. *Delivering Together* committed to launching and commencing work on the implementation of paediatric strategies. The two 10 year children's strategies, 'Strategy for Children's Palliative and End-of-Life Care', and the 'Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community', were published in November 2016.

120. To date, work to implement these strategies has focused on delivering age-appropriate care, reducing Emergency Department attendance and hospital admissions, chronic disease management, establishment of a Child Health Partnership Network, and improving palliative and end-of-life care for children and young people.

121. To deliver age-appropriate care, the initial focus has been on implementing the regional minimum upper age limit for paediatric services to the 16th birthday. Southern, Northern, Western and South Eastern Trusts have now implemented this across their paediatric services.

122. The Belfast Trust is working towards full implementation of the upper age limit at the Royal Belfast Hospital for Sick Children, subject to resources continuing to be made available. The next phase will be to develop improved transition arrangements and to secure wider adolescent health service improvements.

123. Transformation Funding has also allowed Trusts to introduce a range of initiatives, including strengthening community services to reduce the need for unscheduled hospital attendances, and expanding short-stay assessment services. These short-stay assessment units provide ambulatory care as well as assessment and treatment of acutely unwell children, avoiding the need for hospital admission where possible. Other new models of care are also being developed, including the development of primary care paediatric hubs where specialist paediatrians work alongside general practitioners and other members of the primary care team.

124. In the management of chronic disease, all HSC Trusts have identified psychology support as a priority development area. Investments have been proposed to improve equity of access to psychology services for children with long term conditions.

125. Design of a Paediatric Network was completed in January 2018, with a view to establishing a Child Health Partnership which would oversee strategy implementation, allocate resources, agree on the optimal configuration of services and ensure equity of provision across Trust boundaries. The programme manager for the partnership took up post in March 2019.

126. Implementation of the paediatric palliative care strategy is underway. A pilot, *Palliative and Life Limited Service (PALLS)* has been funded to base a specialist palliative care nurse in the Royal Belfast Hospital for Sick Children, and the Royal Jubilee Maternity Hospital since September 2018, as well as one additional bed in the Northern Ireland Children's Hospice since October 2018. The PALLS nurse works closely with teams across the HSC to identify infants, children and unborn babies who are life-limited or have palliative care needs, and put in place support and services, including advanced care plans.

127. Funding has been provided to give every Trust a named medical lead for children's palliative care.

128. Advanced nurse practitioner roles in children's nursing have also been developed with the first locally trained advanced nurse practitioners qualifying in 2019. The introduction of these new roles will serve to enhance the children's nursing workforce in the provision of high quality, safe and effective care to children and their families.

RECONFIGURATION OF PATHOLOGY SERVICES

129. Work is under way to develop a new regional management structure by 2021 for the delivery of modern, flexible and agile pathology services that can respond to changing demands arising from wider service reform.

130. Progress is also under way to enable significant modernisation by replacing current laboratory systems with a modern, single, regional Laboratory Information Management System by 2023.

131. This new system will ensure ongoing and sustainable delivery of information management to HSC pathology services across the region, through provision of a modernised information technology (IT) solution. It will support and enable transformation of both HSC pathology services and wider HSC services, and reduce unnecessary variation in delivery of pathology services. It will also support improved clinical outcomes through enhanced integration and sharing of information.

RECONFIGURATION OF BREAST ASSESSMENT SERVICES

132. In the absence of change, waiting times for breast assessment are expected to worsen, with demand projected to increase in the years ahead. A public consultation was launched on 25th March 2019 with proposals for the future of breast assessment services in Northern Ireland. The public consultation proposes three breast assessment locations: Altnagelvin Hospital; Antrim Area Hospital; and a greater Belfast location, likely to be the Ulster Hospital. The aim is to establish a model of care which will ensure high quality, safe, sustainable, accessible and timely services. A centralised appointment booking system is also planned as part of the proposed reforms.

133. The future model of care will also include the establishment of a regional Breast Assessment Network to shape and support service provision. There are no plans to change the current breast screening arrangements.

134. The public consultation will run until 19th July 2019, and is available at: www.health-ni.gov.uk/consultations/reshaping-breast-assessment-services. A rapid review of breast surgery has also been initiated and will report by the end of 2019.

RECONFIGURATION OF URGENT AND EMERGENCY CARE (UNSCHEDULED CARE)

135. A review of urgent and emergency care – also referred to as unscheduled care - is now underway. The review aims to establish a new regional care model, giving specific consideration to the most appropriate arrangements for the assessment and admission of older people, as well as providing the best appropriate care for people of all ages.

136. A project has now been established to take this work forward, with initial engagement activity and information gathering underway. The proposals arising from this work will also be subject to public consultation in due course.

137. This review follows completion of a 'Public Health Needs Assessment for Urgent and Emergency Care' commissioned by the Department of Health and which is available to view at: www.health-ni.gov.uk/publications/northern-ireland-needs-assessment-urgent-and-emergency-care.

138. Later this year, the first 10 locally trained emergency care advanced nurse practitioners will take up permanent posts within Emergency Departments, fulfilling a vital function in the assessment, diagnosis, treatment, referral and discharge of patients.

139. This work will link closely with reforms in primary care, including testing new models for early evening care, and the development of multi-disciplinary teams.

RECONFIGURATION OF PLASTICS AND BURNS SERVICES

140. The Regional Plastic Surgery and Burns Project Board continues to make good progress to identify a future service specification for the service in 2019.

141. A needs assessment is completed or is substantially underway in a number of sub specialist areas including orthoplastics, skin cancer, hand and upper limb, breast and burns. The Belfast Health and Social Care Trust is also finalising its self-assessment against the National Burn Care Standards.

142. To date one additional plastic surgeon has been appointed. Commitment has also been given for two more plastics surgeons, one with a sub specialism in orthoplastics and the second with a sub specialism in sarcoma and skin cancer. Investments are also planned in paediatric burns for nursing and psychology and for AHP hand therapists.

RECONFIGURATION OF CANCER SERVICES

143. Work is underway on a review of oncology services to understand how the HSC can best meet patients' needs so that they can receive the most appropriate care in the most appropriate place.

144. New treatment pathways are being developed, involving those with lived experience of cancer services, and staff, to provide treatments closer to home where possible, and centralised where necessary. In future patients will be able to have more systematic anti-cancer therapy (chemotherapy) treatments in their local cancer unit.

145. To improve sustainability, work is ongoing to set out developments needed within the nursing, pharmacy, radiography and medical physics workforce to enable them to deliver some less complex activities in patient treatment.

146. This will result in medical staff time being made available for patients who require more complex treatments. These developments will improve the access and experience of care for many patients, particularly when there is a predicted significant rise in the population who will experience cancer in the future.

147. The Department of Health has also announced that it is to commission a new cancer strategy for Northern Ireland. The central goal of the new strategy will be to identify new ways of working to secure further advances across cancer care, working with patients, staff and cancer charities in its development. Decisions on the implementation of a new strategy would be for a future health minister.

RECONFIGURATION OF NEUROLOGY SERVICES

148. In response to service pressures, the Department of Health announced a review of neurology services in July 2018. A *neurology review team* has been established to identify the optimal service specification for neurology services for the next 10-15 years. This will include the development of principles and standards, the design of improved pathways for patients and measures to address workforce pressures. An interim report will be published shortly, with a final report later in 2019.

NEW CLINICAL RESPONSE MODEL FOR THE NORTHERN IRELAND AMBULANCE SERVICE

149. Recognising the pressures on services, the Northern Ireland Ambulance Service developed a new Clinical Response Model for public consultation. The next steps in this process are now under consideration.

150. In the short-term, a number of measures have been introduced to reduce pressures. Transformation Funding is currently being used to train student paramedics, emergency medical technicians and ambulance care attendants in the full range of clinical skills which will support the ambulance service to deliver its vital services.

151. In the longer term there are proposals for further paramedic training. A 10 year forward plan is being progressed that will include a programme of innovative projects.

ORGANISING OURSELVES TO DELIVER:

152. We continue to implement the decision to close the Health and Social Care Board (HSCB), and put in place new organisational arrangements which will see the Department of Health take firmer strategic control of the health and social care system, with clearer accountability and reduced complexity.

153. A new operating model has been agreed, and detailed design is underway. All changes are being developed in the context of supporting the new models of care and the broader transformation agenda as set out in *Delivering Together*.

ENABLING TRANSFORMATION:

How we plan, design, support and implement service transformation is as important as the changes we wish to make.

PARTNERSHIP WORKING

154. Significant progress has been made to enable better partnership working with those who use and deliver our services. A key step in this work has been the formation of a *co-production working group*. Led by the Chief Nursing Officer, and involving people with a vast range of relevant experience, this group developed a co-production guide to support partnership working across health and social care.

155. Launched in August 2018 the guide is a living document that provides underpinning principles for co-production; providing definitions of key terms, and giving practical guidance.

156. Building on this the focus now is on embedding these new ways of working through amongst other things a series of co-production implementation discussions and planning events for the health and social care system and its partners.

157. In addition, work continues on the development and procurement of an online Real Time User Feedback System.

IMPROVE QUALITY

158. *Delivering Together* outlines that, in the design and delivery of health and social care, quality and safety will always be a fundamental priority. It outlines the need to establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. Working on the principles of: Learn together, Share together, Improve together, the Health and Social Care Quality Improvement team (HSCQI) is focused on building relationships and connections across system and professional boundaries.

159. Since its launch in April 2019, HSCQI has begun to provide greater focus on delivery of its main objective – providing co-ordinated regional support for the spread of specific quality improvement initiatives to build on what already exists; by connecting improvement activity and people together, to deliver regional improvement.

160. HSCQI communities of practice have been established to share and promote collective approaches to practice across organisational boundaries. Each community of practice has a different focus, in areas such as workforce, innovation, and evaluation.

161. To inform HSCQI development and its operation, an improvement prototype has been identified to test scale and spread through extending the work of the safety forum on sepsis management.

162. 26 participating units have been identified across all HSC Trusts encompassing Emergency Departments, Acute Medical and Acute Surgical Units and a Critical Care Unit. This prototype will seek to improve compliance on sepsis across Northern Ireland.

163. For more information go to: http://qi.hscni.net/.

INVEST IN OUR WORKFORCE

164. The HSC Workforce Strategy[7] has been developed by organisations across the health and social care sector in close co-operation with trade unions and other key stakeholders. It includes a detailed look at the workforce challenges and was produced following significant engagement with the workforce.

165. The strategy considers areas such as retention and recruitment of staff, opportunities for introducing new job roles and upskilling initiatives. It also focuses on ensuring that health and social care is a rewarding and fulfilling place to work and train.

166. Early work is now underway on a plan to establish a HSC careers service to promote health and social care careers and allow returners to the service to easily re-engage with the system.

167. Paramedics are now formally members of the allied health professions, and a paramedic science foundation degree began in January 2019, with 48 students taking place, in preparation for the commissioning of a Bachelor of Science course.

168. Work is also well underway on the single lead employer project for doctors and dentists in training, with the initial tranche to transfer by 1st August 2019.

7. https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

169. Significant developments have also been made in recruitment, with, for example, 11 new physician associates placed in March 2019, a further 20 trainees now engaged in training, and 99 additional nursing and midwifery places taking the total nursing and midwifery students to over 1000; the highest level ever educated in Northern Ireland.

170. The implementation of the *Retain Scheme* – a project focused on nursing staff working in ten older peoples' wards across the five HSC Trusts - has resulted in improved retention of nursing staff with up to a 66% improvement in nursing vacancies in these wards. Also proving successful is the *GP Retainer Scheme*, designed to assist in the retention of GPs in primary care, with 11 places available due to Transformation Funding support.

171. The *GP Induction and Refresher Scheme* is another investment in our workforce, which provides an opportunity for GPs who meet the required criteria to safely return to general practice following a career break or time spent working abroad. This scheme is also supporting the safe introduction of overseas GPs and provides support to GPs returning to or entering clinical practice. At March 2019, seven doctors were completing the scheme, with six already completed.

172. Health literacy is about giving health professionals the skills to explain medical issues in a way that people can understand and empower them to better manage their own health or medical condition. *Making Every Contact Count* training has been provided alongside health literacy to give staff the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them.

173. As part of the development of primary care, multi-disciplinary team training is being delivered to a wide range of primary care professionals including community pharmacists and GPs to help them improve health literacy.

174. Work is also underway on the development of a long-term training and development strategy, a review of medical school places has been published, and work is ongoing on criteria for prioritising workforce reviews, to populate the proposed optimum workforce model.

PLACE A STRONG FOCUS ON COLLECTIVE LEADERSHIP

175. The implementation and embedding of the HSC Collective Leadership Strategy is now being mobilised. Launched in October 2017 it sets out the framework for creating a leadership culture based on the principles of quality, continuous improvement, compassionate care and support.

176. The development of the strategy embodied a partnership approach. The work was led by a core group with a wide membership, including representatives from across the health and social care system, the Department of Health, trade unions, clinicians, service users and the voluntary and community sector with over 400 people contributing to its development through engagement events.

177. Work is advanced on the delivery of the actions as set out in the strategy. A set of core values and behaviours have been developed for the health and social care system and will be launched later in 2019.

178. In 2019/20, baseline information will be gathered through a regional staff survey and a cultural assessment tool. This information will be used to monitor the outcomes and review the implementation of the collective leadership strategy.

179. For more on the new HSC values and behaviours, and on collective leadership in action, go to the Interactive Delivering Together Progress Report at: https://www.health-ni.gov.uk/progressreport2019.

FOCUS ON MAKING BETTER USE OF TECHNOLOGY AND DATA (eHEALTH)

180. The eHealth and Care Strategy sets out the HSC's approach to technology focussed on better supporting people, sharing information and fostering innovation in order to support change. An important element of this work will be the modernisation of outdated systems and hardware. Delivering this strategy is essential if we are to deliver on the ambitious aims set out in *Delivering Together*.

181. The continued roll-out of eTriage is speeding up referrals to hospitals and reducing unnecessary paperwork. This system will also allow hospital doctors to give written advice to GPs to help them manage patients. As part of this roll-out a new approach to dermatology referrals has been trialled which uses technology in GP practices to take images and transfer them safely to hospital clinicians for assessment. This has resulted in a 59% downturn in the most urgent 'red flag' demand and a 30% decrease in patients requiring an outpatient appointment so far.

182. Northern Ireland already has an award winning clinical portal, the Northern Ireland Electronic Care Record (NIECR) which allows clinicians in different settings to see and record key information about patients improving safety and supporting better care. This system continues to be developed, widening access to community pharmacists and optometrists, for example, to help improve the accuracy of prescriptions and support the provision of more tailored advice to patients.

183. While the NIECR continues to help transform care, it has to draw on a large number of separate systems to present key summary information to clinicians and other professionals. *The Encompass programme* is intended to deliver an integrated electronic health and care record across our acute and community services – replacing the myriad of separate systems currently in place. It will remove the need for many paper based processes which are currently required, freeing up professionals to spend more time providing direct patient care - and it will improve patient safety by allowing all professionals involved in a patient's care to view the same information, improving treatment plans.

184. Having *Encompass* in place will underpin transformation and help ensure service users receive the best possible care whichever location they are in. *Encompass* will enable data to be used more pro-actively to predict where we can make interventions before people need hospital care, and to work more closely with service users to help them manage their own care.

185. A new platform for sharing information about patients in general practice – the *General Practice Information Platform* – which is currently being rolled out, will support GPs to provide this proactive and preventative care for their patients.

186. Alongside *Encompass* the systems used to support the work of our HSC laboratories, who complete vital tests to help clinicians diagnose and manage care, and the system used to capture images such as x-rays and computerised tomography (CT) scans, which are equally critical to diagnosis and condition management will be replaced. Both these programmes will consolidate existing systems, make it easier to share information across sites, and underpin change and transformation in these service areas.

187. Supporting people to manage their own health and wellbeing is at the centre of *Delivering Together* and a continued investment in technology will give people access to their health and care record to allow them to do that. A patient portal pilot, *'My Care Record'* provides secure on-line access to the health and care electronic records for both patients and carers. The first group of patients and carers using the system are those living with, or caring for those, with dementia. Both the functionality and the availability to other patient groups will expand over time.

188. To further support people to self-manage their own health and wellbeing a new on-line A-Z symptom search facility is now available on the nidirect website at: www.nidirect.gov.uk/information-and-services/health-and-wellbeing/illnesses-and-conditions .

189. In addition telecare services have been successful in enabling people to lead independent lives and remain in their own home for longer.

190. Technology has never been so important in underpinning transformation. It is therefore important that these new uses of technology are built on firm foundations, with the right technical infrastructure in place, and reassurance that our systems are secure. Investment continues in cyber-security and technical infrastructure. The recent appointment of a new Chief Digital and Information Officer at the Department of Health provides a single point of leadership to help ensure best use of technology and our rich data sources in order to enable transformation.

SECTION 6: SUMMARY

191. Two and a half years – a quarter of this 10 year journey – have now passed, with health and social care transformation well underway.

192. Solid foundations have been laid, in the shape of new multi-disciplinary teams, and day case surgery hubs, which are directing the flow of patients away from under pressure hospitals and emergency departments, and supporting primary care colleagues to better manage the needs of local people.

193. The Confidence and Supply Transformation Fund has allowed many initiatives to get underway in 2018/19, that would not otherwise have been able to do so; and the recruitment that this has supported, into vital roles across the system, will make a significant difference in terms of the capacity to progress new, transformative ways of delivering services.

194. The work being undertaken to review and reconfigure important services, such as urgent and emergency care, cancer, pathology, stroke and breast assessment services, will build on progress to date, and see new ways of working introduced and – importantly informed, by those who use, and deliver them.

195. There is no doubt that there is much more to do.

196. It is widely accepted that transformation of HSC services is a complex, long-term ambition dependent on a wide range of enablers, including political leadership and additional investment.

197. However, the clear direction of travel, set out within Health and Wellbeing 2026: *Delivering Together*, continues to guide the changes which need to be made and represents the only long-term answer to the significant challenges currently faced by the Health and Social Care system here.

APPENDIX 1:

MEMBERS OF THE TRANSFORMATION ADVISORY BOARD:

- Minister of Health (Chair)
- Rafael Bengoa (Chair of Expert Panel)
- John Patrick Clayton (Trade Union representative)
- Seamus McAleavey (Voluntary and Community sector representative)
- Mairead McAlinden (Expert Panel member)
- Brian O'Hagan (Co-chair of the regional PPI forum)
- Richard Pengelly (DoH Permanent Secretary and Chair of the Transformation Implementation Group)
- Maria Somerville (Person with caring experience)

MEMBERS OF THE TRANSFORMATION IMPLEMENTATION GROUP:

- Richard Pengelly (Permanent Secretary, DoH; Chair)
- Michael Bloomfield (Chief Executive, NIAS)
- Shane Devlin (Chief Executive, SHSCT)
- Martin Dillon (Chief Executive, BHSCT)
- Sharon Gallagher (Deputy Secretary, DOH)
- David Gordon (Director of Communications, DoH)
- Neil Guckian (Interim Chief Executive, SEHSCT)
- Sean Holland (Chief Social Services Officer, DoH)
- Jackie Johnston (Deputy Secretary, DoH)
- Anne Kilgallen (Chief Executive, WHSCT)
- Charlotte McArdle (Chief Nursing Officer, DoH)
- Michael McBride (Chief Medical Officer, DoH)
- Liam McIvor (Chief Executive, BSO)
- Deborah McNeilly (Deputy Secretary, DoH)
- Tony Stevens (Chief Executive, NHSCT)
- Alan Stout (General Practitioner)
- Mark Taylor (Consultant in General and Hepatobiliary Surgery, BHSCT)
- Valerie Watts (Chief Executive, HSCB and Interim Chief Executive, PHA)
- Dan West (Chief Digital Information Officer, DoH)

APPENDIX 2: The table below sets out an update on the 18 priority actions within *Delivering Together.*

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work the Health and Social Care Board, as well as the recommendations from the Expert Panel	January 2017	Complete - Elective care plan published.	
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by: • increased GP training places; • continued investment in practice based pharmacists; • ensuring every GP practice has a named district nurse, health visitor and social worker to work with; • supporting the development of new roles such as physician associates and advanced nurse practitioners; and • further rollout of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies.	March 2017	Complete - Multi-disciplinary teams are being rolled out in three areas, with a focus now on practice based social workers. Consideration is being given to consultation on GP Federations in the absence of a minister.	
3	Bring forward proposals relating to the extension of placement options for **Looked after Children**.	October 2017	Complete - A consultation analysis will be published in the coming weeks.	
4	Following the completion and evaluation of a pilot project, roll out access to the NIECR to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists**.	October 2017	Complete – Access for independent optometrists is now available. Roll out to community pharmacies is ongoing.	
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	November 2016	Complete - A contractual framework has been developed.	

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	November 2016	Complete - Criteria for service reconfiguration published. Programme of service reconfiguration reviews underway.	
7	Following extensive review and engagement, launch a public consultation on proposals to modernise and transform **pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future	November 2016	Complete - Consultation completed in February 2017.	
	Move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups.	November 2016	Complete - Diabetes Strategic Framework published November 2016.	
	Launch and commence implementation of the **paediatric strategies** (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families.	November 2016	Complete - Paediatric strategies published in November 2016.	
	Launch a public consultation on proposals to develop sustainable **stroke** services and further improve the standard of treatment and care provided to stroke patients.	February 2017	Complete - A consultation on reshaping stroke care was launched on 26th March 2019.	
	Following a recent review, launch a public consultation on the configuration of **imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice.	February 2017	Complete - Public consultation launched 26th October 2017.	

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres**.	October 2017	Complete - Work concluded in November 2017 with delivery of a Task and Finish Group report.	
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	March 2017	Complete - Operating model agreed.	
10	Identify current ***innovative HSC projects*** at a local level and develop a rolling programme and implementation plan to scale up these projects across the region.	April 2017	Complete - Programme of innovative projects agreed.	
11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	November 2016	Complete - Engagement launched by minister.	
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	November 2016	Complete - Oversight structures in place.	
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the longer term sustainability of the adult social care system.	April 2017	Complete - Consultation complete.	
14	Design complete and procurement in progress for a **new user feedback platform** open to all those who both use and deliver our services.	October 2017	Complete – Design complete and procurement in progress.	
15	Complete the initial design work for the **Improvement Institute**.	February 2017	Complete - Initial design work completed by February 2017.	
16	Develop a **workforce strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	May 2017	Complete - Workforce strategy agreed.	

	KEY DELIVERABLE	TARGET	COMMENT	STATUS
17	Develop an **HSC-wide leadership strategy**, to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	May 2017	Complete - Strategy agreed August 2017.	
18	Expand the range of information and interaction available to citizens on-line and development of a **patient portal** for dementia patients.	October 2017	Complete - Symptom Checker available on nidirect in January 2019. A patient portal went live in December 2018.	

Exhibit 82

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

HEALTH AND WELLBEING 2026 DELIVERING TOGETHER

PROGRESS REPORT – 2021

CONTENTS

SECTION 1: MINISTERIAL FORWARD

'Health and Wellbeing 2026: Delivering Together" was published in 2016 in response to huge strategic challenges, including an ageing population, increasing demand, long and growing waiting lists, workforce pressures, the emergence of new and more expensive treatments, and ongoing budget constraints. The strategic direction sought a transformed health and social care service, both in delivery and in planning.

Since becoming Health Minister, I have repeatedly expressed a wish to continue the journey to improve our health and social care services. I am determined to strengthen the health outcomes for our population by making our system better.

This is particularly relevant considering the current context when our services are under considerable pressure. Whilst the pressures were present before the pandemic, they have only increased since March 2020. In my time as Health Minister I have therefore continued with the improvement journey started in Delivering Together. Even whilst in the grips of a pandemic almost £100m of transformational projects were delivered in 2020/21 further improving outcomes through new, innovative, working.

The impressive progress outlined in this report highlights the effects of a dedicated workforce, who are committed to always improving the outcomes for the whole population of Northern Ireland.

I would like to thank all those who have been involved in planning and delivering these projects. You deserve full recognition and admiration. With your help and support to continue to strengthen our health and social care service we are undoubtedly in a better place than we would have been without the successful delivery of the projects. By doing this we can collectively ensure that Northern Ireland continues to improve our health and social care services to deliver the best outcomes for everyone in society.

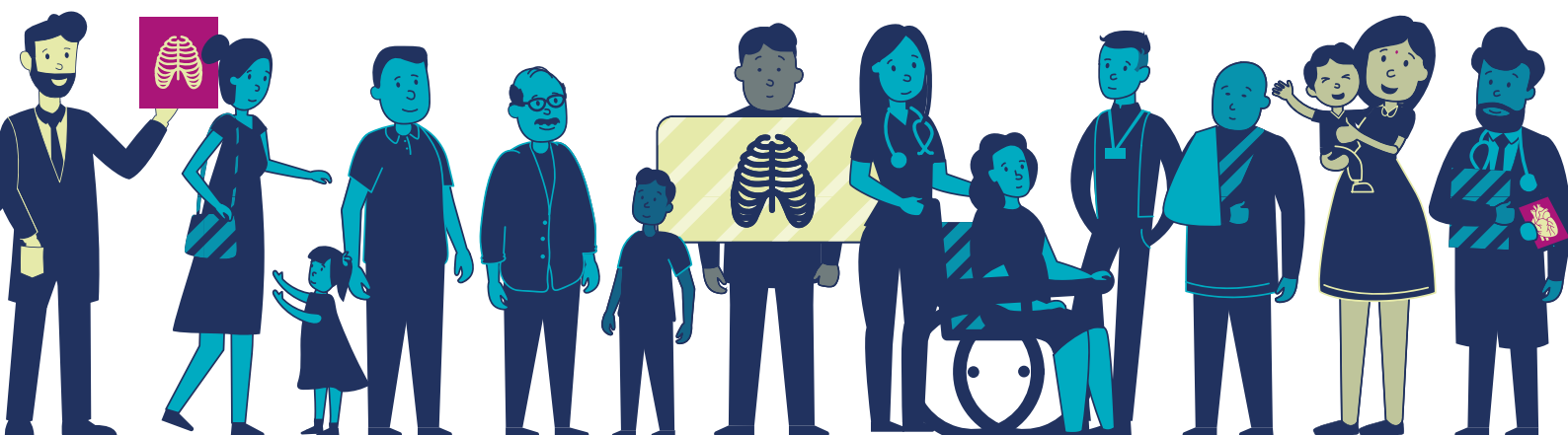
This reports outlines the progress made by projects on the ground across a broad range of critical areas – amongst many other initiatives – the reconfiguration of existing services, improved capacity and flow of patients through hospitals, supported and expanded primary care services, strengthened the workforce, invested in e-health, innovation and leadership and developed new practises in social work.

The evidence contained within this report confirms that this programme of activity has been hugely successful in stabilising, reconfiguring and improving our health and social care services.

I am delighted to publish this third progress report which provides an update on the extensive activity undertaken during 2020/21 to help realise the complex long term ambition to improve our health and social care system as detailed in Delivering Together.

Robin Swann, MLA
Minister of Health

SECTION 2:
AMBITION



SECTION 2: AMBITION

Since the advent of 'Health and Wellbeing 2026: Delivering Together' in October 2016, it has been recognised that the journey of Transformation would be an iterative one. And this has been the case.

As was clearly set out in Delivering Together, we faced huge strategic challenges prior to Covid-19. These 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.

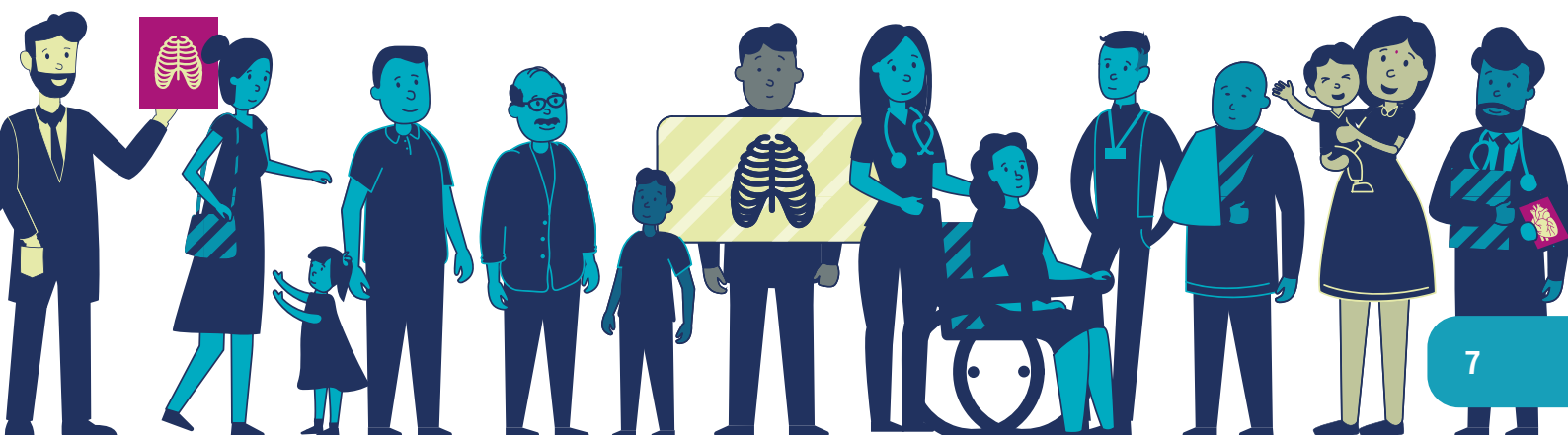
In just under four and a half years, an extensive catalogue of initiatives - spanning the length and breadth of the HSC - has been progressed which has both challenged and supported the system.

The process of transformation has supported the stabilisation of services and laid important cornerstones in services - such as acute care at home and ambulatory care - which have become integral to the effective running of the system.

It has significantly tested our appetite and ability to reconfigure services in areas such as Stroke and Urgent and Emergency Care, and shone a light on the system's capacity, capability and willingness to truly transform through the creation of new care pathways in Primary Care Multi-Disciplinary Teams and through Day-Case Elective Care Centres.

It has also supported a much needed focus on workforce, and re-emphasised the importance of this most valuable asset in creating a sustainable system for the future.

SECTION 3:
LEADING & SUPPORTING CHANGE



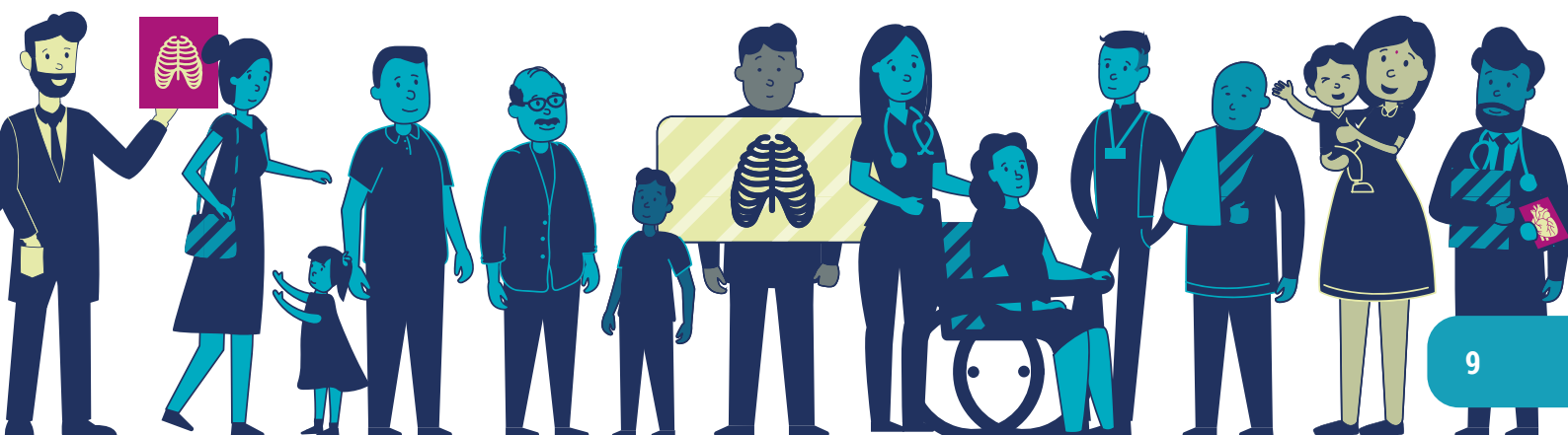
SECTION 3: LEADING AND SUPPORTING CHANGE

The governance arrangements for the Transformation of Health and Social Care services initiated by Health and Wellbeing 2026: Delivering Together had two elements; the Transformation Implementation Group which provided strategic leadership for the Transformation programme, and the Transformation Advisory Board, whose role was to act in an advisory capacity to oversee the direction of reform and complement the work of the Transformation Implementation Group.

In response to the COVID-19 pandemic the Strategic Framework for Rebuilding HSC Services was published on 9 June 2020. A new Rebuilding Management Board was established to oversee the Department's work on Rebuilding. The Rebuilding Management Board, subsumed the role of the Transformation Implementation Group and took on responsibility for consideration of key strategic Transformation decisions, in the context of rebuilding.

The Transformation Advisory Board will continue as a forum for engagement on the approach to transformation within the broader strategic context.

SECTION 4:
PROGRESS AGAINST OUR AMBITIONS



SECTION 4: PROGRESS AGAINST OUR AMBITIONS

Delivering Together committed to transforming the whole HSC, as one system, by:

- Building capacity in communities and in prevention
- Providing more support in primary care
- Reforming our community and hospital services
- Organising ourselves to deliver
- Enabling transformation

This section of the report details the funding allocations made to and progress made by 92 Transformation projects which were on the ground in the 2020/21 financial year.

IMPLEMENTING A DIABETES PREVENTION PROGRAMME FOR AT RISK PEOPLE IN NORTHERN IRELAND

Objective

To introduce and evaluate a diabetes prevention programme in Northern Ireland.

Total Investment

£1,613,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementing a diabetes prevention programme for at risk people in Northern Ireland	253	558	802	1,613

Regional Project

Yes.

Progress

An evidence based diabetes prevention programme has been introduced across Northern Ireland.

After its first year of operation the project demonstrated evidence of lifestyle changes within those patients taking part in the programme, including reduction in weight and a reduction in HbA1c levels which will reduce the risk of the development of Type 2 diabetes.

There have been 107 diabetes prevention programmes with 2120 participants commenced between April 2019 and March 2020. Positive early outcomes, for those completing the programme over a nine month period: include 63% reduced HbA1c, 29% no longer within pre-diabetic range, and 25% remaining the same (delayed onset).

For the first year of the programme, an evaluation plan was developed and operationalised with data evidencing that the service was acceptable from both the perspective of those taking part, and from primary care teams making referrals to the service.

The impact of COVID-19 meant that the programme became virtual in the second year of operation, demonstrating its adaptability.

A further 54 virtual programmes began in 2020 hosting 578 participants and whilst it is too early to ascertain what the retention rates are with this virtual programme, 80% of participants remain engaged.

In total, of the 1,064 participants who have completed the programme to date (as at November 2020):

- 72.6% had reduced HbA1c
- 59.8% are now within a normal range
- 12.6% had no change in HbA1c – a positive outcome as no progression
- 15% of participants had an increased HbA1c
- There was an average 4.4kg weight loss
- There was an average weight loss of 5.7% of body weight

Strategic Importance

Type 2 diabetes is one of the most common long-term health conditions in Northern Ireland, associated with significant morbidity, mortality and healthcare costs. Delivering Together aims to manage the ageing population with long term conditions. It is estimated that by 2027 there will be a further 45,000 cases of Type 2 diabetic patients across Northern Ireland.

In addition, NHS England and Diabetes UK have summarised their findings on the links between COVID-19 related deaths and diabetes stating that of all COVID-19 hospital deaths in England between March and May 2020, a third of these deaths happened in people with diabetes.

TRANSFORMATION OF HEALTH CARE IN THE CRIMINAL JUSTICE SYSTEM

Total Investment

£1,588,000

Objective

To improve access and the quality of health care in the Northern Ireland prison system in line with the strategic direction set out in the Joint Department of Justice / Department of Health Action Plan.

In addition, in terms of the wider criminal justice pathway, to pursue the partnership working between the Department of Justice and the Department of Health to roll-out nurse led provision in custody suites across Northern Ireland.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Prison Healthcare	142	333	350	825
Piloting a nurse-led on-site police custody healthcare service	290	220	253	763
	432	553	603	1,588

Regional Project

Yes. The South Eastern HSC Trust (SEHSCT) provides healthcare for the whole of Northern Ireland's prison population.

Progress

The SEHSCT have progressed five projects in relation to prison healthcare that have been assessed by HSCB and PHA professionals, as delivering real benefits to the prison population across all prison settings.

Allied Health Practitioners have provided new services across a range of areas, for example, dietetic practitioners have supported over 200 men with advice and courses, such as the expansion of the Cook It programme via the training of 12 new tutors.

Physiotherapists have held over 85 new clinics, seeing over 580 clients for Chronic obstructive pulmonary disease related issues, with 275 GP appointments released as a result of this work.

Additional pharmacy capacity within prisons has improved medicines management along with the promotion of the physical health benefits to prisoners with regard to smoking cessation. Between April 2019 and March 2020, 34 prisoners participated in smoking cessation activities.

A peer support worker initiative has assisted in addressing the high levels of mental health and anxiety

within the prison population. Peer support workers provide both group, and one-to-one interventions, and hold a case-load of 10 individuals at any one time.

Nursing Assistants were introduced to offer skills mix and ensure nursing time was used effectively. In addition, these nursing assistants are now in a position to be accepted on to the Open University's Nursing Programme and to work towards professional registration.

In respect of the provision of health care in police custody suites, this joint initiative with the Department of Justice was established as a pathfinder in Musgrave Street Police Station, Belfast.

Such has been the success of this pathfinder that, in May 2020, the Police Service of Northern Ireland (PSNI) and Public Health Agency (PHA) submitted a joint business case for its roll out across all PSNI custody suites. The business case detailed monetary and non-monetary benefits including that since the introduction of the nurse led model, there has been a significant reduction in detained persons being referred for treatment in hospital emergency departments as they are now able to receive appropriate treatment within the custody suite. The number of referrals to hospital dropped by 42% from December 2018 – November 2019, compared to the previous year. Since the business case was submitted the custody pathfinder has also embarked on a pilot to screen for Blood Bourne Viruses (BBV), commenced a Clean Needle Provision Service and administers Covid-19 screening to help limit the spread of the virus in police custody. The roll-out of the scheme has been delayed but it is envisaged that it will be operational in Antrim Custody Suite by the end of 2021/22.

Strategic Importance

These initiatives support delivery of the, Improving Healthcare within the Criminal Justice Strategy and Action Plan, Health and Wellbeing 2026: Delivering Together, and the draft Programme for Government for Northern Ireland in that they are helping to address inequalities in Northern Ireland.

This is also further reflected in Making Life Better, and also in New Decade, New Approach, which reiterates the Northern Ireland Executive's intention to 'Delivering a fair and compassionate society that supports the most vulnerable'.

IMPLEMENTING A NEW METHOD OF CARDIAC REHABILITATION DELIVERY, OUR HEARTS, OUR MINDS PROJECT

Objective

To help individuals across the cardiovascular disease spectrum by implementing an innovative evidence-based, community preventive cardiology programme delivered by a multidisciplinary team.

Total Investment

£1,697,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementing a new method of cardiac rehabilitation delivery, Our Hearts, Our Minds	199	758	740	1,697

Regional Project

No. Project delivered within Western HSC Trust only.

Progress

A total of 990 patients have taken part in the programme which is now well established and has shown substantial improvements across all the domains of cardiovascular health including:

- A reduction of 54% in smoking status;
- Improvement in adherence to a cardio-protective diet, evidenced by an increase of three units in the Mediterranean Diet Score. To put this in context, an increase of 1.5 units is associated with a 30% relative risk reduction in cardiovascular disease events;
- Improvement in physical fitness as evidenced by an increase in METs (a ratio of your working metabolic rate relative to your resting metabolic rate) from 6 - 7.5. To put this in context, one MET increase is associated with an 8-17% reduction in all-cause mortality;
- A reduction in weight by 3.2kg in those who had a BMI greater than 25kg/m2, as well as reductions in central obesity – i.e. waist circumference reduced by 5cm;
- Overall achievement of blood pressure and cholesterol targets of 89%, and prescription of statins and Angiotensin-converting enzyme (ACE) inhibitors of 98% and 96% respectively at the end of the programme.

In May 2020, in response to the Covid-19 pandemic, the programme transitioned rapidly to a virtual platform which included assessment via video/telephone, group virtual education sessions and the provision of a Fitbit smartwatch to patients.

The Western Trust is to become the first healthcare institution in the world to offer its cardiovascular patients a Fitbit smartwatch in combination with an app to detect atrial fibrillation through the programme. The Trust is reporting adherence and attendance rates being extraordinarily high and demonstrating a decrease of 9% in re-admission rates compared to the same period the previous year.

Strategic Importance

The Our Hearts Our Minds project contributes to the Delivering Together aim of Building Capacity in Communities and in Prevention. The outcomes for the project will be used to inform the future delivery of cardiac rehabilitation across Northern Ireland. A cardiac rehabilitation needs analysis is due to be carried out across all Trusts from March 2021 to assist with this.

COMMUNITY DEVELOPMENT FRAMEWORK IMPLEMENTATION

Objective

To implement the Community Development Framework through the development of a capacity building programme, ELEVATE, and the establishment of a governance structure, the Implementation and Innovation Board.

Total Investment

£649,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Community Development Framework implementation	113	350	186	649

Regional Project

Yes.

Progress

The ELEVATE programme was established to build the capacity of individuals and organisations to use community development approaches as a way to reduce health inequalities.

Significant progress has been made including:

- Establishment of an online Community Development Portal that has seen almost 6,000 users this year;
- Building sustainable resilient communities through positive collaboration mentoring of organisations / groups via the development of a community mentorship programme, with five mentor organisations (one per Trust area) supporting a total of 34 organisations in 2020/21.
- Online training has been delivered to 201 participants this year, from a range of sectors including the community and voluntary, HSC Trusts, Allied Health Professionals, GPs, and other Government Departments.
- Developing and refining an evaluation framework to demonstrate the impact of Community Development. To date 38 participants have received training on the framework, which will be piloted by the Public Health Agency from April 2021.

In addition to the ELEVATE programme, a Community Development Implementation and Innovation Board (IIB) has been established to support the delivery of ELEVATE and embed effective community development practice across health and social care and wider statutory and community based organisations.

The programme adapted very quickly and moved online in response to the pandemic, with feedback from participants positive throughout. To date this year, all 20 of the planned training workshops have been carried out with 201 participants while a waiting list for further training has been established.

An early evaluation completed in March 2020 by Community Evaluation NI, highlighted that the programme has been welcomed across the wider health and social care system and community and voluntary sector, and demonstrates enhanced skills and knowledge regarding community development approaches to tackle health inequalities as a result of the training.

The project is playing a vital role in supporting the most vulnerable by equipping grass roots community development organisations, practitioners and volunteers with the tools, knowledge and resources to identify, and take collective action on root causes of health inequalities.

In addition to the successes noted above, the IIB and the ELEVATE programme have also been supporting a number of other key transformational projects including an Integrated Care Partnership workshop with a subsequent health inequality pilot currently underway within the South Eastern Health and Social Care Trust (SEHSCT).

The long term aim of the project is to upskill community development practitioners with the knowledge, resources and support to engage with their local communities to identify local priorities, and to work in partnership with statutory providers to tackle the root causes of health inequalities. The project is assisting local communities to identify and find solutions to improving their own health and wellbeing outcomes and doing so with maximum economy

Strategic Importance

Community Development has a strong contribution to make to achieving health and wellbeing outcomes. The health and social care system, irrespective of how effective and efficient it can be can only ever address a limited dimension of health. It is the intrinsic resources of communities - their strengths, knowledge and skills that the Community Development Framework is harnessing. The project is aligned to a number of strategic plans including the draft Programme for Government, Making Life Better, Delivering Together and Community Planning Processes. The project contributes to the Delivering Together aim of Building Capacity in Communities and in Prevention.

DYSPHAGIA NI:
A PARTNERSHIP APPROACH TO SUPPORTING EATING, DRINKING AND SWALLOWING DIFFICULTIES FOR ADULTS IN NORTHERN IRELAND

Objective

To develop a partnership approach to support the eating, drinking and swallowing (dysphagia) needs of adults in Northern Ireland and enable an integrated approach to supporting improved access to services, early identification and prevention, learning from patient experience and improving the safety of people with swallowing difficulties.

Total Investment

£1,905,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Dysphagia NI	131	930	844	1,905

Regional Project

Yes.

Progress

A mandated safety programme has been implemented across Northern Ireland to improve the safety of adults and children with eating, drinking and swallowing difficulties and as a result, the eating and drinking care plans for 1,300 service users has been reviewed.

A regional eLearning programme has also been developed to support health care workers' knowledge, identification and management of people with swallowing difficulties. Within six weeks of the launch of this programme, 390 staff members had completed this online training and received certification. In addition, approximately 2,500 face-to-face dysphagia awareness training sessions have been provided across the HSC, including Trusts and independent care homes.

Work has also been progressed to improve the identification and management of dysphagia and to work towards regional consistency including; the introduction of a regional swallowing difficulties observational checklist; health professional access to dysphagia friendly medication information; and regional priorities and guidance documentation available on a single online platform.

With COVID-19 acting as a catalyst for the need to move to digital engagement, in this and many other services, a regional TeleEDS pilot was progressed.

This pilot has allowed clinical consultation via teleconferencing, improving access to services for care home residents, and providing professional support for staff managing people with swallowing difficulties.

As a result of this service redesign there has been a 91% reduction in waiting times for a routine swallowing assessment in care homes from 52 weeks to an average of 4.7 weeks. 109 patients were assessed and treated as part of the initial pilot phase.

As part of this pilot 1,550 dysphagia menus in residential care homes and acute care were audited to ensure suitable eating and drinking plans were in place, and a regional scoping exercise was carried out, with 120 service users, 74 stakeholders and 62 speech and language therapists consulted, to put people's voices at the heart of system change.

Work has also been progressed to raise public awareness of swallowing difficulties through GPs, pharmacies, and HSC Trusts. A regional partnership has been established between HSC Trusts, the HSCB, and PHA to collect and share Dysphagia data. Dysphagia guidance packs - sharing links to online information - were sent to 249 nursing homes, and 234 residential care settings during the pandemic.

Strategic Importance

The project is aligned to a number of strategic plans including Delivering Together which aims to build capacity in communities and in prevention, reform community and hospital services, and organise ourselves to deliver.

DEVELOPING A MULTI-DISCIPLINARY IN-REACH SUPPORT FOR NURSING AND RESIDENTIAL CARE HOMES

Objective

To enhance and expand the knowledge and skill of care home staff to meet the urgent and critical care needs of residents with the aim of reducing avoidable attendance at emergency departments, admission to hospital, and the appropriate use of out-of-hours services.

Total Investment

£1,917,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a Multi-disciplinary In-reach Support for Nursing and Residential Care Homes	240	879	798	1,917

Regional Project

Yes.

Progress

Multi-disciplinary Care Home Support Teams have been established in each Health and Social Care Trust area with a total of 23 staff including nursing, social work, physiotherapy and dietetic professionals working across five teams.

All Care Home Nursing Support Teams have been enhanced to respond to COVID-19, and became the single point of contact with care homes during the pandemic. These teams, provide updates / support in relation to the ever-changing guidance including e-learning links, Infection, Prevention and Control (IPC) guidance, swab testing, face fit testing and, COVID-19 testing. They also provide clinical care support to meet the needs of those communities of critically vulnerable people living in care homes.

Since 2018, the Care Home Nursing Support Team in the Belfast Health and Social Care Trust has placed emphasis on upskilling nursing home staff to develop clinical skills by undertaking routine catheterisations, gastrostomy tube changes, and managing syringe pumps independently. The result is that nursing teams now rarely have to provide this service.

In the Northern Health and Social Care Trust in 2019/20, as a result of the work of the Care Home Nursing Support Team, the number of referrals to the hospital diversion team reduced from a peak of 12 per month, to a maximum of two per month.

The overall complaints and incidents reported by care homes to the South Eastern Health and Social Care Trust have reduced since the Care Home Nursing Support Team has been established. The number of complaints has reduced from just under 40 in the first quarter of 2018/19 to five in the same period for 2020/21. The number of incidents has also dropped from over 2,000 per quarter, to less than 500 over the same time period.

In the Southern Health and Social Care Trust, support from physiotherapy through the Care Home Nursing Support Team has raised awareness of fall prevention techniques, utilising technology to keep residents safe, and supported care home staff to deliver individualised care to residents with complex moving / handling needs.

The Western Health and Social Care Trust Care Home Nursing Support Team has delivered bespoke training, with 32 sessions delivered to 302 attendees up to March 2020. Since the onset of COVID-19 bespoke training has been delivered in nine training sessions, with 100 attendees.

Strategic Importance

This project supports delivery of the aims of both Delivering Together – reforming our community and hospital services - and Making Life Better by improving the health of our people; improving the quality and experience of care, and by ensuring sustainability of our service by measuring, monitoring and evaluating the care delivered in care homes.

SUICIDE PREVENTION - TOWARDS ZERO SUICIDE

Objective

To improve patient safety and outcomes, and reduce suicides in mental health patients.

Total Investment

£1,361,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Suicide Prevention - Towards Zero Suicide	127	615	619	1,361

Regional Project

Yes.

Progress

This project is running to timescale, with early set-up targets realised and quality improvement testing rolled out as planned. Work was stalled due to COVID-19 pressures from March – September 2020 but quickly reconvened.

Work to date has included the establishment of a multi-professional, five HSC Trust collaborative team of work streams that includes prison health care. A systematic review of adult mental health services has been conducted against the National Confidentiality Inquiry into Suicide and Self Harm Recommendations for Safe Services to identify new opportunities to improve patient safety, focused on suicide intervention and management.

As a result, six quality improvement projects are now in place and a learning partnership has been secured with Mersey Care NHS Trust including;

1. Co-production – work involving people with lived experience, carers and bereaved families in shaping suicide prevention interventions and priorities;

2. Workforce Learning & Development – producing a learning plan aligned with suicide prevention and self-harm competencies and roles, and developing local capacity to deliver on same, including the development of online training accessible to all HSC staff;

3. Collaborative Safety Planning QI Project- Final implementation testing of two safety planning models for regional use, and a six month spread and scale plan will follow to support consistent evidence-based safety planning practice across services and prisons;

4. Minimising Restrictive Practice (MRP) QI Project - Drawing on Trauma informed practice, service user feedback and evidence-based practice, this work aims to reduce the use of Restrictive Practices by 30% in identified wards in each Trust by the end of December 2021 through MRP project teams established in each Trust;

5. Suicide Prevention Care Pathways (SPCP) QI Project – Approval has been obtained to pilot a SPC Pathway in pilot sites in Adult Mental Health in Northern, South Eastern, Southern and Belfast Health and Social Care Trusts and in Northern Health and Social Care Trust Child and Adolescent Mental Health Service (CAMHS).

6. Early Post-discharge appointments – A new work stream has recently been set up to explore the safety benefits and resource/service changes required in order to offer earlier post discharge follow up to inpatient mental health care.

Significant work has also been progressed in the areas of safety planning, minimising restrictive practice in line with the ongoing Mental Health Action Plan Review of Restraint and Seclusion, three day follow-up, and the learning plan.

Strategic Importance

Northern Ireland has the highest prevalence of mental health problems in the UK. The legacy of the Troubles is also recognised as having an impact on mental health in Northern Ireland with 39% reporting experiencing a traumatic event relating to the Troubles.

This project aligns with the aims of the Department's Protect Life 2: A strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024, the Department's Mental Health Action Plan (2020), and Mental Health Strategy 2021-31.

It also aligns with the NI Executive's renewed commitment to transformation which focusses on well-being and support for mental health services, through both Delivering Together, and New Decade New Approach.

SUICIDE PREVENTION - PROTECT LIFE 2

Total Investment

£176,000

Objective

The project objectives are to:

- Support responsible media reporting on suicide by promoting the use of, and compliance with, media guidelines and promoting best practice guidelines on memorials and social media gatherings.
- Support the development and implementation of local Protect Life 2 action plans across the region.
- Build knowledge and awareness of the function and role of local Protect Life 2 Implementation Groups, in meeting community needs.
- Build knowledge and awareness of mental health / suicide prevention services.
- Support and inform the commissioning of community-based suicide prevention services by the Public Health agency.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Suicide Prevention- Protect Life 2	0	0	176	176

Regional Project

Yes.

Progress

The project has supported responsible media reporting on suicide by promoting the use of, and compliance with, media guidelines and promoting best practice guidelines on memorials and social media gatherings through the delivery of a series of engagement workshops and interviews with persons with lived experience and stakeholders to test and evaluate the pilot concept and the development of a web platform.

Each of the five Protect Life 2 Implementation Groups have developed local action plans which are currently being delivered in each of the five HSC Trust areas across NI. These plans are addressing unmet needs within local communities to either support those that are awaiting services to ensure that they do

not escalate, or to provide a support to individuals to help keep them from requiring access to services by promoting resilience and emotional wellbeing. The delivery of the action plans also builds knowledge and awareness of the function and role of local Protect Life 2 Implementation Groups, in meeting community needs.

Delivery of the action plans were completed by the end of March 2021 with approximately 11,000 people benefiting from this work. It is anticipated that the outcomes from the delivery of the action plans will include increased awareness of prevention and post-event services and how these can be accessed; increased hope and resilience; improved collaboration; and enhanced community capacity to prevent and respond to suicidal behaviour within communities.

To inform and support the commissioning of community based suicide prevention services, a specially appointed facilitator has held two engagement events with five individuals bereaved through suicide, with twelve community and voluntary sector organisations, ten statutory organisations, and academia including Ulster University and Queens University Belfast, Barnardo's, YEHA (Youth Education Health Advice), Family Forum, Families Voices Forum, Papyrus, Extern, PSNI, various local councils and members of HSC Trusts. One to one interviews have also been carried out with five people with lived experience of suicide ideation, or who have been bereaved through suicide to inform this important work.

Strategic Importance

This project links directly to actions outlined within, Protect Life 2 (PL2): A strategy for Preventing Suicide and Self Harm in Northern Ireland 2019 -2024.

It also supports the aim of Delivering Together to build support in communities and in prevention.

DEVELOPING A MULTI-AGENCY TRIAGE TEAM

Total Investment

£754,000

Objective

This initiative enables the Police Service of Northern Ireland, Northern Ireland Ambulance Service, and Belfast and South Eastern Health and Social Care Trusts' mental health professionals to work collaboratively, to ensure the most appropriate care possible for people when concerns about their mental wellbeing are reported via the 999 and 101 systems.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a Multi-Agency Triage Team (MATT)	0	577	177	754

Regional Project

The initiative is currently delivered in the Belfast and South Eastern Health and Social Care Trusts areas only.

Progress

Progress: The Multi Agency Triage Team (MATT) is a service of mental health professionals working alongside dedicated police officers and paramedics. It has been proven through this initiative that both users and those delivering the service consider MATT to be a positive alternative to the existing services for those experiencing a mental health crisis out of hours.

Prompt response times, the reduced need to attend / wait in emergency departments and the reduction in incidences of arrest have been welcomed by both users and staff, e.g. in 300 cases who would normally have been taken to emergency departments this was prevented in 238 cases, representing a 79% reduction.

In addition, 123 referrals would have been considered for the use of an Article 130 of the Mental Health (NI) Order 1986 and due to MATT input this was prevented in 114 instances, indicating a 93% reduction of involving potentially stigmatising legal processes whilst still providing the most suitable care for the individual. In over half of the referrals during the evaluation period the immediate crisis was de-escalated (n=225); in 72 of these instances referrals to mental health and substance misuse services were made to address the person's issues comprehensively and without having to use the emergency department route.

Strategic Importance

This initiative supports the delivery of a number of key strategies including Making Life Better and Delivering Together and No More Silos. In addition to supporting the delivery of targets in the Joint Commissioning Plan and Commissioning Plan Direction on reducing conveyancing rates and ED presentations, the programme also supports the delivery of the Protect Life 2 Strategy which identifies the need for early intervention to promote emotional resilience and frontline intervention for those in crisis.

DEVELOPMENT OF DERRY COMMUNITY CRISIS INTERVENTION SERVICE

Total Investment

£107,000

Objective

To respond to individuals observed to be in distress and potentially vulnerable and who would in all likelihood come to significant harm through self-harm and/or suicidal behaviour.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of Derry Community Crisis Intervention Service	20	27	60	107

Regional Project

Project delivered in the Western Trust area only.

Progress

The project commenced in January 2019 and is operational three nights per week over the weekend period in the Londonderry/Derry area. In 2019 the scheme had 212 interventions and in 2020 had 431. The majority of those helped by the service were in suicidal crisis, or there was a significant risk of loss of life as a result of the presenting crisis.

The service, which is provided by Extern, delivers a non-clinical community response within 30 minutes to individuals experiencing social, emotional or situational crisis. Individuals are offered a short term solution which includes risk assessment, de-escalation, support and identification of personal support options from friends or family. The service will also identify appropriate onward referral and signposting, advising the service user on how to avail of the appropriate service.

Strategic Importance

The objectives of this initiative align with the Protect Life 2 Strategy, Delivering Together which aims to build more capacity in communities and in prevention, and New Decade, New Approach which reaffirms the NI Executive's commitment to transformation and which includes a greater focus on mental health and wellbeing.

DEVELOPING AN EARLY INTERVENTION SUPPORT SERVICE

Total Investment

£1,779,000

Objective

To provide an evidenced based regional coherent offer of early intervention family support for children, young people and families to support families when problems first emerge before the need for statutory involvement.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing an Early Intervention Support Service	518	831	430	1,779

Regional Project

Yes.

Progress

The Early Intervention Support Service (EISS) has been established and tested as a new family support regional service model supporting circa 600 families annually working closely with the Family Support Hub network. A coherent regional evidenced informed family support model has been developed. One third of the 7,590 families identified annually through Family Support Hubs across NI with emerging vulnerability have access to an evidenced informed EISS.

EISS is monitored on a quarterly basis and report cards are produced annually. In 2019/2020, 720 families were referred to the service with 581 families receiving support.

Outcomes Star™ is the assessment tool used to establish an initial base line and to measure progress by families during and at the end of the intervention. 93% of families showed improvement in at least one of the outcome areas including; improved parenting skills/capacity; improved family relationships; increased participation/involvement in education/training/employment or improved emotional wellbeing.

An evaluation of the EISS completed by Queen's University Belfast (QUB) indicated that EISS is an extremely well received service that is clearly addressing unmet need.

Strategic Importance

EISS contributes to the Delivering Together, Health and Wellbeing 2026 commitment to give every child and young person the best start in life, and to increase the support provided to children, young people and families from before birth to adulthood. It also supports the implementation of the Executive's Public Health Framework "Making Life Better" and its ambition to give every child the best start.

Delivering together has committed to build on the success of the Early Intervention Transformation Programme and enhance early intervention services. By increasing early support to families the need for later intervention will be reduced, such as the need for children to come into care. This is consistent with New Decade, New Approach commitment to maintain the transformation agenda.

EISS will be particularly relevant and important in supporting the implications of disruption and pressure on families in the context of COVID-19 which has created very specific challenges to the psychological health and wellbeing of the whole population. The pandemic has brought increased pressure to children, young people and families in Northern Ireland.

HIV / PRE-EXPOSURE PROPHYLAXIS (PREP) SERVICE

Total Investment

£1,233,000

Objective

A Risk Reduction Clinic was introduced in Northern Ireland in July 2018. The clinic offered interventions aimed at reducing unsafe sexual behaviour, along with PrEP (Pre-exposure prophylaxis), to patients meeting risk-based criteria. PrEP is the use of antiretroviral drugs to protect individuals at risk of acquiring HIV.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
HIV/PrEP Service	210	620	403	1,233

Regional Project

Yes.

Progress

The PrEP service was established three years ago in 2018/19 with the use of transformation monies into both the Belfast and Western Trust. In 2020/21, due to Covid related pressures the Belfast service ceased at the end of March 2020 with staff being transferred to support COVID-19 related pressures. All patients were advised they could be repatriated to their Trust of residence as of November 2020. The Belfast clinic is not anticipated to be fully operational until April 2021. The WHSCT service continued to accept patients from across Northern Ireland throughout 2020/21 and from the monitoring information available we can see that against a target of 720 client/patient visits that there were 773 client/patient visits with 308 patients established on PrEP since the commencement of the WHSCT PrEP service in September 2019.

This PrEP service, in conjunction with the online testing service has the potential to increase sexual health testing and to detecting and treating more Syphilis, Chlamydia and Gonorrhoea infections, thereby reducing their onwards transmission. Trusts are working with the HSCB/PHA to provide the necessary monitoring information to reflect the project delivery period within each Trust.

The use of PrEP is worldwide and it has been deemed as a "miracle drug" in the fight against AIDS/HIV. It is already available through the NHS in England, Scotland and Wales. Much has been written about the use of PrEP, its efficacy and cost effectiveness. The establishment of a PrEP clinic in each Trust area is truly transformational within Northern Ireland and is widely supported by patients and clinical teams – it is fully endorsed as a necessary and strategic way forward.

In addition, for those at sexual risk of HIV and who are aware of PrEP and willing to take it, HIV is almost completely preventable with appropriate access to this service. Failure to continue to provide a recommended intervention will leave NHS clinics open to complaints, as well as possible legal recourse should a patient become infected with HIV as a result of not being able to continue to access appropriate PrEP services.

It is acknowledged that the availability of PrEP clinics is meeting a previously unmet need of at-risk clients to the service for HIV testing and STI ((Sexually Transmitted Infection) screening, who have never previously attended clinics or been tested. From the latest PHA figures we can see a clear decline in the number of new HIV diagnoses among MSM. This suggests that at least 20 new infections were prevented in the first year of PrEP clinics being made available

Strategic Importance

The development of a Northern Ireland PrEP service is enshrined within the ethos of the Delivering Together vision as it seeks to radically reform the way services are designed and delivered with a focus on person centered care and to build capacity in communities and in prevention to reduce inequalities.

While PrEP represents an important new method of preventing HIV transmission, it is part of an overall prevention strategy which includes HIV testing, risk-reduction counselling, condoms, sexually transmitted infection management and viral suppression through treatment of those infected with HIV. England, Scotland and Wales have already commissioned a HIV PrEP service as a core standard of care within their Sexual Health services.

DEVELOPING HEALTH AND SOCIAL CARE SERVICES FOR PEOPLE EXPERIENCING HOMELESSNESS IN NORTHERN IRELAND

Objective

To continue and develop health and social care services for people experiencing homelessness in Belfast and establish appropriate services in other Trusts on a sustainable and equitable basis.

Total Investment

£1,146,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing health and social care services for people experiencing homelessness in Northern Ireland	225	507	414	1146

Regional Project

Yes. Homelessness services are now available in all HSC Trusts.

Progress

Many elements of a comprehensive homelessness service have been established on a pilot basis in Belfast. This includes GP sessions for previously unregistered patients, additional general nursing care, specialist mental health support, dentistry, podiatry and enhanced hostel and hospital liaison. Ongoing evaluation by service users and colleagues has been excellent, for example feedback from 35 service users was over 90% positive in terms of accessibility, being comfortable to attend, and feeling that the service catered to their needs. Feedback in relation to the GP service from 50 service users was also more than 90% positive.

In Belfast the number of patients accessing GP, nursing, podiatry and dental services in dedicated premises are detailed in the table below:

Summary of activity - Belfast Inclusion Health Service, January – December 2019

Activity	Number
New registrations with GP	359
Consultations with GP	700
Active Nursing case-load	606
Nursing consultations	1966
Nursing interventions	4200
Triage calls (mostly from hostels)	1010
Blood-borne virus screens	360
Follow-up of people who did not wait at Emergency Department (high-risk)	55
Flu vaccinations	345
Podiatry new patients (part-year)	145 5% - high risk
Dental new patients (part-year)	272 99.7% requiring treatment

There was a reduction of 23% in attendance at emergency departments (ED) in the 4 months before and after follow-up of attenders at EDs who did not wait to be seen. For example, a patient who attended ED 18 times, and was also admitted to hospital 9 times during a two month period was subsequently linked with more appropriate services by a multi-disciplinary intervention provided by the project. Such patients are considered high-risk for adverse outcomes. Following this intervention, the patient attended the ED twice and was admitted four times to hospital in the next nine months. Multidisciplinary team meetings continue to ensure that the most appropriate services are provided to patients who are considered high-risk.

During COVID-19, this project liaised with those experiencing homelessness, hostels, the Northern Ireland Housing Executive and other relevant agencies to ensure that plans were in place to identify people experiencing symptoms of the virus, and that testing, isolation and care were available. This was very successful in preventing outbreaks of COVID-19 within this vulnerable population with no cases or outbreaks confirmed in those experiencing homelessness in Belfast during the first wave. A survey of 218 clients, using swab tests for active virus and blood tests for antibody levels, following the first wave, yielded no positive results, confirming the success of the prevention measures. Assessment of clients over 50 years of age regarding the need for shielding was also completed and appropriate shielding arrangements put in place for clients.

Pilot projects in other Trusts have also been established to provide nursing and enhanced GP provision to the homeless.

Strategic Importance

This project links with the recommendations in New Decade, New Approach and the Nursing and Midwifery Task Group Report to maximise the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

The PHA and HSCB, in partnership with a number of key stakeholders across General Practitioner Services (GPS), produced a General Practice Nurse Framework for Northern Ireland 'Now and the Future' (2016). This initiative aims to provide guidance to support systems and processes that are required for the development of The General Practice Nurse workforce. The recommendations of the Framework have contributed to the DoH recommendations for GP-led services across Northern Ireland in respect of the development of structures and nursing teams to support GPs (2016).

The Delivering Together aims include enabling people to stay well and to deliver services in the community where appropriate, which is congruent with the project's objectives and achievements. People experiencing homelessness have some of the worst health outcomes and lowest life expectancy in Northern Ireland. They have higher rates of physical and mental ill-health, and addiction issues, but experience more difficulties with access to appropriate health and social care services leading to more ill-health and high emergency department attendance. The project also contributes to the draft Programme for Government objectives on decreasing preventable mortality, living healthy active lives, and decreasing numbers in absolute or relative poverty.

GENERAL PRACTICE NURSE DEVELOPMENT

Total Investment

£295,000

Objective

To address the need for access to appropriate structured and validated education and training for GP nurses. This will provide appropriate and consistent training to meet the requirements for the complex and changing service needs for patients in primary care settings.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
GP Nurse Development	145	70	80	295

Regional Project

Yes.

Progress

GP Nurses require a depth and breadth of knowledge across a variety of clinical therapeutic areas. This project is providing appropriate structured and validated education and training. The range and type of education is varied e.g. standalone modules in non-medical prescribing at Queens or Ulster University, mandatory 3 yearly update for cervical cytology to ensure that the requirement listed in the Northern Ireland Standards for Nurse and Midwife Education Providers: Cervical Screening Sample Taking (PHA 2016) are met.

General practice nurses/healthcare assistants identified the topics which they believed where required to ensure their practice was safe, effective and up to date. Topics covered included management of long term conditions, awareness and management of sepsis and antimicrobial resistance and awareness of safeguarding, record keeping, consent and mental health issues in general practice. In addition, the Royal College of Nursing (RCN) facilitated the regional network for practice nursing and nursing assistants across four localities in Northern Ireland to which all practice nurses were invited as part of professional development and governance arrangements. A range of induction programmes and therapeutic clinical updates on core topics and bespoke education programmes for general practice nurses/healthcare assistants are being delivered, with almost 300 training programmes being delivered.

The training provided through this project will be completed at the end of March 2021. Interim feedback from nurses who have completed the courses and through their contribution to service delivery has indicated that the training has been beneficial.

Strategic Importance

This project links with the recommendations in New Decade, New Approach and the Nursing and Midwifery Task Group Report to maximise the contribution of nursing and midwifery to deliver population health and wellbeing outcomes.

The PHA and HSCB, in partnership with a number of key stakeholders across General Practitioner Services (GPS), produced a General Practice Nurse Framework for Northern Ireland 'Now and the Future' (2016). This initiative aims to provide guidance to support systems and processes that are required for the development of The General Practice Nurse workforce. The recommendations of the Framework have contributed to the DoH recommendations for GP-led services across Northern Ireland in respect of the development of structures and nursing teams to support GPs (2016).

PRIMARY CARE MULTI-DISCIPLINARY TEAMS (MDT)

Total Investment

£29,496,000

Objective

The rollout and implementation of MDT services 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.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Primary Care Multi-Disciplinary Teams (MDT)	1,488	10,234	17,774	29,496

Regional Project

Yes.

Progress

The MDT programme has been fully rolled out in the Down area and is progressing towards completion in Derry, West Belfast, Causeway and Newry area & District. Proactive planning is now underway to develop a road map for rollout across all 17 GP Federation areas. Staff in post as of December 2020 is as follows:

Across all the MDTs the following core staff are in post:

- Social Worker: 53 wte;
- Social Work Assistant: 23.5 wte;
- Mental Health Practitioner: 44 wte;
- Physiotherapist: 37.3 wte.

In addition the following nursing staff are supporting MDTs:

- District Nursing: 66.5 wte;
- Health Visiting: 34.5 wte.

By March 2021, this will be supplemented by the following additional staff:

- Social Worker: 10 wte;
- Social Work Assistant: 6.4 wte;
- Mental Health Practitioner: 10.8 wte;
- Physiotherapist: 10.2 wte.
- District Nursing: 8 wte;
- Health Visiting: 6 wte.

This means that, in the region of 600,000 people in Northern Ireland have access to an element of a Multi-Disciplinary Team within their GP practice with the overwhelming majority having access to a practice based mental health practitioner.

Strategic Importance

The MDT Project builds on the commitments in Delivering Together to invest in primary care to ensure there is a multidisciplinary team focused on the patient. New Decade, New Approach has committed to the ongoing roll out of Multidisciplinary Teams to build capacity in General Practice.

The Department of Health, Mental Health Strategy identifies the need for better mental health care and treatment in the primary care setting. It supports the roll out of further mental health workers as the key delivery measure. The Strategy also highlights the role Multi-Disciplinary Teams have in early intervention and prevention. The roll out of primary care multi-disciplinary teams, including mental health workers, will provide better access to mental health support in an easily accessible format where people need it. This will lead to quicker access to services, less referrals and better outcomes for people.

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.

COVID Work

Mental health and social work services have played a key role in the COVID-19 response by pro-actively engaging with the most vulnerable in our society. For example, social workers contacted vulnerable patients during the first wave of the pandemic and, working with statutory services and the local community, put in place in excess of 3,500 support packages.

Ongoing Evaluation

The Q3 Evaluation Report from RSM has highlighted the following promising signs of early impacts across the HSC during 2019/20:

- Whilst the number of GP referrals (per 1,000 patients) of Musculoskeletal (MSK) has decreased at a faster rate than in non MDT areas, referrals in MDT areas were broadly in line with the NI average in 2017/18. In Down and West Belfast, were the First Contact Physio (FCP) role within the MDT was fully in place during 2019/20, the reduction has been even more pronounced.
- There has been a decrease in the number of patients on waiting lists for imaging (14.7%) and physiological measurement (10.1%) in MDT areas between October 2019 and March 2020; and
- The average length of stay for chronic Ambulatory Care Sensitive (ACS) conditions (all ages) was considerably lower in the MDT areas than non-MDT areas, however, the time series trends across the MDT areas are not consistent.

As more patients self-refer to the new MDT roles, this will in turn release more GP time to better manage the more complex practice patient cohort. This 'Releasing Time to Care' approach will improve outcomes for these patients and further reduce demand to secondary care, for those who can now be safely managed in practices with this increased capacity.

These potential benefits and impacts will be closely monitored going forward but it is too early to make a definitive statement on them.

MULTI-DISCIPLINARY TEAM (MDT) EVALUATION

Total Investment

£173,000

Objective

To undertake an independent evaluation of the Multi-Disciplinary Team model that will help shape and improve the model as it is expanded across the remaining GP Federations, bringing benefits to patients and the wider HSC.

Regional Project

Yes (initially the scope of the evaluation is the 5 current MDT areas Down, Derry, West Belfast Causeway and Newry & District).

Progress

Having gathered primary and secondary care data (from 2019/20 returns), the MDT evaluation partners, RSM Consulting have completed the quarters 1 and 3 reports as required. The quarter 2 report was deferred due the impact of COVID-19 on data collection.

The Quarter 3 report provides an overview of the evaluation plan, baseline data on a range of healthcare indicators (collected Sept-Dec 2020), learnings from international case studies where MDTs have been successfully implemented (conducted Summer 2020), findings of MDT strategic stakeholder interviews, who expressed their views and opinions on the design, implementation, roll-out and impact of the primary care MDT model in NI (conducted Summer 2020). This report also provides findings from surveys with both service users and MDT staff, to capture their perceptions of the MDT model, its operation and its impacts on service users, staff and health services (undertaken Nov-Dec 2020).

The report contains the following analysis, including a range of positives, which support the current MDT model:

- A literature review has been undertaken which includes interviews with Nuka, PORT Germany, Primary Care Clinic for Integrative Health at Witten/ Herdecke University Germany, Ontario & Dudley. Key learning from these interviews highlighted the importance of team meetings, co-location, early engagement with professionals, formal links to secondary care and robust data collection.

- 26 Strategic stakeholder interviews have taken place with stakeholders from various organisations across the health and social care sector. There was a high level of enthusiasm amongst stakeholders for the MDT model, and all stakeholders felt that the model would positively impact upon care.

Areas identified by these stakeholders for further discussion included a training needs assessment of the staff within MDTs, guaranteed funding for the model and detailed workforce modelling and projections across primary and secondary care.

Service user and staff surveys closed on the 4 January 2021 with 195 and 216 responses respectively. Analysis of the survey results indicates a high level of patient satisfaction reported by patients with 89% satisfied or very satisfied with the service received and 78% feeling that the care received at their local practice had improved by the introduction of the expanded team.

In addition, 91% of staff surveyed, agreed/strongly agreed that the MDT has impacted positively on the health and wellbeing of service users. 81% agreed/strongly agreed that the MDT makes effective use of GP time and 75% agreed/strongly agreed that it has increased the sustainability of primary care. 78% agreed/strongly agreed that it has reduced referrals to secondary care.

To support the evaluation, additional work is ongoing to quality assure the primary care 2020/21 activity data extracted from the GP Intelligence Platform.

Strategic Importance

The development and implementation of Primary Care MDTs and this evaluation project will help shape and improve the MDT model which contributes to the Delivering Together theme of 'Providing more support in primary care'. It also supports the other Delivering Together themes:

- Building capacity in communities and in prevention;
- Reforming our community and hospital services; and;
- Organising ourselves to deliver.

PRIMARY CARE ELECTIVE REFORM IN NORTHERN IRELAND

Total Investment

£5,030,000

Objective

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, in line with Delivering Together: Elective Care Plan.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Primary Care Elective Reform in Northern Ireland	1,094	2,981	955	5,030

Regional Project

Yes.

Progress

A range of pathways have been designed to facilitate patients being managed more appropriately in primary care without the need to refer to secondary care. Beyond primary care capacity, they support 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 GP 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. At the end of January 2021 a total of 4,052 (including dermatology surgery) patients had been seen face to face plus a further 933 patients managed remotely;

- Gynaecology: to safely manage a range of routine gynaecological conditions (Coil fitting) in a primary care setting. A total of 2,538 patients were seen and treated and a further 1,007 remote consultations provided;

- Vasectomy: to safely deliver non-scalpel procedures in a primary care setting. A total of 1,479 patients were treated;

- MSK/Pain: to safely manage a range of routine MSK conditions in a primary care setting; A total of 2,302 were seen in clinic and a further 233 patients managed remotely;

- 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. A total of 548 patients were treated.

Planning is currently underway to introduce new pathways in specialties such as Cardiology and Dementia in 2021/22.

Strategic Importance

Delivering Together, commits to the development of a comprehensive approach for addressing elective care waiting lists on a sustainable basis. The Elective Care Plan which sets out the plan for the Transformation and Reform of Elective Care Services has 6 key objectives. Objective 3 is to Expand capacity and capability in primary care.

The continued development pathways and services within primary care delivered by this project are therefore strategically important in the management of waiting lists.

TRANSFORMATION OF PRIMARY CARE IN NORTHERN IRELAND

Total Investment

£5,955,000

Objective

To assist in transformation of Primary Care. Develop innovative primary care based models to build capacity in networks and build on GP Practice capabilities.

Development of Multi-Disciplinary Teams, GP Federations working with Primary and Secondary care professionals to provide integration of services which are patient focused and orientated around population health.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Advanced Nurse Practitioners (ANP)	682	1,113	1,852	3,647
GP Federations to develop crisis response	0	271	889	1,160
GP Federations Core funding	285	283	285	853
Trial a GP Hub model for providing early evening services	40	0	60	100
Primary Care GP Development	0	86	109	195
	1,007	1,753	3,195	5,955

Regional Project

Yes.

Progress

Progress against each of the services currently being provided by the GP Federations is as follows:

Advanced Nurse Practitioners

ANPs are now embedded within Practice teams including in Derry, Armagh & Dungannon, Down, East Belfast and Mid Ulster GP Federation areas and are making valuable contribution to the delivery of primary care services. There are 34 trained / trainee ANPs working across the five Federation areas.

Crisis Response

The Crisis Response team provide a regional service to all practices that are experiencing difficulty with recruitment and with management of the practice. Urgent support is available, especially for those rural and single-handed practices. During the year ending December 2020 a total of 241 sessions were provided

by the GP Crisis Response team to practices at risk. The Crisis Response Team has been involved with 45 practices during this time (37 practices now stable with ongoing support provided to the remaining 8 practices).

Core Funding

Eastern, Northern, Southern and Western Federation Support areas each have staff employed to support the 17 GP Federations. Development of the administration function across these areas is underway, aiming to provide dedicated finance, HR and administrative support within each area. Four Federation Support Units (FSU) have been established to provide support to the GP Federations as follows:

- Northern FSU supports four GP Federations (73 Practices)
- Southern FSU supports three GP Federations (73 Practices)
- Eastern FSU supports eight GP Federations (133 Practices)
- Western FSU supports two GP Federations (48 Practices)

Trial GP Hub

This funding will assist 'Out of Hours' (OOH) providers in moving towards new ways of dealing with OOH services in the overall transformation. The funding supports the transition from GP OOH to a new Urgent & Unscheduled Care Service model in line with No More Silos.

Primary Care GP Development

With respect to funding for Primary Care GP Development, the allocation was used to fund GP Mentoring Scheme, Retainer Scheme and Practice Manager Training:

- GP Mentoring Scheme – A total of 20 GP Mentors have been trained in delivering mentoring support to the GPs on the Northern Ireland Performers List;

- Retainer Scheme – This scheme is designed to assist in the retention of GPs in Primary Care. It aims to provide the retainer with stable work in a practice and some Out of Hours sessions. During the current financial year 25 retainers have been recruited into General Practice and a waiting list (five) has also been created for those interested in joining the scheme.

- Practice Manager Training provides an accredited training course to a number of GP Practice Managers across Northern Ireland. The course has been provided to 32 Practice Managers to date.

Strategic Importance

This project contributes to the Delivering Together commitment to improving access and resilience within primary care and to supporting the development of new models of care, which will include the development of MDT's, introducing more skill mix, including practice pharmacists and Advanced Nurse Practitioners.

In 2019/20 HSCB committed to providing more support in primary care, including multi-disciplinary teams, increasing skill mix across GP Practices and rolling out new initiatives to all 17 Federations to further enhance the integrated approach to provision of services. This project contributes to the achievement of this commitment.

NEIGHBOURHOOD DISTRICT NURSING (NDN)

Total Investment

£1,220,000

Objective

The Neighbourhood District Nursing (NDN) model aims to improve safety, quality and experience by developing a 'one team' approach, provided by a 24 hour NDN team within a designated community and aligned to the GP Practice, with the ethos of home being the best and first place of care. To do this, the team work in partnership with patients, carers and their families, General Practitioners, and other health and social care professionals as part of a wider multidisciplinary team.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Neighbourhood district nursing	73	735	412	1,220

Regional Project

Yes.

Progress

Progress has been made against a number of key objectives including:

Test a new model of District nursing linked to Primary Care Multi-Disciplinary Teams

Five district nursing teams, one in each HSC Trust area, started to test the model in summer 2019. Enhancement to existing district nursing teams meant that almost 4% of the district nursing workforce aligned to 3% of the GP population tested in the model. A Quadruple Aim approach was used in the evaluation. Quarter 3 2019/20 showed a total working caseload of 819 people, average 17 patients per whole time equivalent (WTE) which is higher than the regional average of 13.

Improve patient care through proactive management of population health

A structured local population health needs assessment informed the development of community health improvement plans and Quality Improvement (QI) projects e.g. the Ballycastle team undertook a Palliative Care QI project which indicated that 18% of people died in hospital compared with the Northern Ireland average of 48%. This quality improvement project was primarily focused on improving the patient experience however there was also an indirect cost impact.

Promote a new public health model for District Nursing

In Quarter 3 (2019/20) 59 patients were supported to self-manage in areas of diabetes, continence, medicines and weight management. Individuals were provided with the skills that increased their confidence to take control of their own health and wellbeing and make better lifestyle choices.

Test a coaching model for district nursing

Teams were allocated a coach to test the new model of district nursing services. Five Nurse Coaches were appointed and all were supported to undertake the Institute of Leadership and Management (ILM) Level 5 Coaching qualification, developed and delivered by the HSC Leadership Centre.

Develop self-organised teams under a collective leadership model

In order to measure the people impacts of the intervention, the project team utilised the engagement measurement methodology from the HSCNI employee survey. This methodology utilised three Key Findings (KFs) consisting of nine questions in total which when analysed provides a single index measure of engagement out of a total of 5.0 The overall staff engagement score was 4.39 from 29 respondents.

Whilst these results allow for an initial benchmark they also compare favourably with HSCNI (2019) engagement levels which were 3.78.

Patient and client experience is recognised as a key element in the delivery of quality healthcare. A 10,000 More Voices survey indicated that 83% of respondents rated their experience as strongly positive thus building on public confidence.

The Neighbourhood District Nursing Interim Report December 2020 confirms that the model is a proof of concept and the principles of the model will be integrated into the strategic direction for the District Nursing service in NI and the Primary Care MDTs.

Strategic Importance

This project contributes to the Delivering Together commitment to further develop primary care ensuring that every GP practice has a named District Nurse assigned. The NDN model has strengthened named District Nurse alignment and partnership working within the MDTs.

The DoH District Nursing Framework 2018-2026 (DoH 2018) is the strategic direction for district nursing services in Northern Ireland and advocates that district nurses will be instrumental in population health management. Care will be integrated and population based. One outcome is to develop a regional community nurse-led model of care prototype and then to determine the scale and spread of the model.

New Decade, New Approach has committed to further rollout of primary care multi-disciplinary teams (MDTs).

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 Northern Ireland HSC system.

PRACTICE NURSING

Total Investment

£1,672,000

Objective

To progress over the next 5/6 years the recruitment of additional general practice nursing workforce across GP federations to ensure that the NI benchmark (1:2222) is in keeping with national recommendations and to incorporate a phased approach with GP Federations and GP practices to implement the recommendations of the review of the pre-school vaccination delivery model.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Practice nursing	181	404	1,087	1,672

Regional Project

Yes.

Progress

In 2020/21 this project has enabled the recruitment of an additional 28 post registration trainee General Practice Nurses (GPN), across five GP Federations including: Ards, Antrim / Ballymena, Armagh/ Dungannon and South West and West Belfast. These nurses are currently completing the GPN training scheme and will be employed on a permanent basis within the five federation areas as Practice Nurses from September 2021.

The implementation of the recommendations from the review of the pre-school vaccination delivery model continue to be progressed on a regional basis. Pilot sites in the South West and West Belfast Federations continue to progress and monitor the uptake of vaccinations by 0-4 year olds. Project activity has also progressed across the five GP Federation areas with 32,085 vaccinations delivered.

Strategic Importance

The project links to New Decade, New Approach which committed to building capacity in General Practice and to the Delivering Together commitment to invest in primary care to ensure there is a multidisciplinary team focused on the patient. General practice nurses are an essential part of that team.

The General Practice Nursing Framework (PHA 2016), Phase 7 Delivering Care Policy framework and the Nursing and Midwifery Task Group Report, recommends the development of a system for workforce planning at a strategic level for General Practice Nursing which is linked to population needs and meets the requirements of patients in Primary Care and in addition can act as a catalyst for delivery on population based health initiatives including childhood immunisations.

PHOTO TRIAGE

Total Investment

£169,000

Objective

To continue with implementation of dermatology photo-triage service across Mid-Ulster and South Belfast GP practices as pilot areas in the first instance, prior to regional roll-out in 20/21.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Photo Triage	0	65	104	169

Regional Project

Yes.

Progress

Progress in the two pilot areas of the Mid-Ulster and South Belfast GP practices has been positive with 16% of referrals not needing to be seen in outpatients and a further 15% bypassing outpatients and going straight to surgery. As well as reducing demand for outpatient Dermatology services, patients being referred straight to surgery removes a step from the pathway, which ultimately ensures patients are treated quicker.

Photo triage is delivered in line with NICE COVID-19 guidance and safety recommendations to enable efficient planned care while minimising the risk of COVID-19. It is managing the care of elective patients who would not otherwise have access and/or have lengthy delays for assessment and treatment throughout and beyond the pandemic.

The success of the pilot has informed the full rollout of photo triage across all GP practices in NI and a project team is in the process of being recruited to support the roll out. A Hub model to help address the dermatology waiting list has been implemented in East Antrim and Mid Ulster and work is ongoing to further develop the Hub model which has been instrumental in the management of demand for dermatology services during the COVID-19 pandemic.

Work has commenced on reconstituting a project board and a full end to end review of the pathway has been completed with a list of enhancements agreed to improve the pathway for all users. The development of an electronic document transfer of the appointment outcome letters and image back function is underway. A minimum dataset and dashboard to capture and present the outcomes and uptake to the pathway has been agreed which will provide robust performance monitoring of the objectives of the project. Qualitative data will also be captured throughout the project which includes the capture of patient feedback on their experience of the pathway. A patient information leaflet has been developed in partnership with the PPI representative on the project team. The Project Team, have developed a Project Initiation Document, a project plan, communication and engagement plan and Terms of Reference for

both the Project Board and the Project Team. A review of the original modelling assumptions has been undertaken as part of the development of the project plan and it is anticipated that the pilot will be rolled out to eight or nine GP Federation areas in 2021. This will include the provision of training and awareness sessions to GPs and the deployment of the relevant equipment to support the pathway.

Strategic Importance

Delivering Together commits to the development of a comprehensive approach for addressing elective care waiting lists on a sustainable basis. The Elective Care Plan sets out six key objectives and associated actions for the Transformation and Reform of Elective Care Services in line with Delivering Together. The Photo Triage project contributes to the achievement of actions 1, to reduce waiting times; 3, to expand capacity and capability in primary care; 4, to improve direct access between primary and secondary care reform; and 5, modernisation.

DEVELOPING A NEW CANCER STRATEGY FOR NORTHERN IRELAND

Total Investment

£321,000

Objective

To develop a new Cancer Strategy for Northern Ireland for the period 2020 to 2030 which provides direction and coordinated action, across a wide range of fronts, and enables a comprehensive refresh of the HSC's approach to preventing and treating cancer.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a new Cancer Strategy for Northern Ireland	0	167	154	321

Regional Project

Yes.

Progress

The new Cancer Strategy phases one and two were developed by June 2020 with phase three recommendations subsequently completed following a short delay due to the impact of COVID-19. The draft strategy was developed in the context of a rapidly changing landscape of prevention, diagnosis and treatment options, workforce gaps and opportunities for change. The recommendations contained in the strategy will be costed and subject to review to ensure they provide a quality service and value for money. The implementation of the recommendations will be subject to ongoing monitoring and reporting.
The commitment to co-production underpinning the new Cancer Strategy will continue in the next stage through extensive use of consultation. This will ensure that the recommendations made meet the needs of all stakeholders and that the strategy outcomes continue to focus on quality and value for money.

It is envisaged that the strategy will go out to formal consultation at the end of June 2021 before being presented to the Minister for Health. This timeline is however dependent on the continuing engagement of HSC staff and the impact of COVID-19 on the provision of services.

Strategic Importance

The new Cancer Strategy for Northern Ireland for the period 2020 to 2030 contributes to the Delivering Together theme 'Reforming our community and hospital services' and the key enabler to 'Improve Quality'. The project also links to the Rebuilding HSC focus on rebuilding cancer services.

New Decade, New Approach outlined a commitment that the Executive would produce a new 10 year Northern Ireland Cancer Strategy. The strategy produced by this project will set the direction of travel and support the transformation of the current model of cancer service provision to ensure less people contract cancer and more patients recover from it.

REVIEW OF URGENT AND EMERGENCY CARE – NO MORE SILOS

Total Investment

£1,011,000

Objective

To review models of provision for urgent and emergency care across Northern Ireland to ensure that services are designed effectively to meet current and future needs.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Review of Urgent and Emergency Care – No more silos (NMS)	0	84	927	1,011

Regional Project

Yes.

Progress

The report on the review of Urgent and Emergency Care is due to be published summer 2021. The review of urgent and emergency care informed the DoH COVID-19 Urgent and Emergency Care Action Plan, No More Silos. This Action Plan brings together key leaders in primary and secondary care to implement the 10 key actions to improve the provision of unscheduled care service provision across the HSC.

Key Action 1

Urgent Care Centre (UCC) to be operational in Royal Victoria Hospital. Craigavon centre has opened, providing a limited service due to COVID pressures. An interim UCC solution at Downe Hospital has been developed as capital works at the Ulster site are due to complete autumn 2021.

Key Action 2

Keep Emergency Departments (ED) for emergencies. NMS Programme Team have developed a draft dashboard to monitor outcomes.

Key Action 3

All HSC Trust areas are developing rapid access pathways with supporting Clinical Communication Gateway electronic referrals for common clinical presentations. These pathways are fundamental to providing ED alternatives, for scheduling referrals from General Practice, Phone First and Urgent Care Centres.

Key Action 4

Regional Phone First model is now operational in Northern, Southern and Western HSC Trust areas. A local service model is operational in Downe Hospital and Belfast HSC Trust is planning a pilot with the Mater hospital.

Key Action 5

Scheduling Unscheduled Care – All HSC Trusts will have systems in place to schedule unscheduled care. This enables patients to wait at home before attending their scheduled appointment thus reducing congestion in ED and reducing risk of nosocomial infection.

Key Action 6 & 7

Anticipatory Care / Acute Care at Home - The NMS Network continues to work closely with Department of Heath senior nursing colleagues to ensure regionally consistent models for these services including standards and specifications.

Key Action 8

Ambulance Handover Zones – The BHSCT handover zone is now open. Handover zones will open in other Trusts areas by the end March 2021 with the exception of SEHSCT area which is scheduled to open in autumn 2021.

Key Action 9

Enhanced Framework for Clinical and Medical Input to Care Homes - HSCB Integrated Care have developed a model of care for enhanced Practice support for care homes, this has been issued to GP practices.

Key Action 10

Timely Discharge - Local Implementation Groups have been tasked to deliver additional domiciliary support to facilitate timely discharge including Enhanced Direct Payments. Pilots have been established in WHSCT and SHSCT areas with plans in place to roll out the service to all areas. NMS Network is engaging with the Regional Discharge Group to establish priority discharge.

Strategic Importance

Although the review of Urgent and Emergency Care is not yet complete, the move to implement the 10 key No More Silo's actions is already achieving the four aims of Delivering Together.

INTERMEDIATE CARE

Total Investment

£6,426,000

Objective

This transformation proposal was informed by the Northern Ireland findings of the National Audit of Intermediate Care (NAIC) 2017 and developed as an enhancement to a therapeutic frontline home based intermediate care team, responding rapidly and with a focus on recovery, independence and patient experience.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Intermediate Care	500	3,067	2,859	6,426

Regional Project

Yes.

Progress

Trust Intermediate Care implementation plans have continued to develop at varying pace, partly influenced by different starting positions. The project specification outlined the need for a 'home first' ethos (similar to work in Wales and England) and that is progressing within HSC Trusts and aligning with other regional Discharge to Assess (D2A) work for example one Trust demonstrated a 115% increase from 2018/19 to 2019/20 and another Trust reported an 8% reduction in rehabilitation bed days used which equates to 4,018 less bed days. User and '10,000 more voices' carer stories (unique to the Northern Ireland Intermediate Care approach) have helped drive further change through HSC Trust improvement plans.

These Intermediate Care local plans have focused on locality specific issues including reducing bed base, improving response times and accessibility over six or seven days. Support worker roles have been implemented in some HSC Trusts as substitution for workforce challenges. Project performance is monitored using digitalised community information systems.

During the COVID-19 surge, Intermediate Care services have been prioritised by HSC Trusts to maintain hospital flow and admission avoidance in line with the UK approach.

Strategic Importance

The work of this project contributes to a number of strategic drivers including:

- Delivering Together - Building Capacity in communities by using the knowledge gained from NAIC to focus on the enhancement of home-based intermediate care to standardise provision, through adopting a defined service specification which was to:

    - Embed a 'home first' (D2A) ethos;
    - Focus on rehabilitation and independence; and;
    - Begin to rebalance bed-based usage to align with national figures.

- Northern Ireland's "Intermediate Care Guidance" published by DoH in 2007.

- NICE guideline 74 'Intermediate care including reablement' in September 2017 (adopted in Northern Ireland);

- The new Rebuild Management Board (RMB) project "Intermediate Care Services for Northern Ireland - A Regionalised Approach" approved in December 2020.

DEVELOPMENT OF AN NORTHERN IRELAND WIDE ACUTE CARE AT HOME SERVICE

Objective

To provide Acute Care at Home in all areas in order to avoid unnecessary attendances at and admissions to hospital for the frail elderly.

Total Investment

£7,216,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of an Northern Ireland wide Acute Care at Home Service	752	3,360	3,104	7,216

Regional Project

Yes.

Progress

The development of an Acute Care at Home service in all HSC Trust areas in Northern Ireland continues to progress. The service is now fully operational and available to all residents in the Southern and Belfast HSC Trusts. A variation known as Enhanced Care at Home is available to all residents in the South Eastern HSC Trust. In the Northern HSC Trust, a Hospital Diversion Nursing Team is operational across the Trust area, in addition to an Enhanced Support for Care Homes project and the development of Direct Assessment Units at Antrim and Causeway hospitals. In the Western HSC Trust, Acute Care at Home is available in the northern sector and has recently been extended into the southern sector.

A regional Acute Care at Home Model is being developed as part of the No More Silos initiative in partnership with the Regional Management Board "Intermediate Care – A regionalised approach" project. Local variations in the developments within each HSC Trust will be adapted to conform to this regional model.

Strategic Importance

Delivering Together committed to rolling out Acute Care at Home to the whole population within three years and to better integrate it with social care and ensure it is supported by other services, including short stay hospital services, GPs and palliative care. It has also been identified as a key action from the Urgent and Emergency Care Review and is being implemented as part of the No More Silos Programme, particularly in supporting the frail elderly in care homes.

AMBULATORY CARE

Total Investment

£5,230,000

Objective

To make significant changes in the management of unscheduled care patients, whose condition can be managed in ambulatory pathways, by both scaling up existing models, creating new pathways and changing working patterns.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Ambulatory care	754	2,219	2,257	5,230

Regional Project

Yes.

Progress

Overall the project objectives have either been met or partially met on a regional basis. This project helps to support the response to the COVID-19 pandemic by reducing hospital admission at a time when hospitals in Northern Ireland are under extreme pressure. In addition, patients needing unscheduled care are also higher risk patients and treatment outside of hospital may reduce their risk of also contracting COVID-19 which could impact on their recovery.

Each HSC Trust is focussed on different priorities:

- SHSCT implemented a respiratory ambulatory service. From May 2019 to January 2020, 95 patients were accepted on to an ambulatory pathway and given an appointment at the Respiratory Ambulatory Clinic. A further 47 patients from other wards and clinics were treated at the Respiratory Ambulatory Clinic at that time;
- NHSCT established a Programmed Treatment Unit which managed, on an ambulatory basis, those patients who would otherwise have had to be admitted as an inpatient for specific programmed treatments/interventions. Between April 2019 and March 2020 an average of 114 patients were treated each month;
- SEHSCT used the transformation funding to enhance and develop a number of established ambulatory pathways. This led to significant growth in the numbers of patients routed through ambulatory clinics. In 2019/20, 3,407 patients were managed at these clinics;
- WHSCT established ambulatory clinics in the South West Acute Hospital. Patients were referred by their GP or diverted from emergency departments. From January 2019 to March 2020, 877 patients were seen in ambulatory care;
- Building on the success of ambulatory pathways in the Royal Hospital, BHSCT established a clinical assessment unit in the Mater Hospital. In 2019/20, 5,332 patients were treated at the unit.

Strategic Importance

The management of unscheduled care patients whose condition can be managed in ambulatory pathways, is critical to the effective flow of patients through the hospital systems. The importance of this is highlighted in three documents:

- COVID-19 Urgent and Emergency Care Action plan 'No More Silos' Oct 2020, where they contribute to points 5, 7 and 10;
- National Priorities for Acute Hospitals 2017, Good Practice Guide, Focusing on patient flow, and;
- Delivering Together.

BREAST ASSESSMENT SERVICE

Total Investment

£222,000

Objective

To develop advanced practice radiographers within breast assessment services in order to reduce the reliance on radiologists and to enable the service to continue to meet the increasing demand and maintain acceptable access times.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Breast Assessment Service	14	73	135	222

Regional Project

Yes.

Progress

Advanced practice roles have been introduced in two HSC Trusts, which have been able to demonstrate a positive impact.

SEHSCT - The investment in a full time principal radiographer has driven forward the breast interventional service. The post holder delivers a range of advanced procedures with a reduced reliance on consultants. This has included an expansion of the stereotactic vacuum biopsy service to include seven gauge therapeutic biopsy, which helps to avoid the need for surgery. The Trust also provides stereo-localisation using magnetic seeds which has led to improved patient flow.

SHSCT - Between November 2019 and March 2020 the Trust appointed two principal radiographers, each working 16 hours per week. These roles enabled the Trust to enhance clinic throughput seeing an additional 300 patients between November 2019 and March 2020, and to stabilise the breast two week wait. Due to staff turnover the Trust is currently looking at succession planning and hope to have appropriately skilled staff ready to take up post from September / October 2021.

Strategic Importance

This project contributes to the Delivering Together theme; Investing in our Workforce and the need to upskill staff to meet the workforce challenges.

New Decade, New Approach also commits to improving breast assessment as the demand for breast assessment continues to grow year on year. In light of the ongoing shortage of radiologists at national level it is essential that NI invests now to develop a 4 tier radiography service which supports the development of advanced practice roles thereby reducing the reliance on consultants and creating additional capacity within teams to meet the growth in demand.

DELIVERY OF THE DIABETES STRATEGIC FRAMEWORK

Total Investment

£9,746,000

Objective

To deliver against the priorities set in the Diabetes Programme (2020-2026) to support effective treatment and care for people living with diabetes as outlined in the Diabetes Strategic Framework (2016).

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Diabetes Strategic Framework	1,832	3,681	4,233	9,746

Regional Project

Yes.

Progress

The project has made progress across a range of activities, despite COVID-19 challenges including:

Structured Diabetes Education: effective investment has been used to drive down waiting lists and enable a regional approach to education.

Diabetes in Pregnancy: a service model, reflecting NICE guidance is being effectively delivered to support diabetes antenatal service and systems to support women with gestational diabetes, which is growing exponentially. The service has been successfully reorganised to provide flexible high quality 52 week care pre and post pregnancy. This level of provision is essential to meet additional demands within the service and support growing patient numbers through a safe and effective delivery. Trusts have been delivering virtual review clinics with expectant mothers to reduce significant hospital attendance and associated travel for expectant mothers (pre COVID-19). Both patients and health care professionals reported satisfaction with this approach.

Foot care: the project ensures that each person living with diabetes in Northern Ireland can receive the right foot care, at the right time in the right place with equitable service provision across the region through this clinical pathway.

Inpatients: the project enables HSC Trusts to appoint staff dedicated to inpatient diabetes care. The project has improved diabetes knowledge and understanding of insulin prescribing and administration across medical and nursing staff in inpatient services including those people living with diabetes, particularly those requiring complex treatment and care.

New Models of Care: these were explored by individual HSC Trusts in varying ways with a degree of success. This area is a priority within the refreshed Diabetes work programme. The potential to build on the Northern Ireland Prototype risk stratification and utilise opportunities to work in the intermediate space are areas for development. The focus will be on the development of the Type 2 pathway, an understanding of where care is delivered and by whom to identify new ways of working and the 'right patient, right place' ethos of Delivering Together.

Network infrastructure: this supports the delivery of the Diabetes Programme of work. Funding supports continued momentum and delivery, stabilisation of the staff team and secure retention of knowledge and relationships. The Network has developed a new programme architecture with a membership of over 150 people across the clinical, lived experience, voluntary community and health service network. This comprehensive architecture supports eight active working groups, a collective of Task and Finish Groups and Clinical Working Groups, as well as Locality, Primary Care and Communication's functions. People living with diabetes are represented at every level and within every group across the Network and within a Service User Reference Group which is administered by Diabetes UK as Network Partners.

Strategic Importance

The Diabetes Network was established in 2016 to support the implementation of the DoH Diabetes Strategic Framework (2016) as set out in Delivering Together. The framework was sponsored by the then Health Minister and is a priority work stream overseen by Chief Medical Officer (CMO) under unique management arrangements.

The Northern Ireland Diabetes Network takes responsibility for population needs assessment, service planning, resource allocation and service evaluation. Built on a collective leadership ethos in partnership with HSC, Public Health Agency and Diabetes UK, the network has formalised a new programme architecture. This effectively aligns primary and secondary care to support diabetes treatment and care as per the Department of Health Rebuild agenda. This fulfils the direction of the Regional Management Board with opportunities to support the wider strategic 'No More Silos' agenda.

IMPLEMENTING THE STRATEGY FOR PAEDIATRIC HEALTHCARE SERVICES PROVIDED IN HOSPITALS AND IN THE COMMUNITY (2016-26) AND THE STRATEGY FOR CHILDREN'S PALLIATIVE AND END OF LIFE CARE (2016-26)

Objective

To progress the implementation of the Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community 2016-26 and the Strategy for Children's Palliative and End of Life Care 2016-26.

Total Investment

£5,291,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementing the Paediatric Strategy and Strategy for Children's Palliative and End of Life Care (2016-26)	477	2,218	2,596	5,291

Regional Project

Yes.

Progress

The HSCB and PHA have worked collaboratively with all of the HSC Trusts to progress the implementation of the Paediatric Strategies. The Child Health Partnership has been established and a range of project activity has been prioritised across the HSC Trusts including:

Paediatric Palliative Care Strategy

A regional Paediatric Palliative Care Network has steered progress on the implementation of the Strategy. Three projects have been taken forward: The Paediatric and Life Limited Service (PALLS) has delivered a dedicated specialist nurse working alongside families of babies and children at the end of their short lives to provide access to a bed in the Children's Hospice or the child's own home. A dedicated regional paediatric palliative care consultant has been appointed and is currently in training in Great Ormond St Hospital in London. Appointment of paediatric palliative care leads across the Trusts have brought a much greater focus to the co-ordination of services to drive forward improvements to pathways for this cohort of children.

Paediatric Strategy for healthcare services

Age appropriate care has seen investment in clinical staff to ensure children up to their 16th birthday can be appropriately managed in paediatric wards. This is a key recommendation of the Report of the Inquiry into Hyponatraemia related deaths. All HSC Trusts ensured that they had the appropriate trained staff in place to manage this cohort of patients in age appropriate settings;

A Child Health Partnership Network has been created drawing representation from across the HSC Trusts and supported by the HSCB and PHA which will drive forward the implementation of the Paediatric Strategies.

Additional psychology support for children with chronic conditions has been made available. The service has been used by over 900 children and their families who are living with a range of conditions.

Admissions alternative schemes have supported paediatric ambulatory pathways to ensure children can be managed more appropriately. HSC Trusts used different metrics to measure the impact: WHSCT, for example, witnessed a reduction of 560 in paediatric admissions from 2017/18 to 2019/20. Other HSC Trusts achieved a reduction in their paediatric unplanned attendances of between 2-5%.

GP paediatric hubs have been established with visiting paediatricians meeting regularly with GPs and other practice staff to review and discuss paediatric cases which would otherwise have resulted in a referral to secondary care. This has led to the upskilling of GPs to manage a wider range of paediatric issues within primary care and is modelled on similar initiatives in England which have led to a reduction in paediatric referrals to secondary care. This was a very small scale initiative to test the model and to give confidence to GPs and paediatricians about the merits of this approach. In the SHSCT, 91 paediatric patients were discussed at multidisciplinary team meetings involving practice staff and a paediatric consultant. As a result, 18 children were referred to hub clinics and 8 referred onwards to secondary care.

Feedback from all of the project activity indicates that the objectives are being met.

Strategic Importance

Implementation of the Paediatric Strategy is a key priority in Delivering Together. This strategy has reached the halfway point in its lifetime and there is a need to accelerate implementation to ensure that all objectives can be achieved within the strategy's lifespan. A very solid foundation has been established with the creation of the Child Health Partnership and the collaboration between HSC Trusts and practitioners has been pivotal in terms of agreeing a system-wide paediatric response to the COVID-19 surges. In addition, objectives such as the provision of age appropriate care are mandated by the Hyponatraemia report and are critical to ensuring safe and appropriate care for all children and young people.

TRANSFORMING STROKE SERVICES

Total Investment

£4,061,000

Objective

To put in the place key building blocks for Reshaping Stroke Services out with the Minister's consultation, in line with the commitment in New Decade, New Approach to improve stroke services.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Transforming Stroke Services	625	1,705	1,731	4,061

Regional Project

Yes.

Progress

The transformation of Stroke Services has been progressed through project activity focused on increasing the uptake of thrombectomy across all areas of NI, establishing a 24/7 on call rota for thrombolysis, establishment of a stroke trainee consultant programme to sustainable workforce, introducing early supported discharge to a further 2 Trusts and strengthening the performance network.

The expansion of thrombectomy has increased numbers of patients across Northern Ireland benefiting from the procedure and thereby reducing mortality and long term disability. In terms of progress, thrombectomy procedures carried out by Belfast HSC Trust have increased from 79 in 2017/18 to 118 in 2019/20 and 123 in 2020/21. This expansion has benefitted stroke patients from all HSC Trust areas.

Prior to 2019, NI was the only UK Region without a sub-specialist stroke training programme, impacting on workforce capacity. Transformation funding has enabled the establishment of a Stroke Trainee post. The NIMDTA (Northern Ireland Medical and Dental Training Agency) was allocated £103k to appoint a Stroke Specialist Registrar to the Stroke Training programme for 1 year commencing in February 2019.

This post is vital to the delivery of thrombectomy services for NI as a region and more importantly to the establishment of an adequately trained sub-specialist consultant workforce for the future in NI.

ESD (Early Support Discharge) services provide patients with rehabilitation at home at the same intensity of inpatient care. They are commissioned to improve transfer of care arrangements, offer client choice, deliver efficiencies in acute bed usage and deliver improved clinical and wellbeing outcomes. The establishment of an ESD service in WHSCT and SHSCT has improved the equity of service provision. Four Trust areas (Belfast, South Eastern, Southern and Western) can now offer ESD to stroke patients. There is a proposal to extend to NHSCT subject to securing a funding source.

The Stroke Network has been strengthened through the appointment of a support team which has focused on performance monitoring the improvement of services against national standards. Service users and voluntary organisations are being engaged in the development of a long term support pathway.

Strategic Importance

This project contributes to the Delivering Together commitment to further improve the standard of treatment and care provided to stroke patients.

New Decade, New Approach committed to improving Stroke services by the end of 2020. In 2019 the Department carried out a public consultation, Reshaping Stroke Care – Saving Lives, Reducing Disability.

CANCER TRANSFORMATION: ONCOLOGY PROTOTYPES & HAEMATOLOGY

Objective

To stabilise and modernise oncology and haematology services through the investment in multidisciplinary teams and advanced practice roles.

Total Investment

£2,101,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Local Haematology	37	333	363	733
Specialist Haematology Service	62	395	505	962
Oncology Prototypes	0	81	325	406
	99	809	1,193	2,101

Regional Project

Yes.

Progress

In relation to oncology, South Eastern and Southern HSC Trusts have each successfully appointed a full-time Advanced Nurse Practitioner (ANP) and a full time speciality doctor. Both roles are providing valuable extra support at oncology clinics. The ANP is delivering non-medial prescribing clinics and, on completion of specialist training in 2021, will commence delivery of nurse-led follow up clinics. Belfast HSC Trust have also appointed advanced practice radiographers. Post holders are about to commence the delivery of radiographer-led clinics for consent and palliative mark-up, freeing up valuable consultant time to meet the growth in demand.

All HSC Trusts have made progress and while not all of the haematology transformation posts were appointed, HSC Trusts have significantly benefited from the investment.

Strategic Importance

This project activity contributes to the DoH Rebuilding and Stabilisation Plan and the commitments within New Decade, New Approach and with the new Cancer Strategy. This investment responds to significant growth in service demand and increasing concern about the resilience of services. It seeks to expand capacity through an expansion of multi-disciplinary teams whilst ensuring a focus on skills mix and advanced practice to support the modernisation of care pathways.

CANCER TRANSFORMATION:
INVESTMENTS INTO SPECIALIST SERVICES WITHIN BHSCT (MOHS, PARTIAL NEPHRECTOMY AND LYNCH TESTING)

Total Investment
£1,480,000

Objective
To invest in a number of specialist services within Belfast with a view to:

- Enhancing regional capacity for Mohs surgery for basal cell carcinoma;
- Centralisation of partial nephrectomy provision;
- Introduction of testing for Lynch Syndrome.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Consolidation of partial nephrectomy treatment	45	342	236	623
Basal Cell Carcinoma (MOHs Surgery)	31	177	292	500
Lynch Syndrome	31	135	191	357
	107	654	719	1,480

Regional Project
Yes.

Progress
The regional capacity for Mohs surgery for basal cell carcinoma has been enhanced by the recruitment of 7 staff (5.1WTE) in the Belfast Health and Social Care Trust (BHSCT). Despite delays with recruitment to the nursing post and a 4 month pause in provision due to COVID-19, the number of patients waiting has reduced from 150 to 38 between March 2019 and September 2020.

The centralisation of partial nephrectomy has progressed with the availability of an additional surgeon from another Trust providing a weekly surgical list. This has enabled BHSCT to expand its radiofrequency ablation (RFA) service. The project has increased the RFA capacity from 34 to 41 cases per annum. In 2019/20, an additional 35 cases were provided for, although the number of cases was affected by the onset of the COVID-19 pandemic in March 2020. Despite the on-going impact of the pandemic in April and May 2020, 31 cases had been provided for by October 2020 which is satisfactory progress given COVID-19 challenges.

Lynch testing is performed on patients with a confirmed diagnosis of colorectal cancer. The Lynch testing service provision commenced in November 2019 and from then to January 2020 212 tests were delivered which was in excess of the anticipated testing levels. The impact of COVID-19 on cancer referrals and diagnostic and treatment pathways has meant that the system is around 21% behind the expected number of colorectal cancer diagnoses for 2019/20 compared to previous years. While this has inevitably resulted in reduced Lynch testing activity in year; the testing service is now established and able to provide testing at the commissioned level once normal service provision resumes in 2021.

Strategic Importance

This project activity contributes to the Delivering Together commitment to ensuring the sustainability of the service including clinical quality and resilience. MOHs surgery is the gold standard treatment for patients with a basal cell carcinoma of the head or neck as it optimises outcomes and reduces scarring when compared to standard excision. The service was provided by two part time clinicians. The waiting list had extended beyond 100 patients with many waiting over a year. Investment was needed both to increase capacity and improve service resilience.

Waiting lists

RFA is an alternative to surgery as a first definitive treatment for patients with smaller renal tumours. This additional capacity is critical in terms of being able to deliver reasonable waiting times for patients with renal cancer. Cancer Improving Outcomes Guidance recommends that partial nephrectomy surgery should be centralised in one place. Provision in Northern Ireland is currently happening across 3 sites with the single surgeon who provided surgery within Belfast having gone on a career break. Cancer Peer Review highlighted the need to centralise the provision of surgery to the specialist centre. This investment was intended to support that centralisation and to provide increased capacity to meet the increase in patient numbers.

Lynch testing supports the implementation of NICE Diagnostics Guidance DG27- Molecular testing strategies for Lynch syndrome in people with colorectal cancer. It identifies people at high risk of developing colorectal and gynaecological cancers and enables active surveillance, earlier detection and treatment and improved outcomes.

PATHOLOGY TRANSFORMATION

Total Investment

£1,794,000

Objective

To establish a new regional pathology service management structure, ensure the independent Laboratory Information Management System (LIMS) programme successfully achieves its objectives, and oversee delivery of a range of complementary regional projects necessary to address existing service challenges and deliver service transformation.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pathology Transformation	162	730	902	1,794

Regional Project

Yes.

Progress

The project continues to make progress against the following five objectives:

- The programme has been set up and terms of reference have been agreed;
- Regional standardisation and implementation of new technologies is well underway including:
  - Establishing the Pathology Network project to standardise technical data, business processes and develop regional Standard Operating Procedures (SOPs) to support new LIMS implementation;
  - The roll out of new blood analysers in all HSC laboratories;
  - The implementation of a regional digital pathology solution;
  - Regional point of care equipment roll outs and the development of regional policies to support these new technologies;
  - Work is ongoing to plan regional cellular pathology equipment procurement to deliver maximum standardisation and coordinate activity alongside significant wider service changes;
  - Rolling out new rapid COVID-19 testing technologies supported by regional Standard Operating Procedures.

- Implementation of Workforce audit recommendations underway to address workforce gaps; for example:
  - The Pathology Network has approved training for advanced and expert practitioners in specimen dissection. This investment will help address gaps in the consultant workforce which cannot be filled through recruitment;
  - Training delivered in advanced Biomedical Science (BMS) dissection is ongoing to address gaps in consultant histopathology;
  - Regional recruitment of band 5/6 Biomedical Scientists has streamlined processes, and reduced duplication for the region by having one annual regional recruitment event and waiting list rather than 6 individual ones;
  - Work is underway to define the training requirements for consultant clinical scientists and reporting biomedical scientists in histopathology;
  - Input has been provided to the new Cancer Strategy on pathology cancer diagnostics, workforce, and training.
- Continued focus on quality, productivity and regulatory compliance; for example:
  - Continued participation in national benchmarking by all HSC laboratories;
  - Ongoing maintenance of United Kingdom Accreditation Service (UKAS) accreditation;
  - Provision of advice to Expert Advisory Group on COVID-19 testing, as well as DoH and HSCB Commissioners.
- New regional testing services have been setup, with some services redesigned to offer better quality and greater value for money and any service that is no longer clinically relevant stopped. For example:
  - Regional H-Pylori testing service established;
  - Regional faecal calprotectin testing service established;
  - Regional Faecal Immunochemical Test (FIT) testing established to support bowel cancer screening programme, and work underway to establish FIT testing in Primary Care to replace Faecal Occult Blood (FOB) testing in line with NICE guidance;
  - New process in place for introduction and funding of new technologies into pathology services (COVID-19 testing – range of platforms in first instance);
  - Plan in place to establish Network Clinical Approval Board during 2021/22;
  - Molecular diagnostics business case approved (BHSCT);

- Work underway to define the remit and membership of a regional molecular diagnostics forum;

- Continuing work to establish regional (single integrated) haematological malignancy diagnostic service.

Strategic Importance

Systems not Structures: Changing Health and Social Care' (2016) identified Pathology as one of the specialties in most need of reform. Delivering Together committed to a public consultation to modernise and transform Pathology services to improve service and workforce sustainability, ensuring a high quality pathology service for the future. This consultation was completed in 2016. The pathology transformation programme represents the out workings of that process.

The Pathology Network, which coordinates pathology transformation programme delivery, also coordinates SARS-CoV-2 testing delivered in Pillar 1. This has impacted on the timeline for programme delivery. The programme's link to 'Rebuilding' is that rebuilding plans must recognise that COVID-19 testing capacity is managed as a regional resource, and may impact diagnostic testing for non-COVID-19 service delivery.

UNSCHEDULED CARE (EX-AMBULATORY)

Total Investment

£8,414,000

Objective

This project's objectives were to make significant improvements in the management of unscheduled care patients across NI, and improve patient flow focusing on three areas:

- The control room function;
- Seven day working in base wards;
- Outpatient Parenteral Antibiotic Therapy (OPAT).

This project was developed due to growing pressures in the provision of unscheduled care along the patient pathway from attendance at emergency departments through to discharge into the community.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Unscheduled Care (ex-Ambulatory)	938	3,587	3,889	8,414

Regional Project

Yes.

Progress

Project progress is as follows:

- All HSC Trusts have put control rooms in place which have reduced in-patient admissions, length of stay, and patients who are experiencing delayed discharge. These have been particularly important in helping Trusts to manage the significant challenges of COVID-19.

- Seven day working has been introduced for social work and allied health professionals and is having a positive impact across hospital sites in managing in-patient flow. This is enabling discharge planning to commence early in the patient journey and so contributes to reduced length of stay and improved flow through the system.

- Patient flow has been significantly improved by OPAT which is facilitating admission avoidance and reduced length of stay. It has allowed a number of medically stable patients requiring antibiotic therapy, who had been cared for in acute hospitals, to be discharged and managed in the community.

Strategic Importance

This project contributes to the achievement of the New Decade, New Approach commitment to reconfigure hospital services to deliver better patient outcomes with improvements in urgent and emergency care as a key focus. This project is also a core component of the COVID- 19 Urgent and Emergency Care Action plan 'No More Silos'. It also significantly contributes to the Delivering Together theme – reforming our community and hospital services.

PALLIATIVE CARE IN PARTNERSHIP PROGRAMME

Total Investment

£3,580,000

Objective

The Palliative Care in Partnership programme objectives are to:

1. Improve the early identification of patients with palliative care needs (i.e. those likely to be in their last year of life) in order to provide appropriate support and services to enable them to die in their preferred place.
2. Scale and spread the Marie Curie Rapid Response Service to cover Out of Hours periods in all localities.
3. Enhance the specialist palliative care workforce to support people with complex care needs in all care settings.
4. Promote a programme of palliative care awareness across HSC and with the general public.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Palliative Care	702	1,715	1,163	3,580

Regional Project

Yes.

Progress

There has been significant progress across the four key objectives including:

Early identification:

- The Early Identification Local Enhanced Service, to promote the use of the AnticiPal screening tool in general practice has been developed and rolled out in 57 GP practices and has facilitated monthly palliative care multi-disciplinary team meetings.

- The AnticiPal algorithm was also developed for use on the web clinical system and work continues to encourage the inclusion of the AnticiPal algorithm within the General Practice Improvement Programme (GPIP).

Marie Curie Rapid Response Service:

- The expansion of the Marie Curie Rapid Response Service has provided equity of service to patients living in the South Eastern, Belfast, and southern sector of the Western Health and Social Care Trusts. It has also supported an increase in provision to the existing services in Southern and Northern Health and Social Care Trusts.

Enhancing the specialist palliative care workforce:

- Fifteen full-time specialist palliative care professionals (allied health professionals and social workers) are now in post across the five HSC Trusts to complement existing multi-disciplinary teams. This addition to the workforce is supporting the complex needs of patients being cared for in their own homes and in care homes as they approach the end of their lives.

Raising awareness of palliative care:

- 25,000 copies of the Your Life, Your Choices: Planning Ahead booklet have been distributed across NI including to all care homes and community pharmacies.

- A Palliative Care in Partnership website (www.pcip.hscni.net) has been developed to provide support and resources for HSC professionals and for people with palliative care needs and those important to them.

- A Palliative Care in Partnership "Voices4Care" reference group for service users and carers has been facilitated.

- To progress the planned activities in the regional palliative care work plan two events and three workshops have taken place. This has included members and stakeholders of the Palliative Care in Partnership programme.

Strategic Importance

- The Palliative Care in Partnership programme supports the strategic direction as set out in; Delivering Together's commitment - building capacity in communities and in prevention;

- New Decade New Approach which commits to delivering service developments in palliative and end of life care;

- The Specialist Palliative Care Workforce Review to explore the workforce requirement to meet the NI population needs to 2024.

- Department of Health Living Matters, Dying Matters: Palliative and End of Life Care Strategy (2010).

In addition, the impact of COVID-19 has brought into sharp focus the need for additional capacity in palliative care services to meet the increasing need of people being cared for at the end of their lives in their own homes and care homes.

COVID-19 TRAINING IN CARE HOMES

Total Investment

£100,000

Regional Project

Yes.

Objective

To enhance the delivery of safe, effective, compassionate care to service users living in care homes across Northern Ireland.

Progress

Training was developed for Care Home nursing staff to respond to identified COVID-19 and Non COVID-19 related needs. A bespoke training programme 'Leading in Crisis' was developed and delivered to 100 staff to enhance clinical leadership and management capability within care homes. Access to e-learning for care home staff was also provided. A total of 127 training and engagement sessions were delivered with 4,225 participants.

Strategic Importance

This project contributes to the Delivering Together ambition of reforming our community and hospital services and the key enabler of investing in our workforce. Training and development of care home staff has enhanced the confidence and competence of nursing staff to meet the care needs of people living in nursing and residential care homes. This has resulted in direct care delivery to meet the increasing acuity, care and support needs of patients and residents, improving the quality and experience of care and reducing reliance on both primary and secondary care services.

All Trust Care Home Support Teams have been up-skilled to respond to the COVID-19 pandemic. The provision of regional training and development has improved access to training and supported a consistent regional approach to ensure that care home staff are equipped with the skills to recognise, prevent and treat COVID-19.

TRANSFORMING CHILDREN'S SERVICES- ADOPTION AND FOSTERING SERVICES

Total Investment

£4,788,000

Objective

To Transform Fostering and Adoption Services through (a) promoting mother and baby fostering, (b) adopting a regional approach to recruitment of foster carers, (c) recruiting more specialist foster carers and (d) developing post adoption support.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Establish a Mother & Baby Foster Placement Scheme for vulnerable mothers	84	288	350	722
Increased capacity to recruit specialist foster parents	0	237	100	337
Recruiting more Specialist Foster Carers	0	1,207	555	1,762
Looked After Children – Post Permanence placement support team	200	860	907	1,967
	284	2,592	1,912	4,788

Regional Project

Yes.

Progress

10 Specialist foster placements including placements for mothers and babies have been recruited to offer placements to vulnerable children and young people.

In terms of Mother and Baby fostering, 10 new carers have been recruited and there has been an increase in;

- Resources available for recruitment and training
- Uptake of training by foster carers and social workers
- Rehabilitation of parent and child together
- Planned permanency with parents understanding the rationale for the care plan and assisting with its arrangements

The post permanence support ensures that adopters continue to be supported to prevent adoption breakdowns. 17 new social work and 9 social care staff are all in place and are delivering services to adoptive children and families across the HSC Trust areas. These services include support for direct and indirect birth family contact and therapeutic interventions at both an individual child and family level. Social work staff across all HSC Trusts have availed of additional training to enable them to provide these interventions where appropriate.

The Regional Recruitment team has worked to promote fostering to the wider community through engagement such as the development of social media campaigns and use of marketing expertise.

Strategic Importance

All of the project activity contributes to the following strategies:

- The Delivering Together commitment to expand foster placement options.
- The Department of Health A Life Deserved: A Strategy for Looked after Children.
- The Children and Young People's strategy 2019-29 priority to secure stability for Looked after Children.
- The New Decade, New approach priority for post permanence support.

SERVICE REFORMATION FOR CHILDREN WITH SPECIAL EDUCATIONAL NEEDS (SEN)

Objective

To develop a consistent and standardised approach for the provision of HSC advice for children under-going Statutory Assessment to ensure compliance with the 6 week timeframe.

Total Investment

£989,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Service Reformation for Children with Special Educational Needs (SEN)	175	452	362	989

Regional Project

Yes.

Progress

Health and Social Care advice for Children and Young People (CYP) undergoing Statutory Assessment has been standardised and reformed across Paediatrics, Occupational Therapy, Physiotherapy and Speech and Language Therapy. Performance across these professions in respect of the 6 week timeframe for statutory assessments has increased from 49% in December 2019 to 90% compliance as a result of this project. Project progress includes;

- Successful implementation of an electronic information exchange system across the health and education sectors has been successfully implemented.
- There has been enhanced compliance with HSC advice for children undergoing statutory assessment with the Education Authority through training, the establishment of standard pro-forma and consistent pathways.
- There is enhanced working between HSC staff, the Education Authority and schools to ensure the requirements of the Children's Services Co-operation Act Northern Ireland (2015) are met.
- There is early identification of children with Special Educational Needs (SEN) through timely provision of advice reports as part of the Statutory Assessment process. This helped ensure timely intervention for children and subsequently enhanced outcomes for children and their families.

Strategic Importance

This project contributes to the achievement of the New Decade, New Approach commitment to addressing the issues highlighted as part of the Northern Ireland Audit Office (NIAO) review into SEN.

The NIAO report (2017) identified that only 21% of Statements of SEN were completed within the 26 week statutory time limit and the Education Authority have stated that the majority of delays were primarily relating to delays in receiving advice reports from a HSC Trust.

This project has supported Trust adherence to requirements within the Children's Co-operation Act (2015) and the Special Educational Needs and Disability Act (2016).

TRANSFORMING CHILDREN'S SERVICES - COURT BASED SOCIAL WORK (CARE PROCEEDINGS PILOT)

Objective

To transform children's court based social work.

Total Investment

£288,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Court based Social Work (Care Proceedings Pilot)	64	107	117	288

Regional Project

No. This is not a regional service although there is interest from the other Trusts.

Progress

The Care proceedings pilot has been fully introduced as a practice model in WHSCT and SEHSCT.

In both Trust areas there has been positive feedback from the Judiciary regarding the improved standard of Trust reports being submitted to court and the valuable role of the Court Liaison Officer in Court. This view is also echoed by the Trusts legal representatives in the Directorate of Legal Services. Social Work teams have also expressed their appreciation for the Court Liaison Officer as they are not required to attend Court for long periods of time. For each review saving valuable social worker time Progress includes:

- Improvement in the quality of social work assessments and analysis by the Court Liaison Officer;
- Development of consistent and improved quality in court;
- Provision of training programmes and increased social work confidence.

Strategic Importance

This project contributes to the achievement of the Delivering Together theme of reforming community services. The Northern Ireland Access to Justice Review Report (2011) recommended a fundamental review of family justice in Northern Ireland and highlighted a number of major systemic and policy issues with an impact on the quality and cost of access to justice. In December 2015 the Department of Health and the Department of Justice launched the Care Proceedings Pilot aimed at promoting good decision making and minimising unnecessary delay for children subject to care proceedings.

TRANSFORMING CHILDREN'S SERVICES - EARLY INTERVENTION APPROACHES

Objective

To transform Early Intervention Approaches.

Total Investment

£2,532,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Enhancing Family Support Hubs	485	862	610	1,957
The PAUSE project	63	119	393	575
	548	981	1,003	2,532

Regional Project

Yes.

Progress

PAUSE aims to reduce the number of children being removed into care by working directly with women who have previously had children removed into care. Following initial implementation in the Northern Health and Social Care Trust (NHSCT) it was rolled out to the other Trust areas. In NHSCT the following was achieved:

- A scoping study was completed to establish the level of need for mothers in recurrent Care Proceedings and those with children placed outside of their parents' care e.g. Kinship placements;
- Using co-production a bespoke Northern Ireland PAUSE Model was developed;
- The PAUSE Model is being delivered to 24 parents.

The PAUSE project has been expanded to the other Trust areas where the infrastructure and initial work has been established. PAUSE projects were established in Belfast, South Eastern, and Western Health and Social Care Trusts to test the need for the project resulting in staff being recruited and women identified and engaged with.

Family Support Hubs coordinate statutory and early intervention services to support vulnerable families and divert them from statutory services. The project enabled the Hubs to expand their work to include outreach to families. In 2019/20, 7,590 families were referred to Hubs, 453 more than previous year. 21% of referrals were from families with a child with a disability. The Hubs also dealt with 2,909 telephone query/advice calls.

A survey conducted between March and June 2020 confirmed that all 29 Hubs continued to operate during the first lockdown period. Hubs noted a rise in referrals for food, fuel and practical help including managing the behaviour of children, particularly those with an ASD or ADHD presentation.

Strategic Importance

This project contributes to the Delivering Together commitment to enhance the capacity of Family Support Hubs (FSH) as part of building capacity in communities and in prevention. It also contributes to the Families Matter support strategy and aligns with the New Decade, New Approach commitment to maintain the transformation agenda.

The Outcomes Delivery Plan (2019) includes an action under outcome 12 to deliver the PAUSE pilot, contributing to the Looked After Children (LAC) strategy by reducing admissions to care from a very vulnerable cohort of mothers.

TRANSFORMING CHILDREN'S SERVICES - SUPPORT TO CHILDREN AND YOUNG PEOPLE IN THE LOOKED AFTER SYSTEM

Total Investment

£7,757,000

Objective

To transform outcomes in the Looked After Children (LAC) system through;

(a) Development of Peripatetic Support Teams;

(b) Putting a LAC Interface Worker in each HSC Trust;

(c) Developing a Regional Chair post to manage access to secure care and;

(d) Developing a new solution for homeless young people.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Outworking from service review of children's residential care - peripatetic support	218	1,808	1,791	3,819
Testing a new housing solution for 16/17 year olds presenting as homeless	295	300	300	895
Transformation of regional facilities for children and young people	241	1,486	1,316	3,043
	754	3,594	3,409	7,757

Regional Project

Yes.

Progress

A regional chair post for overseeing a multi-agency panel for access to secure care has now been developed, replacing five HSC Trust panel members.

LAC Interface workers are now working in each of the five HSC Trusts improving the interfaces between services. Based on a cohort of 43 children across HSC Trusts, the interface workers have identified and addressed issues relating to:

- Accessibility and timeliness of interventions;
- Barriers and constraints to children in care accessing the care services they need;

- Seamless transitions across children and adult services, in particular related to Child and Adolescent Mental Health (CAMHs), adult mental health services, children with disabilities, and adult disability services.

Delivery of the LAC interface worker against specified objectives was overseen by a regional project group. In July 2020, a review of the project identified a number of findings and recommendations which confirmed that this role effectively supported, tracked and examined the pathways of Looked After Children with highly complex needs. Impacts include:

- Ability to improve cross agency / disciplinary collaboration and the development of approaches to youth homelessness. The second phase of the evaluation was completed in early 2021.

Peripatetic Support Teams are working to support young people in existing residential placements. In May 2020, an interim evaluation provided evidence (quantitative and qualitative) of progress towards delivery against objectives. However this early evidence is caveated with an acknowledgement that longer timeframes are required to fully assess and evidence effective delivery.

This evaluation was completed by the HSCB in conjunction with Social Care Institute for Excellence (SCIE) and the HSC Trusts. It confirmed that there was early quantitative data which indicated a reduction in placement moves and a reduction in young people being reported missing. It is also found that from September 2019 there were indicators of positive relationships being established between young people and those delivering the service.

Strategic Importance

This project contributes to Delivering Together's commitment to further support young people and children in the looked after system, the regional review of residential facilities supported by DoH and DoJ, and the Children and Young People's strategy 2019.

REFORM OF ADULT SOCIAL CARE

Total Investment

£485,000

Objective

To improve the social wellbeing of citizens who require social care services so that they live safely and well; improve quality and experience for people receiving care and support in their own home, ensure sustainability of services within local communities, and support and empower front line staff in both the statutory and independent sectors to deliver high quality services.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Reform of Social care – Power to People	0	0	485	485

Regional Project

Yes.

Progress

This project has made progress in a number of key areas:

- A new model of delivery for care and support at home has been developed and aspects of that reformed model have been tested across the HSC system for potential upscaling.

- The benefits of the new model are currently being rolled out across the South Eastern Health and Social Care Trust (SEHSCT). While this is providing significant evidence of modernisation, there is a need to "scale up" the provision of the new approach across all five HSC Trusts so that the benefits of the new approach can be fully realised.

- Roll out of Self Directed Support (SDS) approaches which enabled all service users and carers to be assessed or reassessed and offered the choice to access direct payments, a managed budget, HSC Trust arranged services, or a mix of those options, to meet any eligible needs identified.

- Supported Northern Health and Social Care Trust (NHSCT) front line staff to prepare for change through a project which assessed and tested the preparatory work required to equip the homecare workforce to implement a new model of care and support at home. Provision of a winter pack ensured that staff felt valued and supported during the difficult winter months. Items in the pack also supported and equipped staff in the delivery of care, thus contributing to an improved working experience and improving staff morale, health and well-being. Additionally, NHSCT hosted 8 engagement sessions for domiciliary care staff to enable staff to contribute to the development of a new model of care and support at home. This has provided a good practice model for other Trusts and providers;

- 3,499 front line HSC staff were provided with enhanced training through the Northern Ireland Social Care Council (NISCC). This aspect of the project was shortlisted by the European Social Network for the Collaborative Practice Award.

Strategic Importance

This Project is integral to the implementation of the recommendations contained in “Power to People: Proposals to reboot adult care and support in Northern Ireland” (2017).

REFORM OF ADULT SOCIAL CARE - SOCIAL CARE WORKFORCE STRATEGY

Total Investment

£171,000

Regional Project

Yes.

Objective

To support the development of a career structure and CPD framework for the social care workforce, and to inform a cohesive approach to workforce development across the HSC and Independent Sector.

Progress

This project has made progress with the development of a standardised continuous professional development framework with four workshops held and a benchmarking exercise (against Wales) completed. A career structure and CPD framework have also been progressed with consultations with qualifications panels and workforce sub groups taking place. £47,000 has also been directly invested in workforce training for staff in HSC and the independent sector. This training enabled 50 members of staff to attain a Diploma in Health and Social Care at Levels 2, 3 or 5 and included areas such as management and leadership in residential, adult and children's services.

The 'Social Care – Making a Difference' campaign has been developed by the Northern Ireland Social Care Council (NISCC) on behalf of the Department of Health as part of its ongoing work to reform Adult Social Care. The campaign highlights that social care staff are an integral and valued part of the health and social workforce and their work is critical to the sustainable provision of social care services now and in the future.

Strategic Importance

This project contributes to the achievement of the New Decade, New Approach priority focused on the Reform of Adult Social Care.

Project activity also aligns with the wide reaching reform and transformation of the adult social care sector in Northern Ireland guided by the 'Power to People' report.

In addition, the project also contributes to the achievement of the Social Care Strategy objective to support staff through direct training and skills building to enhance support service delivery. This strategy will raise the profile of social care as a profession and improve workforce retention while also increasing recruitment of staff to support the rebuilding of services.

REFORM OF ADULT SOCIAL CARE - MY HOME LIFE (MHL) PROGRAMME

Total Investment

£96,000

Objective

To meet the unique needs of care home managers by supporting them to improve quality of life for residents, relatives and staff.

Regional Project

Yes.

Progress

The My Home Life programme project commenced as planned in October 2020 despite the challenges of the COVID-19 global pandemic. Fourteen Care Home Managers have participated in the programme to date. Feedback from participants indicates that it has been a positive experience and has helped to improve the quality of life for residents, relatives and staff by applying the relationship centred course learning to all aspects of service delivery.

The course itself is a one year academic course with continued in work learning. The roll out of the programme to the 400 plus Care Home Managers will take 4 years to complete.

Strategic Importance

The My Home Life Programme project contributes to the Delivering Together recognition that increasing pressure on services has contributed to difficulties in attracting and retaining experienced staff and the vacancy rate in a range of disciplines continues to grow. The Minister for Health has given his support for the MHL Leadership programme as one of the training and career pathway options to help recognise the skills, values and attributes of people who work in adult social care in Northern Ireland. The MHL Leadership training provides Care Home Managers with a programme which is underpinned by relationship-centred care that recognises the importance of seeing the care home as a 'community' where the quality of life of staff, family, friends and residents are all crucial to improvements in practice.

The My Home Life Programme project will contribute to the rebuilding of HSC services for those residing in a care home setting.

REFORM OF ADULT SOCIAL CARE - OPEN UNIVERSITY NORTHERN IRELAND PROVISION OF THE DEGREE IN SOCIAL WORK

Total Investment

£144,000

Regional Project

Yes.

Objective

To commission 15 places for social care workers on the OUNI Degree in Social Work programme.

Progress

15 places for social care workers were commissioned on the Open University Degree in Social Work in October 2020 and filled by November 2020.

Strategic Importance

This project contributes to many of the ambitions identified in Delivering Together including improving the skills and quality of the HSC workforce, providing career development opportunities for the largest staff grouping within HSC and ultimately enhancing service user experience. It will also support most of the Delivering Together key enablers particularly partnership working.

MENTAL HEALTH RECOVERY MODEL & CO-PRODUCTION

Total Investment

£607,000

Objective

To support the ongoing development of mental health recovery and co-production through peer support groups for service users and family carers, and Recovery Colleges.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Mental Health Recovery Model & Co-production	151	320	136	607

Regional Project

Yes.

Progress

The mental health recovery and co-production project activity in all Trusts enables individuals with lived experience to take responsibility for managing their own health and wellbeing. The project works in partnership with clinicians, professionals and other service providers to help individuals develop the knowledge, skills and motivation to engage in civic life, work and education. This project is a real example of how specifically the HSC has embedded the Department of Health Co Production Guide (2016) and how Mental Health Services (MHS) in general, have been leading by example to ensure that the legal requirement around personal and public involvement (PPI) are complied with. It has focused on informing, involving and including individuals with lived experience in all aspects of service development and commissioning. Each HSC Trust has employed staff to support co-production and recovery.

Progress also includes commissioning the external evaluation, the introduction of the outcomes tool and the availability of the Outcomes Star.

A service user consultant is a member of the Belfast Trust Mental Health collective leadership team and is integral to the setting of direction for all services. Belfast Trust currently employs 10 peer support workers. There are an additional 6 vacant positions for which a recruitment process is currently underway. The recovery college employs, 3 staff with lived experience and in 2020/21 ran 39 courses which reached 2100 people.

Co-production is the cornerstone of the Belfast Trust Recovery College. It is at every level and stage of planning, development, curriculum and quality assurance. All courses are co-facilitated by service users, carers and mental health staff. The Belfast Trust also have independent peer advocates that attend management meetings. They are also part of QI (Quality Improvement) projects and are part of the training and development of clinical teams and services.

The South Eastern Trust employs a number of people with lived experience in a range of roles, including a Service User Consultant. The Trust also employs Peer Workers in Inpatient, Addictions, Personality Disorder Services, Wellness Recovery Network and the Recovery College. The Trust has also commenced recruitment for two further posts through which individuals with lived experience will support people discharged from hospital in making the transition home.

The South Eastern Trust's future direction in building lived experience capacity and involvement will be outlined within a strategy which they aim to have available this year.

The Southern Trust employs 5 peer support workers across mental health and supports a number of ad hoc peer trainers to work within the Recovery College.

To drive forward the Mental Health Recovery Model and promote coproduction, the WHSCT appointed a 'lived experience' Service User Consultant (Band 7) for adult mental health in 2019. This post has now become a permanent role within the Senior Management Team. The recruitment of the peer consultant has led to a significant increase in coproduction activity within adult mental health services in the Western Trust. As part of the Delivering Value: Improving Quality and Safety Big Programme of Work, the Service User Consultant has created opportunities for people with lived experience of using WHSCT mental health services to directly participate in the design and delivery of services. Currently, service users are engaged in coproduction work streams with Trust staff in the following areas: a review of the ED Pathway for clients; evaluating access to psychological therapies; assessing the experience of clients using Paediatric Intensive Care Unit, and reviewing the engagement of families in the Severe Adverse Incidents process.

To promote coproduction further and to create opportunities for clients to build capacity and experience, the Service User Consultant has created a Virtual Reference Group (VRG), where people with 'lived experience' can come together and learn about coproduction activities within the Trust. The VRG was established in response to the challenges to face-to-face working presented by the Covid pandemic. The VRG has been very successful and has proved to be a starting point for service users embarking on a recovery journey and who wish to develop their coproduction skills. The Service User Consultant has also been instrumental in establishing an annual award celebrating Trust activity that promotes coproduction. Following the appointment of the Service User Consultant, Mental Health services in the WHSCT expanded its cohort of 'lived experience' roles with the appointment of 1wte permanent Lead Peer Trainer (Band 5) within the Recovery College. The Lead Peer Trainer supervises a cohort of volunteer peer trainers, however work has commenced around the potential recruitment of a further three part-time, permanent Peer Trainers (Band 4) to work in conjunction with the Recovery College and Mental Health teams.

To further drive forward the Mental Health Recovery Model and to promote coproduction the Service User Consultant has presented to all of the adult mental health teams on the topic of the values and principles of the You in Mind Mental Health Care Pathway (2014). Staff have been engaged in discussion

around the importance of working in partnership with service users and carers – and to promote hope, opportunity and control at all times. Regular meetings have also been established with carer and service user advocates, and these advocacy representatives have been invited on to several coproduction work streams.

To ensure that recovery principles are applied across all aspects of Mental Health services, all WHSCT inpatients at the point of discharge are given the opportunity to express an opinion about their treatment. Clients are asked if they felt involved in their care and whether their families/friends felt involved in their care. This data is analysed systematically and the results are shared with senior management and ward managers and teams on a monthly basis. This continuous survey was designed by the Service User Consultant with the aim of ensuring that clients feel a sense of partnership with Mental Health staff during their care. The continuous survey has now been extended to capture the views of clients using the Crisis Response Home Treatment teams.

As in other Trusts the pandemic resulted in face-to-face services moving to an online presence. Service user views on this period of the Covid crisis were captured by the Service User Consultant as part of the 10K More Voices project.

The Covid pandemic inevitably meant that users of WHSCT MH day centres experienced reduced access in terms of hours each week. At the same time, however, staff trained in the use of the Recovery Star wellbeing tool reported that they were able to engage in more focused, person-centred and recovery oriented work on a one-to-one basis with clients.

Recovery and co-production remains a key priority for MHS in all HSC Trusts which each have an active Recovery College, with a dedicated Recovery Co-ordinator. The HSC Trusts deliver an Annual Prospectus of co-produced and co-facilitated courses concentrating on recovery focused practise while the project funded 150 annual courses at each of the Recovery Colleges. The Process Evaluation of Mental Health Recovery Colleges in Northern Ireland Report (2019) found that the co-production model runs through the ethos of all the Recovery Colleges.

This project activity is building on the success of the peer led initiatives in recovery focused practice across MHS. The project's peer led recovery groups support individuals to positively engage in active care and treatment and to develop interests and activities that will enable them to sustain their health and wellbeing post treatment.

The Covid pandemic has had some impact on project progress in 2020-21, as many mental health services were transferred to online support and remote working, and the timelines for recruitment and selection of additional staff for face to face contact with patients and clients was affected.

Strategic Importance

This project supports the Department of Health Mental Health Action Plan – Action 5 objective to enhance the involvement of people with lived experience, including service users and carers in service delivery and service planning and action 13.2 to review and create a regional protocol for peer support workers including clear governance structure and role subject to funding.

It is also critical to the two key actions set out in the Department of Health Mental Health Strategy 2021-31; Action 16 to further develop recovery service, including Recovery Colleges, to ensure that a recovery focus and approach is embedded in the whole mental health system; and Action 33 to create a peer support and advocacy model across mental health services. The Recovery College model and peer support workers employed as part of this project will directly support these developments going forward. The underlying principle in mental health recovery, no decision about me without me, as reflected in the Regional You in Mind Care Pathway (2014) continues to guide Mental Health Services across Northern Ireland. Both the recovery colleges and the peer support model are key components of this recovery focused practice model and remain fundamental to the provision of high quality mental health care.

ENHANCED MENTAL HEALTH LIAISON SERVICE (MHLS)

Objective

To provide greater access in acute general hospitals to mental health services for patients and staff.

Total Investment

£3,102,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Enhanced Mental Health Liaison Service	227	1,198	1,677	3,102

Regional Project

Yes.

Progress

This project has enabled each HSC Trust to provide Emergency Department (ED) and acute hospital patients and staff with greater access to 24 hour rapid access to specialist mental health assessments (within 2 hours and 24 hours respectively).

The project has achieved the following progress:

- BHSCT – 24/7 coverage and service, covers both the Royal Victoria Hospital and Mater Hospital Emergency Departments. A two hour target is achieved 85% of the time and acute hospital ward referrals are all seen within 24 hrs, providing: timely assessment, onward referral and information advice offered.
- NHSCT – 24/7 coverage and service to ED (2 hrs) and acute hospital wards (24 hrs); Timely assessment, onward referral and information/advice offered. The Mental Health Liaison Service has been fully operational since 2015 and continues to provide a fully enhanced model of liaison care across both hospital sites.
- SEHSCT – Ulster Hospital site only, 24/7 only in ED (2hrs), no night time cover on wards. Repeat attenders policy in place and effective meetings held between services;
- SHSCT – 7 days per week, 9am-9pm, across all sites, ED (2hrs) and wards (24hrs);
- WHSCT – In September 2019 a MHL pilot commenced to cover the inpatients wards in AAH (Altnagelvin Area Hospital) but was suspended due to Covid-19 and staff returned to their substantive posts in March 2020. Following the recruitment of staff the MHLS commenced in South West Acute Hospital in September 2020 and January 2021 in AAH. The service currently operates Monday to Friday 9.00am – 5.00pm in both sites with out of hours crisis assessments being completed by the Crisis Team. As this service is only in its infancy these operational hours will be subject to change.

Strategic Importance

This project contributes to the New Decade, New Approach commitment to increase the focus on mental health and wellbeing.

The project also contributes to the achievement of the Mental Health Strategy 2021-31 Action 27 which calls for the creation of a Regional Mental Health Crisis Service that is fully integrated in mental health services which will provide help and support for persons in mental health or suicidal crisis. Minister Swann published the new, regional mental health, Crisis Service Review Report on 24 August 2021. The new Regional Crisis Service was developed together with the authors of the review, and reflects the recommendations in the review. The Policy outlines what the crisis service will look like and provides 10 actions to make this a reality.

It also contributes to realising the Mental Health Strategy 2021-31 theme of providing the right support at the right time, which includes appropriate crisis support. This results in quicker access to appropriate services without multiple onward referral processes which the MHLS offers currently in both general acute wards and ED services.

ESTABLISH ELECTIVE CARE CENTRES FOR TREATMENT OF CATARACT

Objective

To establish prototype for Elective Care Centres for the treatment of Cataract.

Total Investment

£2,514,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Establish Elective Care Centres for treatment of Cataract	311	1,155	1,048	2,514

Regional Project

Yes.

Progress

The Elective Care Centres for the treatment of Cataract commenced in December 2018.. In 2020/21 a total of 3,373 cataract procedures were carried out which represented a decrease against 2019/20 (6,370).

This decrease can be attributed to the incremental approach to new ways of working, ramping up theatre sessions and lists gradually growing in the three regional cataract elective care/day procedure centres but principally due to the profound effects of COVID-19 and the impact on elective procedures and clinical and nursing teams.

The anticipated introduction of a region-wide electronic patient record system (Medisoft) will facilitate lists being populated from a regional pool, working across Trust boundaries to maximise capacity and resource.

Pre-COVID-19, the progress trajectory was improving, with theatre lists and sessions across all three centres increasing. The COVID-19 pandemic has had a significant impact on cataract waiting lists. Theatre activity in 2021/22 stands at 4,009 procedures at end of October 2021. An additional 1,058 procedures have been carried out via the Independent Sector in-reach to Downe Hospital Cataract Day Procedure Centre (DPC).

The centres continue to operate as resources for the region for pre-assessments and post-operative review, although a new care model introduced in October 2021 will see an increasing number of post-operative reviews delivered by primary care optometrists, freeing capacity in secondary care. This pathway approach complements existing commitments in Minister's Elective Care Framework (June 2021) which has seen the establishment of additional cataract pre-assessment mega-clinics in Q2 2021/22.
It is anticipated that the progress trajectory will be scaled up when COVID-19 pressures allow.

Strategic Importance

This project contributes to the achievement of the Delivering Together commitment to develop Elective Care Centres and has helped to inform the development of Day Procedure Centres and wider strategic reform.

It also contributes to the Elective Care Plan - Transformation and Reform of Elective Care Services (2017) Commitment 6 which states that: "Regional Elective Care Assessment and Treatment Centres will be established to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties." Cataract waiting lists represent treatable sight loss in the population and is therefore a top priority.

The provision of Elective Care Centres is a priority for the Minister. In June 2021 the Elective Care Framework was published. The Framework sets out firm, time bound proposals for how HSC will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how HSC will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed. There are a number of actions in the Framework on the development of the Elective Care Centre model.

DAYCASE ELECTIVE CARE CENTRES (DECC) - PHASE 2

Objective

To develop a regional service delivery model for Day Procedures Centres in Northern Ireland.

Total Investment

£210,000

Regional Project

Yes.

Progress

The Lagan Valley Hospital Day Procedure Centre (DPC) has been established and is currently providing much needed support to other Trusts in response to the downturn in elective services during the COVID-19 pandemic, particularly for regional cancer diagnostic work. Plans are in place to develop the DPC at Lagan Valley in the longer term with a view to tackling the lengthy waiting lists for day procedures. A clinically led Day Procedure Network has been established to develop and expand this model of service delivery.

At 12th February 2021, 216 patients from across the Northern Ireland have had urgent procedures completed in the DPC including Gynaecology, Colorectal, Breast, Plastics, Urology and Ear, Nose and Throat (ENT) specialties. In addition, a successful inguinal hernia pilot (56 patients) has also been carried out at the DPC and plans are in place to roll this out to the region.

As services are rebuilt, DPCs will play a vital role in tackling waiting lists, tackling equity of access, maintaining infection control and delivering value for money.

Strategic Importance

This project is a commitment set out in Delivering Together and New Decade, New Approach. Delivering Together noted that elective care centres would be established to provide a dedicated resource for less complex planned surgery and other procedures. The Department of Health subsequently published the Elective Care Plan which included a commitment to establish elective care centres to provide a dedicated resource for less complex planned surgery and other procedures.

The project also contributes to the achievement of the Establishment of a Regional Service Delivery Model for Daycase Elective Care Centres in Northern Ireland. The DPC at Lagan Valley Hospital was established to maintain robust infection control preventative measures at this site and enable day-case procedures to continue during the pandemic.

In June 2021 the Elective Care Framework was published. The Framework sets out firm, time bound proposals for how HSC will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how HSC will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed. There are a number of actions in the Framework on the development of the Elective Care Centre model.

ESTABLISH AN ELECTIVE CARE CENTRE FOR TREATMENT OF VARICOSE VEINS

Objective

To establish a prototype Elective Care Centre for the treatment of Varicose Veins.

Total Investment

£1,328,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Establish Elective Care Centres for treatment of Varicose Veins	180	873	275	1,328

Regional Project

Yes.

Progress

The Elective Care Centres for the treatment of varicose veins were fully operational by February 2019. In 2019/20 a total of 1,541 patients were treated which is a productivity increase of over 45% against the base year of 1,034 in 2017/18. There was also a significant reduction in both the number of patients waiting for treatment and in the waiting times with the number of patients waiting reduced from 1,417 in September 2018 to 1,092 by March 2020 and in that same period the number of patients waiting over 1 year reduced from 568 to 177.

As with other parts of the HSC system, progress has been impacted by Covid-19 as staff have been re-deployed to support urgent and critical care.

Strategic Importance

This project contributes towards the achievement of the Delivering Together commitment to develop Elective Care Centres requiring the Department to "bring forward proposals for the location and service specification for Elective Care Centres."

It also contributes to the Elective Care Plan - Transformation and Reform of Elective Care Services (2017) Commitment 6 which states that: "Regional Elective Care Assessment and Treatment Centres will be established to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties."

The provision of Elective Care Centres is a priority for the Minister. In June 2021 the Elective Care Framework was published. The Framework sets out firm, time bound proposals for how HSC will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how HSC will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed. There are a number of actions in the Framework on the development of the Elective Care Centre model.

IMAGING REVIEW – OBSTETRIC AND PAEDIATRIC STRANDS

Objective

To implement the Imaging Strategy with regard to Obstetrics and Paediatrics.

Total Investment

£183,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Imaging Review – Obstetric and Paediatric Strands	48	135	0	183

Regional Project

Yes.

Progress

The Strategic Framework for Imaging Services (2018) recommends a regional approach to planning and delivering imaging services, with distinct recommendations for obstetric and paediatric imaging. New clinical groups have been established to take forward these important agendas to drive forward the improvements required across Obstetrics and Paediatrics. Critical to the success of these groups is the appointment of a Clinical Lead for both Obstetric and Paediatric imaging to provide the leadership, expertise and experience required. A clinical lead for obstetric imaging has been appointed and an interim clinical lead is in place for paediatric imaging.

Strategic Importance

Delivering Together places a high priority on planning and delivering imaging services. Imaging spans most service areas and the Strategic Framework highlights the need for a more strategic, uniform and joined up approach to imaging matters to ensure the priority afforded in Delivering Together is realised.

DEVELOPMENT OF THE NORTHERN AREA PATHFINDER

Total Investment

£563,000

Objective

To establish an approach to developing a Population Health Improvement Plan including a proposal for an Integrated Care System (ICS) which can offer a new regional approach.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of the Northern Area Pathfinder	0	374	189	563

Regional Project

This project was developed in the Northern Trust area and has helped inform the development of an Integrated Care System (ICS) model in Northern Ireland which is in the process of being developed and established on a regional basis by the Department.

Progress

The Northern Area Trust /GP Partnership, which is at the core of this prototype, has brought together a range of organisations including HSCB Local Commissioning Groups, PHA, NIAS, the Community and Voluntary sector, local Councils with the Northern Trust, GPs and locally based Integrated Care Partnerships. This partnership working and the relationships which have been established are essential to the achievement of the project's objectives. The Trust/GP Partnership creates an integrated/ cross organisational senior team that acts as a core HSC partner organisation to engage and involve other partners.

It is planned to now embed an Integrated Care System within the Northern Area which aligns with the model set out in the Integrated Care System NI draft framework and which builds on the existing structures that have been developed in the prototype including: the Northern Area Partnership working at an Area level, Integrated Care Partnerships and GP Federations at locality level and community based work around GP practices and neighbourhoods. This will see the Northern HSC Trust and local GPs and others working together on an ongoing basis, in a new way of working.

Whilst the Covid pandemic has impacted on the planned objectives and work of the Prototype taking it in an unforeseen direction, the strength of the already established Partnership supported a joined up Northern Area response.

The Prototype has:

- Built an effective partnership between the Northern Trust and General Practice in the Northern Area which created an opportunity for positive change in particular around dermatology services and waiting lists, phlebotomy services, Treatment room services, Anticipatory Care, the response to Covid and the Covid vaccination programme, and Phone First.

- Proposed and part tested a model for an integrated health and social care system with shared accountability, while maintaining existing architecture – this is in keeping with the 'Delivering Together' strategy and the Bengoa report.
- Developed a methodology for co-producing a population health management plan that can be supported by the HSC, it's partners and empower communities (included a co-produced Workshop on 25 Feb 2020 to provide information relating to population data and trends to a wide range of participants). Following discussion and analysis, five shared population health issues were identified with partners as priorities in the Northern area including obesity, diabetes, mental health, frailty and end of life care. This will form the basis for beginning to build a Population Health Improvement Plan, which will be tested and address the Mental Health priority first. This focus on the development of a Mental health population health plan was temporarily interrupted by the Covid pandemic when partnership efforts were diverted to other Covid related projects.
- Covid related Partner initiatives included the setting up of the Partnerhub in the Northern area. This is a single point of contact for Trust partner organisations, including Care Homes, Independent Sector, Domiciliary Care Providers, GPs, Community Pharmacies and Community and Voluntary organisations. The Partnerhub offered support and advice in the early days of the pandemic and continues to do so. Feedback regarding the Partnerhub from Partner organisations has been extremely positive.
- Covid related projects led by the Prototype included the Ballysally Outreach Covid vaccination clinic. This project used data to determine the low vaccine uptake in the most deprived Super Output area in the Northern Trust, Ballysally. This pilot influenced the roll out of pop-up clinics across the region regarding vaccine uptake in deprived areas. Community Pharmacy, Community and Voluntary organisation, Council and Trust partners worked together to successfully create a model that was further replicated across the region.
- The Prototype worked with PHA to develop a data analytic tool that will inform and shape services.
- Prototype work streams have taken early results from designing and testing a number of new service models –including Diabetes and services for residents of Nursing Homes –these give insight to the benefits of using data to inform and drive service models, keeping service user at the centre.
- Prototype provided leadership for the Phone First model.
- Prototype work streams were developed to take forward population health improvement initiatives that were aligned to local and area priorities. These included diabetes, frailty and musculoskeletal. An Anticipatory Care pilot involving 3 care homes demonstrated reduced ED attendances, reduced repeat ED attendance, reduced ambulance transfers and reduced hospital admissions.

Strategic Importance

This Northern Area Prototype ICS was established to test a new model for planning and delivering health and social care services and was endorsed by the Transformation Implementation Group in February 2020 as the roadmap for developing a new ICS model in Northern Ireland. The Prototype embraces the recommendations of Systems, Not Structures report building on the foundations of GP Federations, ICPs and system wide commitment to co-production. Work is now progressing to develop new systems to replace the existing commissioning functions of the HSCB. This project is key to the development of new and reformed systems.

This model aligns with Systems, Not Structures and also Delivering Together which detailed the need to design new partnership approaches to the planning and management of HSC services which move away from competition towards collaboration, integration and improvement.

DEVELOPMENT OF THE DAISY HILL PATHFINDER

Total Investment

£5,283,000

Objective

To improve unscheduled and acute medical services on the Daisy Hill Hospital (DHH) by:

- Increasing medical and nursing capacity in the emergency department;
- Strengthening the High Dependency Unit (HDU);
- Developing a Direct Assessment Unit (DAU);
- Improving quality and safety across the site.

This is a five year project and as such the final deadlines for achievement stretch into 2022.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Development of the Daisy Hill Pathfinder	500	1,715	3,068	5,283

Regional Project

SHSCT only

Progress

There has been satisfactory progress in all areas, with the recruitment and retention of a number of new senior medical and nursing. The ongoing step wise approach to recruitment has become ever more challenging over the last nine months due to the pandemic and the temporary closure of the Emergency Department in Daisy Hill Hospital between April and October 2020.

Increasing medical and nursing capacity in the emergency department of the planned 16.9 WTE staff to be appointed in both year 1 and 2, 15.74 WTE staff were appointed and in post with remaining 1.16 WTE to be appointed by 2022/23.

Strengthen the High Dependency Unit (HDU) Progress has been made on the recruitment of non-medical staff and in working towards achievement of training targets for nursing staff in line with project programme. The increases are in these areas:

- Nursing support Band 3 = plus 1.94 WTE

- Nursing Bands 5 – 7 = plus 5.82 WTE (skill mix change improves service)

- Enhanced Nurse Practitioners = plus 2.00 WTE

- Non-medical staff Bands 2 – 4 = plus 4.93 WTE

- Additional Consultant Intensivists have been appointed at Craigavon Area Hospital (CAH) which means there are seven consultants now in place.

- Eight Consultant Intensivists are required for CAH ICU/HDU and it is planned, that as numbers increase over time, the Trust will be able to move towards achieving standards through an Intensivist run service in DHH HDU. The SHSCT has developed a phased approach to create a rota of 8 WTE specialty doctors to cover bank holidays and weekends.

Develop a Direct Assessment Unit (DAU) The DAU provides clinical assessments to 10-14 patients per day. Telephone advice is also available to GPs and NIAS with direct access. Due to the direct assessments only 3-4 % of patients are admitted.

Improve quality and safety across the site During the COVID-19 pandemic the ED and DAU were relocated to the Craigavon Hospital, this has adversely impacted on progress with the implementation of this objective. Nevertheless, a reduction in cancelled operations and improvement in patient flows has been partially achieved.

Strategic Importance

The impact of COVID-19 on DHH as an acute provider at the time of this assessment is highly significant. The pathfinder has enjoyed success because of co-production with the local community and its commitment to long term sustainability and Delivering Together.

DEVELOPING A HEALTH & SOCIAL CARE INFRASTRUCTURE FOR QUALITY IMPROVEMENT AND INNOVATION (HSCQI)

Total Investment

£2,104,000

Objective

To implement a Regional Quality Improvement and Innovation System (HSCQI) based on the outcome of the prototyping work as stated in Delivering Together - actions 10 and 15 to better align current resources devoted to safety and quality improvement.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Developing a Health & Social Care infrastructure for Quality Improvement and Innovation (HSCQI)	943	1,002	159	2,104

Regional Project

Yes.

Progress

The Health & Social Care infrastructure for Quality Improvement and Innovation (HSCQI) project was established as a Hub and Spoke network in April 2019. The Director of HSCQI and the Communications and Engagement Lead were appointed by September 2019. Progress with individual project activities includes:

- The development of the HSCQI website.
- On-going development of a Quality, Improvement and Innovation Communications strategy.
- Development of a web based QI repository.

A HSCQI Network of Quality Improvement (QI) leads consisting of the HSCQI Hub team (Legacy Safety Forum Team), QI leads working across other parts of the system (mainly Trusts and Primary Care) and a service user has been created. A regional HSCQI supporting Alliance has also been established and membership includes representatives from Trusts and Departmental Chief Professional Officers, Primary Care and service users.

The HSCQI work plan initially focussed on legacy HSC Safety Forum QI collaboratives i.e. Maternity, Paediatrics and Mental Health. In keeping with its design intent, HSCQI subsequently led on the scale and spread of 4 regionally agreed QI initiatives: (i) Antimicrobial Stewardship (ii) Sepsis Care Bundle (iii) Safety Planning in Mental Health and (iv) Safeguarding. HSCQI delivered this programme of work from September 2019 to March 2020 until COVID-19 pandemic began. Evaluation of this programme of work in July 2020 indicated that all of these scale up initiatives had made good progress and all four had the potential for even greater scale up success should this work re-commence.

In partnership with Healthcare Improvement Scotland (HIS), HSCQI supported the delivery of two regional cohorts of the Scottish Improvement Leaders course (SCiL), resulting in an additional 60 staff from across the system being trained to level 3 QI training criteria as stated within the HSC Attributes Framework.

During the COVID-19 pandemic, HSCQI established a regional COVID-19 Learning System by applying a 90 day learning cycle approach. This resulted in the identification of three regionally agreed key COVID-19 learning themes - the use of technology to support virtual visiting; the use of technology to support virtual consultations; and interventions used to support staff health and well-being. Three HSCQI Learning System subgroups have been established to scale and spread examples of key learning within each of these themes.

Strategic Importance

The establishment of HSCQI fulfils the commitments outlined within the following strategic documents:

Delivering Together (2016)
Action Point 10: Identify current innovative HSC projects at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.
Action point 15: Complete the initial design work for the “Improvement Institute”.

Systems, Not Structures (2016)
Rec 4 - Transforming the NI HSC system by the “Aggressive scale up good practice”; Rec 8 - “The system should identify and scale up at least 2 innovative projects per year where there is clear evidence of improved outcomes for patients and service users”.

The Right Time, The Right Place (2014)
Rec 7, - the NI HSC system should establish a “Northern Ireland Patient Safety Institute”. HSCQI is the realisation of that Institute.

The HSCQI project has responded positively to the emergency response to the COVID-19 pandemic and the subsequent ongoing rebuilding of services by supporting the PHA/HSCB communication and governance response and aligning the HSCQI Learning System programme of work with the HSC Service Delivery Innovation Rebuild work stream.

INFORMATION ANALYSIS - COST PERFORMANCE TO SUPPORT SERVICE IMPROVEMENT

Total Investment

£126,000

Objective

To support the optimisation of performance and embed the principles of reform into measurable improvements –

- Potential for an Integrated Performance Dashboard (IPD)
- Acute Capitation Review
- Patient Level Information and Costing System (PLICS)
- Reference Costs
- Pilot Integrated Performance Dashboard
- Activity Based Funding Model

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Information Analysis - cost performance to support service improvement	0	20	106	126

Regional Project

Yes.

Progress

- A stocktake of existing activity, performance and information sources has been undertaken and a proof-of-concept paper has been written on the potential for an Integrated Performance Dashboard with a pilot IPD now initiated This pilot has been designed for stroke services and full implementation is underway, timetabled for completion by March 2022. Adaptation of the stroke IPD to form a template for data processing and dashboard design that can be applied to other key business areas for performance monitoring and service improvement is timetabled for completion in summer 2022.

- Collation and harmonisation of available Acute Capitation Review data has been completed and its use in benchmarking between HSC Trusts is ongoing.

- A paper on the feasibility of introducing Patient Level Information and Costing System (PLICS) to NI has been approved, with work on acute activity roll-out commencing in February 2021 and timetabled for completion in March 2022.

- Delivery of Northern Ireland reference costs for 2019/20 was completed and published on schedule in April 2021.

- Analysis of an Activity Based Funding model is up-to-date in the current annual cycle.

Strategic Importance

This project contributes to the Delivering Together organising ourselves to deliver theme and supports the development of the Delivering Together key enabler of improving quality. The project is contributing to service improvement across the HSC.

The project also links to the Rebuilding HSC Services work stream , service delivery innovation by demonstrating the potential for design, development and use of Integrated Performance Dashboards to support service improvement and performance monitoring.

FUTURE NURSE FUTURE MIDWIFE

Total Investment

£677,000

Objective

To ensure a co-ordinated and planned approach to the implementation of transformational change associated with the Nursing and Midwifery Council's new Standards for pre and post registered Nursing and Midwifery training education across a range of practice and service settings.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Future Nurse Future Midwife	101	324	252	677

Regional Project

Yes.

Progress

Progress has been made in respect of all the project objectives and milestones. The Future Nurse Future Midwife project's overall implementation timeline was in line with or in advance of that anticipated, recognising that timescales for implementation of new education standards for nursing and midwifery were September 2020 and September 2021 (respectively). Curricula have been developed to meet the new Nursing Midwifery Council (NMC) standards across midwifery and the four areas of Practice within nursing. A Northern Ireland Practice Assessment Document (NIPAD) has been developed and is being utilised by all nursing students studying at local universities. A range of products and resources to support the nursing and midwifery workforce have been provided, including an e-learning programme to support upskilling and preparation to undertake new roles.

A new engagement and communication strategy has been implemented which enabled accurate, timely, relevant and reliable communication in a range of formats which is accessible to all nurses and midwives in Northern Ireland. Face to face and e-learning preparation programmes have been delivered from May 2020. To date approximately 10,000 staff have completed the preparation programme.

Also, through the project a work-stream was established to maximise and expand existing practice placements to increase capacity in the September 2020 intake by 300 additional pre-registration students to 1,325, a year on year increment of 29%, working towards an additional total of 900 students over 3 years. This enabled agreement to be reached on the specific nursing practice learning profiles, maximised learning opportunities across every practice placement and supported the additional 300 student places from September 2020.

These activities have been related to the NMC approval process and as such were critical to regulatory requirements.

Strategic Importance

The Future Nurse Future Midwife project contributes to the Delivering Together commitment to support our workforce and fulfils a regulatory requirement to transform Nursing and Midwifery Education into the future.

This project also supports the development of the Delivering Together 'Improve Quality' enabler.

It also links directly to the Rebuilding HSC Services Work-stream 'Safe Staffing' by ensuring that the nursing and midwifery workforce meets its regulatory requirements to support students undertaking pre-registration undergraduate training to successfully complete their programmes and join the workforce as registrants.

PRE-REGISTRATION NURSING PROJECT

Total Investment

£2,936,000

Objective

To put in place 75 pre-registration nursing students, starting September 2018, with the anticipated completion of training by August 2021.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pre-registration Nursing Project	587	1,006	1,343	2,936

Regional Project

Yes.

Progress

In September 2018, 75 nursing students commenced their pre-registration training. The nursing students completed their training in August 2021. The Pre-registration Nursing Project has provided funding for additional nursing and midwifery training places, to ensure the supply of new professional nursing and midwifery graduates is maintained to support the workforce, and for the continued safe delivery of services.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation. It also aligns with the Workforce Stabiliation strategic theme of the Nursing and Midwifery Task Group Report.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also supports the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

DIRECT ENTRY MIDWIFERY PROJECT

Total Investment

£820,000

Objective

To put in place 15 direct entry midwifery students in September 2018 with the anticipated completion of training in August 2021.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Direct Entry Midwifery Project	135	231	454	820

Regional Project

Yes

Progress

15 midwifery students commenced their Direct Entry Midwifery training in September 2018. The student midwives completed their training in August 2021. The project provides funding for additional midwifery training places, in response to predicted service demand.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity terms of numbers, expertise, motivation and skills. It also aligns with the Workforce Stabilisation strategic theme of the Nursing and Midwifery Task Group Report.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also support the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

SHORTENED MIDWIFERY COURSE PROJECT

Total Investment

£267,000

Objective

To put in place a cohort of 10 midwifery students to commence the shortened Midwifery course in September 2018, with anticipated completion of training in August 2020.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Shortened Midwifery Course Project	56	96	115	267

Regional Project

Yes

Progress

In September 2018, 10 midwifery students commenced their shortened midwifery course. The midwifery students completed their training in August 2020. The Shortened Midwifery Course Project provides funding for additional midwifery training places in response to predicted service demand.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, expertise, motivation and skills. It also aligns with the Workforce Stabilisation strategic theme of the Nursing and Midwifery Task Group Report.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also support the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

ADDITIONAL 900 NURSING PLACES PROJECT

Total Investment

£2,398,000

Objective

To provide an additional 300 pre-registration training places, year on year for three years, commencing in September 2020, with 900 Nursing and Midwifery training places complete by August 2025.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Additional 900 Nursing Places Project	0	0	2,398	2,398

Regional Project

Yes

Progress

300 nursing and midwifery students commenced their pre-registration training in September 2020. These students are on target to complete their training by August 2023. The second cohort of 300 students are due to commence their training in September 2021. The Additional 900 Nursing and Midwifery Places Project is a specific objective of the New Decade New Approach Agreement. It provides funding for additional nursing and midwifery training places, to ensure that the supply of new professional nursing and midwifery graduates is maintained to support the workforce, and for the continued safe delivery of services.

The benefits of these additional training places will start to be realised from autumn 2023 when the first cohort of 300 additional students complete their degree course and take up posts within the HSC.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

PRE-REGISTRATION PHYSIOTHERAPY PROJECT

Total Investment

£369,000

Objective

To provide 10 additional physiotherapy degree course places from September 2018.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pre-registration Physiotherapy Project	53	90	226	369

Regional Project

Yes

Progress

10 additional students commenced their Pre-registration Physiotherapy degree in September 2018. The physiotherapy students completed their degree in August 2021. These additional training places, which are required on a recurrent basis, will ensure that the necessary supply of trainee physiotherapists are in place to meet future workforce demands.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also supports the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

PRE-REGISTRATION DIAGNOSTIC RADIOGRAPHY PROJECT

Total Investment

£352,000

Objective

To provide 10 additional diagnostic radiography degree training places from September 2018.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Pre-registration Diagnostic Radiography Project	61	105	186	352

Regional Project

Yes

Progress

10 additional students commenced their Pre-registration Diagnostic Radiography degree in September 2018. The diagnostic radiography students completed their degree in August 2021. The Pre-registration Diagnostic Radiography Project has provided funding to support the necessary additional training places in response to predicted service demand.

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also supports the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

ADDITIONAL MEDICAL SPECIALTY TRAINING PROJECT

Total Investment

£1,661,000

Objective

To provide additional medical specialty training programmes in response to workforce planning recommendations, which confirm that Radiology, Intensive Care Medicine, Paediatrics, Urology, Trauma and Orthopaedics and Irish Clinical Academic Training (ICAT) Programme training places should be extended.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Additional Medical Specialty Training Project	400	601	660	1,661

Regional Project

Yes.

Progress

The Additional Medical Specialty Training Project has provided funding for additional specialty medical training places to ensure that the professional healthcare skills necessary for the continued safe delivery of services are in place and to meet predicted service demand. Since the project began in 2018, it has provided the following additional specialty medical training places;

- 5 Radiology places
- 4 Urology places
- 6 ICM places
- 4 Paediatrics places
- 2 ICATs places
- 1 Trauma and Orthopaedics place

Strategic Importance

This project contributes directly to the Delivering Together enabler which established that investment in the HSC workforce is critical to the transformation of HSC services.

It also supports the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

This project is in line with the New Decade New Approach recommendations focused on investment in the workforce / safe staffing.

In addition the project also support the Rebuilding of HSC Services and Safe Staffing, by increasing the capacity of the HSC workforce both in terms of actual numbers and skills.

They also support the Health and Social Care Workforce Strategy which aims to develop future workforce capacity in terms of numbers, skills, expertise and motivation.

NIAS CLINICAL RESPONSE MODEL AND PARAMEDIC TRAINING

Total Investment

£11,120,000

Objective

To carry out the preparatory work to develop a new Clinical Response Model (CRM) for Northern Ireland which will change the way in which calls made to NIAS are categorised, ensuring that the sickest patients are identified and dealt with quickly.

1. To transform the approach to the delivery of paramedic education and deliver a comprehensive workforce plan.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
NIAS Paramedic Training	1,670	3,410	5,000	10,080
Clinical Response Model	0	500	540	1,040
	1,670	3,910	5,540	11,120

Regional Project

Yes.

Progress

The project objectives for preparatory work on the development of the new CRM have been fully met. The key product of this was to introduce the CRM Code Set which was achieved to specification, on time and within budget. The Strategic Outline Case (SOC) has been submitted to the Department of Health to secure the resources to implement the model.

The paramedic education project objective has also been achieved on time and within budget. Progress against the paramedic education objective is as follows:

- Successful development and delivery of a new Paramedic Foundation Degree in partnership with Ulster University.
- Delivery of training courses for the following workforce groups:
  - Ambulance Care Attendants (ACA): 182 students successfully completed the course.
  - Emergency Medical Technicians (EMT): 161 students successfully completed the course.
  - Paramedics: 81 students successfully completed the course and qualified as registered paramedics.

Strategic Importance

The development of a new Clinical Response Model and the training for EMT's, ACA's and Paramedics is consistent with Delivering Together in terms of investing in our workforce and ensuring that NIAS has the most effective clinical response model in place to ensure that people are treated in the right place at the right time.

SPECIALTY AND ASSOCIATE SPECIALIST (SAS) DOCTOR DEVELOPMENT PROJECT

Objective

The purpose of this project is to ensure that SAS doctors have the resources and support in place they need to meet the challenges of this role.

Total Investment

£509,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Specialty and Associate Specialist (SAS) Doctor Development Project - DoH	0	0	308	308
Specialty and Associate Specialist (SAS) Doctor Development Project - HSCB	22	74	105	201
	22	74	413	509

Regional Project

Yes.

Progress

While this project is at an early implementation stage it is positively contributing to the development of the clinical and non-clinical skills and knowledge of the SAS workforce by providing increased access to personal and professional development. All five HSC Trusts have appointed SAS leads who are supporting the work of the Regional Lead and the SAS Development Programme. Surveys (to identify issues relating to morale/access to training/resources) and a training needs analysis have been completed to identify gaps in SAS doctor's training.

Strategic Importance

This project contributes to the achievement of the Delivering Together enabler which established that investment in the HSC workforce is critical to HSC Transformation. It supports the professional and personal development of SAS doctors through the recruitment of SAS leads, and a Regional Associate Dean.

This project also supports the Rebuilding of HSC Services and Safe Staffing as SAS doctors are responsible for the delivery of direct patient care, and provide consistency to the medical and dental workforce.

ENHANCE LEVELS OF SENIOR NURSING STAFF ON DESIGNATED WARDS

Objective

To enhance levels of senior nursing staff on designated wards in phase 1 of delivering care in, RETAIN Wards, Older People's Wards, Stroke, Rehab and Psychiatry of Old Age Wards.

Total Investment

£3,543,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Enhance levels of senior nursing staff on designated wards in phase 1 of delivering care	518	1,381	1,644	3,543

Regional Project

Yes.

Progress

This project enables the existing workforce to be retained and senior nursing posts to be filled by uplifting a number of Band 5 posts to Band 6 posts across the five HSC Trusts. A total of 185 uplifts to Band 6 have been supported.

This project has ensured that there is senior nursing cover for a larger proportion of the 24/7 period and has enabled the ward sister/charge nurse to fulfil the complete supervisory role. This has also helped to increase the presence of senior nurse decision makers and retention of nurses in the designated areas. The project has improved the career pathway opportunities for nurses.

Strategic Importance

This project contributes significantly to the transformation of health and social care as set out in Delivering Together and the Nursing & Midwifery Task Group (NMTG) report which provides direction in achieving world class nursing and midwifery services in a reconfigured HSC system over the next 10-15 years. It specifically relates to the NMTG Strategic Theme 2 focused on maximising the contribution of nursing and midwifery to deliver safe and effective person and family centred care.

It also contributes to the achievement of Delivering Care: a Framework for Nursing and Midwifery workforce Planning to support Person Centred Care in Northern Ireland (DoH 2014) which seeks to develop recommended safe staffing levels across nursing care environments and to create a platform for ensuring that nurse staffing is based on the patient needs (acuity) and best evidence available.

FAMILY NURSE PARTNERSHIP FOR NORTHERN IRELAND

Total Investment

£1,213,000

Objective

To increase the Family Nurse Partnership (FNP) capacity by two family nurses per HSC Trust. The overall objectives of FNP are to:

1. Improve pregnancy outcomes and maternal health;
2. Improve child health and development;
3. Improve economic self-sufficiency.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Extension of family nurse partnership	195	515	503	1,213

Regional Project

Yes.

Progress

Two new family nurses have been working within each HSC Trust since October 2018. Full capacity was reached within one year of appointment in line with FNP National Unit Guidance. This project has enabled 179 additional vulnerable young mothers and their families to receive intensive support which could not be provided by current services.

The level of support provided by the project to vulnerable young mothers ensures that a wide range of public health issues related to perinatal health, including smoking cessation, drugs, alcohol, healthy diet, infant attachment, domestic violence, safeguarding children and access to healthcare are being addressed.

Evidence of public health outcomes are starting to emerge such as an increase in breast feeding initiation rates to 44% compared with 17% for non-FNP teenage mothers in Northern Ireland. There is also evaluation evidence of improved educational attainment and employment for the young mothers and their children. Other socio-economic improvements include reduced hospital admission due to injury or ingestion. Children between 12 and 24 months in FNP have an admission rate of 0.02 and there is a 98% vaccination uptake by the time the children reach 24 months.

Strategic Importance

This project contributes to the Delivering Together commitment to give every child and young person the best start in life and to increase the support provided to children, young people and families from before birth to adulthood. It also supports the implementation of the Public Health Framework Making Life Better and its ambition to give every child the best start.

ENCOMPASS PROJECT

Total Investment

£1,800,000

Objective

To deliver the digitally enabled transformation of Health and Social Care Northern Ireland, including a whole system approach to digitisation.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Encompass Project	0	1,000	800	1,800

Regional Project

Yes.

Progress

This project is an integral part of the Encompass initiative which aims to deliver the digitally enabled transformation of Health and Social Care Northern Ireland over the next seven years. It funds the salary costs for staff in training roles and the Encompass licences. This project has enabled the identification of best practices in training and initiated the groundwork necessary to provide relevant training on a large scale across HSCNI. This will underpin the accelerated achievement of the overall Encompass initiative objectives, primarily the provision of a strategic whole system approach to digitisation; and improved patient safety and quality of care.

The funding of Encompass licences is of significant benefit to HSCNI as it decreases future revenue commitments, enables access to specialist advice from the supplier and provides support for new recruitment in line with the wider Encompass initiative objectives.

Strategic Importance

The wider context for the Encompass initiative is laid out in Delivering Together. This project contributes to the Delivering Together 'Organising ourselves to deliver' theme and supports the development of the Delivering Together key enabler of 'Improving Quality and Safety and eHealth'. The project will contribute to service improvement across the HSC.

When fully implemented Encompass will make a significant contribution to rebuilding HSC services through greater access to virtual platforms for service users and health professionals; replacement of existing disparate systems and functionality; a single patient record; and enhanced data analytics and reporting to provide accurate, real-time reporting and dashboards.

ADVOCACY SUPPORT FOR PATIENTS AND FAMILIES OF MUCKAMORE ABBEY HOSPITAL

Total Investment

£89,000

Objective

To provide additional advocacy support to patients and families and ensure that the voice of all patients, carers and families with an interest in Muckamore Abbey Hospital are represented throughout the implementation of the Departmental Assurance Group action plan.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Advocacy Support for Patients and Families of Muckamore Abbey Hospital	0	25	64	89

Regional Project

No.

Progress

This project provides a dedicated advocacy resource to Muckamore Abbey Hospital in response to the Departmental Assurance Group's action plan. The Patient Client Council (PCC) has appointed a specialist advocate for Muckamore Abbey Hospital who is engaging directly with other advocacy organisations and family groups. This engagement is positive and is building trust between the families, the PCC and other stakeholders. Three engagement events with approximately 55 families occurred in December 2020 and a report has been prepared as a precursor for the public inquiry.

Strategic Importance

This project contributes to Delivering Together by providing a voice for service users and carers.

PATIENT CLIENT COUNCIL (PCC) MEMBERSHIP SCHEME

Objective

To support the drive to an active involvement of service users and carers in key decisions about Health and Social Care in Northern Ireland.

Total Investment

£177,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Patient Client Council (PCC) Membership Scheme	0	76	101	177

Regional Project

Yes.

Progress

Three Involvement Officers are now in post and are providing and promoting opportunities for the active involvement of service users and carers in key decisions about Health and Social Care in Northern Ireland through PCC social media channels. 35 training sessions have been completed to support and mentor 519 members of the public on specific programmes of work in readiness for their involvement.

The PCC play a critical role in how the HSC embeds partnership working, bringing people into the decision-making process by working across organisational boundaries; ensuring people are well informed to help reduce knowledge gaps and addressing power imbalances between participants.

Strategic Importance

The work of this project has supported the development of key enablers identified within Delivering Together; partnership working and improving quality. It has provided opportunities for individuals to become involved in programmes of work, for example, the Cancer Strategy, Being Open, Gender Identity, and Elective Care.

PARTNERSHIP WORKING, PERSONAL AND PUBLIC INVOLVEMENT (PPI) AND CO-PRODUCTION

Objective

To drive forward a cultural change within the HSC where service users, carers and their advocates are regarded as partners in the commissioning, planning and delivery of services.

Total Investment

£840,000

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
PPI and Co Production and capacity building	17	86	53	156
Partnership Working Officers	97	245	205	547
Building Co-Production HSC Training and Capacity Build Programme	0	0	50	50
10 WTE service user / peer user	0	0	87	87
	114	331	395	840

Regional Project

Yes.

Progress

Significant progress has been made in ensuring that the awareness and understanding of PPI, co-production and partnership working has been raised within the HSC and the agreed project objectives achieved.

As part of this project, six Partnership Working Officers have become an integral element within the HSC Trusts and PHA. They lead on the operational aspects of work to embed PPI and co-production methodologies across the System.

These officers ensure organisations are able to meet their statutory duty and policy obligations in relation to PPI and co-production and have encouraged greater partnership working since taking up post. They have encouraged consistency of practice and compliance with regionally agreed approaches and standards. All Trusts have now delivered introductory awareness training on involvement and co-production to an estimated 9,000 staff.

HSC staff have also provided targeted education and training with approximately 970 participants having engaged to date in training and development through webinars on consultation, involvement and co-production.

The PHA has also commissioned, designed and co-delivered a range of related training programmes to 120 participants in the last year. In addition, the Leading in Partnership Programme, was delivered to 130 participants (a quarter of which were service users and carers) since its inception in 2019/20. This is an intensive training initiative, during which each participant undertakes 50+hours of direct training and development.

These specialist education and training programmes have built a critical mass of people with experience, knowledge and expertise in relation to PPI, co-production and partnership working that is bringing about the cultural change which is required.

A Peer Mentor programme is also been developed to enhance and embed involvement, co-production and partnership working within the HSC. 10 Peer Mentors have been recruited and trained with further developmental work required to enable this programme to be delivered. To this end, research has been undertaken in highly complex areas such as the remuneration of service users and carers and the impact of such remuneration on benefits.

This research is advancing the HSC understanding of the challenges and difficulties faced in engaging people in peer mentoring, while balancing this with perhaps a long standing health condition or caring responsibilities. So far, approximately 90 people have directly availed of training related to peer mentoring and a lead officer from the PHA will continue to progress the delivery of the peer mentor programme.

Strategic Importance

Delivering Together outlined the importance of partnership working as being one of the five key enablers of HSC Transformation. This project contributes to the Delivering Together commitment to HSC involvement and co-production, strengthening partnership working within and across the health and social care system.

There is also a legislative imperative on the HSC to deliver on its statutory responsibilities in respect of PPI.

IMPLEMENTATION OF ONLINE USER FEEDBACK SYSTEM IN NORTHERN IRELAND

Total Investment

£868,000

Objective

The overall aim of the project is to use learning from patient experience, through the implementation of an Online User Feedback System (OUFS), to inform commissioning which delivers better outcomes and value for money in how services are delivered.

Project Title	2018/19 (£'000)	2019/20 (£'000)	2020/21 (£'000)	Total (£'000)
Implementation of Online User Feedback System in Northern Ireland	74	429	365	868

Regional Project

Yes.

Progress

Significant progress has been made in the delivery of this project. Phase 1 (2018-2020) involved engaging and preparing stakeholders to promote, implement and manage the Online User Feedback System. This involved establishing a Regional Implementation Group to support implementation across the Health and Social Care System. All Trusts have a local implementation group to drive forward this project. The new OUFS "Care Opinion" website was launched in Northern Ireland on 3 August 2020 marking the end of Phase 1 of the Project Implementation Plan.

Phase 2 (Aug 2020-March 2021) focuses on story generation and ongoing promotion and active engagement of Care Opinion with the wider HSC system. To date 523 stories of patient experiences have been shared on the website and these have been viewed over 42,000 times.

74% of these stories have been positive and reach out to say thank you to HSC staff. As a result of these shared patient experiences 31 local changes have been planned or made. This clearly demonstrates how the feedback has informed and influenced the delivery of HSC services.

In addition, Care Opinion is informing regional work in relation to the COVID-19 response and rebuilding of HSC services through the development of specific plans in relation to District Nursing Strategy, No More Silos and the Regional Nightingale Rehabilitation Services.

All HSC Trusts have now implemented Care Opinion and have developed processes to collect and utilise the information they receive. 994 members of staff are now registered as subscribers to Care Opinion with 86% working as responders and 14% working as readers of stories, thus ensuring that stories are responded to within 7 day of publication. So far, 94% of patient experience stories have received a response within the 7 day period.

Engagement is ongoing with Primary Care, Community and Voluntary Sector organisations, RQIA and PCC in order to support a system wide approach to embedding an OUFS into the HSC System as a whole. This work is evaluated through an impact and improvement strategy, which reflects upon 10 key measures to meet the objectives of the project. To date the evaluation has been positive highlighting monthly increases in story generation and engagement with the public. There is also a growing dataset on the changes identified which is available for shared learning across Northern Ireland.

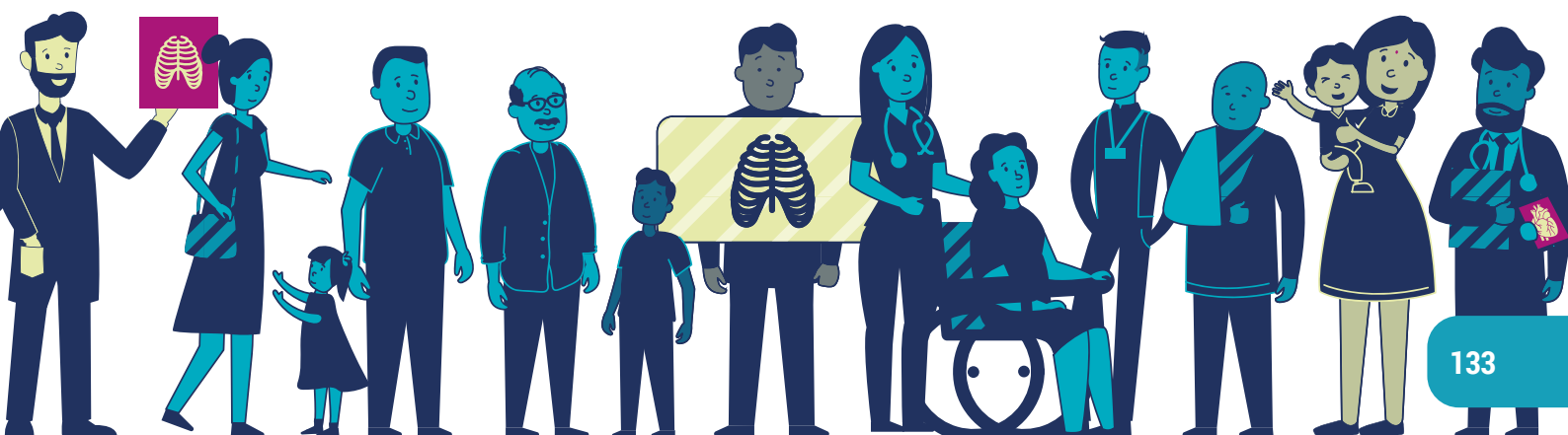
Strategic Importance

This project links to the Delivering Together action to consult on a proposal for and design of a new user feedback service. The primary driver for Online User Feedback is the Programme for Government (PFG), which includes a focus on gathering, and learning from lived experience through Outcome 4, Indicator 5 – "Improve the quality of the healthcare experience – percentage of people who are satisfied with the health and social care based upon their recent contact."

The need for an OUFS also links closely with recommendation 63 included in the report on the Inquiry into Hyponatraemia-Related Deaths.

OUFS is integral to the learning from the COVID-19 pandemic providing contemporary feedback on services. It has also contributed to the rebuilding of services through No More Silos, Regional Nightingale Rehabilitation Services, and District Nursing.

SECTION 5:
SUMMARY



The investment of almost £300 million since 2018, has provided a significant opportunity to stabilise, reconfigure and transform our services in a way that has brought tangible benefits to our population and importantly provided a solid bedrock upon which to build the HSC's emergency pandemic response.

The many challenges facing the HSC system as outlined within Delivering Together were seen first-hand in the work to drive forward the transformation agenda. Increasing demand for services, the need to reconfigure how we deliver these, workforce shortages and the lack of long-term recurrent investment challenged the delivery of this important programme.

And indeed the impact of COVID-19 exacerbated these challenges. However, in recognition of the importance of long-term transformation, the existing transformation projects and funding to support them, was protected throughout the pandemic to retain the important progress already made.

The projects outlined within this report have made significant progress in achieving their objectives or in progressing substantial work towards these.

A number of transformation projects carried out specific pieces of work to inform future plans, including reshaping Stroke Care, reforming Adult Social Care and Support, reviewing Urgent and Emergency Care and developing a New Cancer Strategy for Northern Ireland. These projects all directly contribute to the actions and commitments within Delivering Together and New Decade, New Approach.

Significant progress has been made on the implementation of the New Diabetes Strategic Framework to support effective treatment and care for people living with diabetes. In addition progress has also been made on the implementation of the Paediatric Strategies which are designed to modernise and improve treatment and care for children and their families.

Similarly, proposals to transform and improve services for Looked After Children have shown considerable benefit and there have been some excellent initiatives which are improving access and resilience within primary care.

The need to build resilience and capacity within our workforce now more than ever, is a key factor in our rebuilding agenda. Transformation has enabled commitments made to provide extra nursing, midwifery, physiotherapy, radiotherapy and medical places to commence. This – amongst many other projects outlined within this report – has helped address the workforce challenges and provide more stability in our services.

Positive progress has been made in the establishment of two Daycase Procedure Centre prototypes which has proven that the concept can standardise treatment, consolidate services, reduce waiting times, and ensure equity of access to patients.

Through the development of primary care elective care services, over 13,000 patients who would have been referred to secondary care have had their treatment in primary care. The development of Multi-Disciplinary Teams (MDTs) in primary care has been a flagship initiative to build capacity and capability

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with pharmacists embedded in all GP practice teams and by co-locating mental health practitioners, social workers and physiotherapists in GP practices and ensuring that health visiting and district nursing support is enhanced. With over 600,000 people now having access to MDTs in primary care this has been a significant success to date.

The transformation programme supported the development of a range of services that were later included in commissioning plans for community pharmacy, successfully optimising the sector's contribution to population health by ensuring the public had continuous access to medicines, pharmaceutical advice, medicines optimisation and medication safety support.

Ambulatory project pathways, have kept patients out of hospitals when the need to do so was greatest and are helping to improve the management and flow of patients through the HSC system.

How we organise ourselves to plan and deliver services has also been an important factor in delivering successful and sustainable change. The Northern Area Pathfinder was established to test a new model for planning and delivering HSC services. The prototype embraces the recommendations of the Bengoa Report, building on the foundations of GP Federations, Integrated Care Partnerships (ICPs) and the system wide commitment to co-production. Work is now progressing to develop a new system to replace the existing commissioning functions of the HSCB with a focus on local population need and an integrated approach.

From the evidence contained within this report, there is no doubt that the Transformation programme has been hugely successful in stabilising, reconfiguring and transforming HSC services.

There is much learning that can be gleaned from progress to date and in how transformation supported the HSC system to respond quickly and effectively during the greatest ever stress test, the COVID-19 pandemic. As we enter the next iteration of our transformation journey; Rebuilding Better, we must continue to deliver together, building on the firm foundations that have been laid and integrating these new successful ways of working.

GLOSSARY

MAHI - STM - 300 - 2298

ACA	Ambulance Care Attendants
AHP	Advanced Health Practitioners
A&E	Accident and Emergency
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CAMHs	Child and Adolescent Mental Health services
CCIS	Community Crisis Intervention Service
CHST	Care Home Support Teams
CMO	Chief Medical Officer
CPD	Continuing professional development
CRM	Clinical Response Model
CYP	Children and Young People
D2A	Discharge to Assess
DAU	Direct Assessment Unit
DECC	Daycase Elective Care Centres
DHH	Daisy Hill Hospital
DNS	Diabetes Nurse Specialist
DOE	Department of Education
DOH	Department of Health
DOJ	Department of Justice
ED	Emergency Department
EIF	European Investment Fund
EISS	Early Intervention Support Service
ELEVATE	Capacity building programme
ESD	Early supported Discharge
EMT	Emergency Medical Technicians
FIT	Faecal Immunochemical Test
FNP	Family Nurse Partnership
FOB	Faecal Occult Blood
FSU	Federation Support Units
GMS	General Medical Services
GP	General Practitioner
GPICRT	General Practice Improvement and Crisis Response Team
GPN	General Practice Nurses
GPS	General Practitioner Services
HCPC	Health and Care Professions Council
HDU	High Dependency Unit
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCQI	Regional Quality Improvement and Innovation System
ICAT	Irish Clinical Academic Training
ICPs	Integrated Care Partnerships
ICS	Integrated Care System
IDDSI	International Dysphagia Diet Standardisation Initiative
IIB	Community Development Implementation and Innovation Board
LAC	Looked After Children
LIMS	Laboratory Information Management System
LOS	Length of stay
MATT	Multi-Agency Triage Team
MDT	Multi-Disciplinary Teams
MH	Mental Health
MHLS	Mental Health Liaison Service

MHS	Mental Health Services
MSK	Musculoskeletal
NAIC	National Audit of Intermediate Care
NAs	Nursing Assistants
NDN	Neighbourhood District Nursing
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
NICCY	Northern Ireland Commissioner for Children & Young People
NICE	National Institute for Health and Care Excellence
NIHE	Northern Ireland Housing Executive
NISCC	Northern Ireland Social Care Council
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NMC	Nursing and Midwifery Council
NMTG	Nursing & Midwifery Task Group
OBA	Outcomes Based Accountability
OOH	Out of Hours
OPAT	Outpatient Parenteral Antibiotic Therapy
OU	The Open University
OUFS	Online User Feedback System
PALLS	Paediatric and Life Limited Service
PAS	Patient Administration Systems
PCC	Patient Client Council
PHA	Public Health Agency
PL2	Protect Life 2
PLIGs	Protect Life Implementation Groups
PPE	Personal Protective Equipment
PPI	Personal and public involvement
PrEP	Pre-exposure prophylaxis
PSNI	Police Service of Northern Ireland
PSS	Peripatetic Support Services
QI	Quality improvement
QUB	Queen's University Belfast
RCN	Royal College of Nursing
REaCH	Responsive Education and Collaborative Health
RMB	Rebuild Management Board
RQIA	Regulation and Quality Improvement Authority
RSM	RSM UK Consulting LLP
SALT	Speech and Language Therapists
SAS	Specialty and Associate Specialist
SCIE	Social Care Institute for Excellence
SDE	Structured Diabetes Education
SEHSCT	South Eastern Health and Social Care Trust
SEN	Special Educational Needs
SHSCT	Southern Health and Social Care Trust
SOC	Strategic Outline Case
SOPs	Standard Operating Procedures
TZS	Towards Zero Suicide
UKAS	United Kingdom Accreditation Service
WHSCT	Western Health and Social Care Trust
WTE	Whole Time Equivalent

MAHI - STM - 300 - 2302

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

CONTACT US TODAY

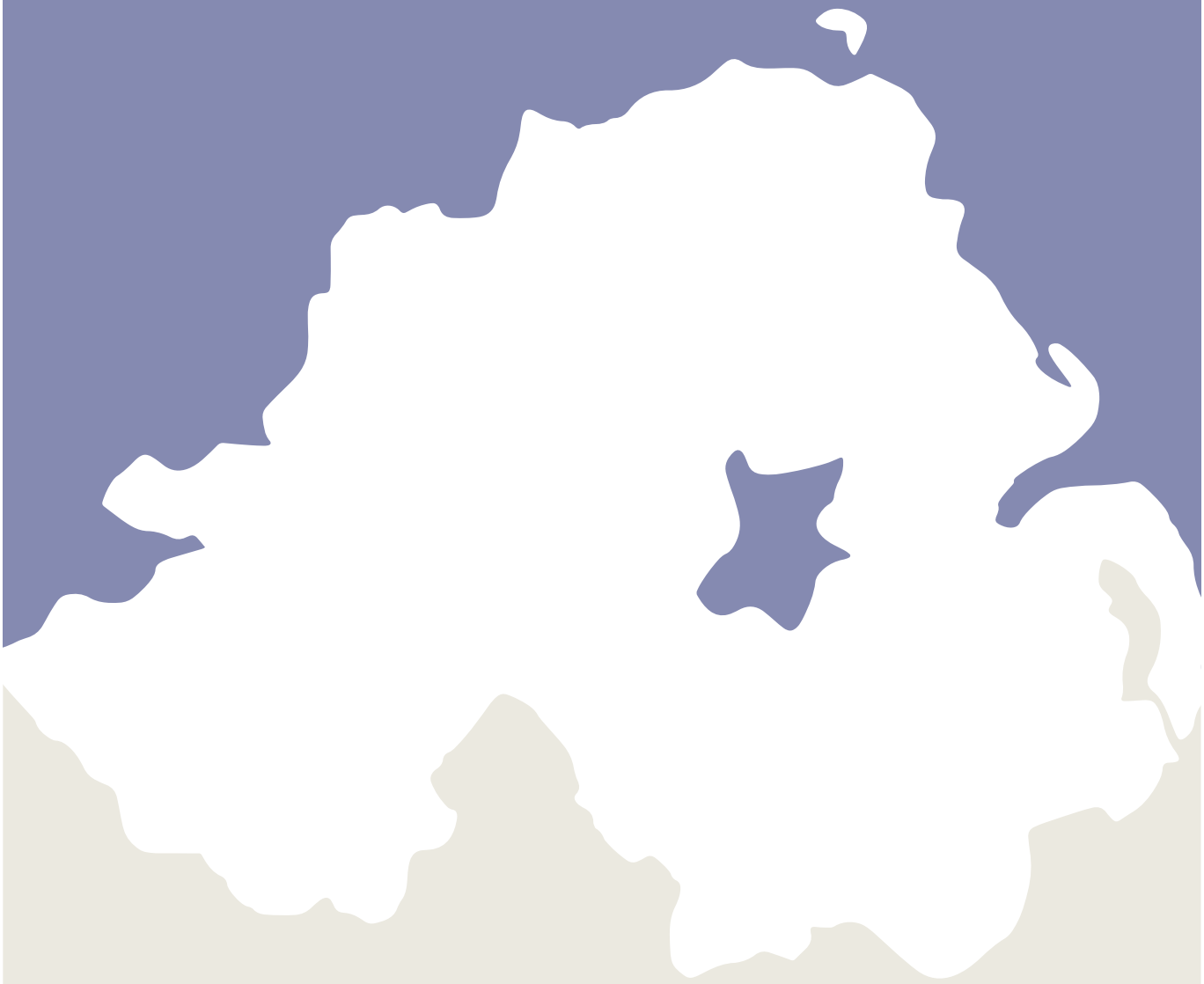
HSC Transformation Directorate
Department of Health,
Annex 3, Castle Buildings,
Stormont Estate, BT4 3SL

028 9052 0250 | hsctransformation@health-ni.gov.uk

THE RIGHT TIME, THE RIGHT PLACE

An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland

DECEMBER 2014



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

CONTENTS

1 CONTEXT

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

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

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

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

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

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

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

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

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

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

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

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

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

2 TERMS OF REFERENCE AND WORKING METHODS

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

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

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

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

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

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

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

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

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

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

3 THE CHALLENGES OF DELIVERING HIGH QUALITY, SAFE CARE

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

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

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

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

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

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

4 KEY THEMES ESTABLISHED BY THE REVIEW

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

4.1 A SYSTEM UNDER THE MICROSCOPE

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

4.1.1 A stream of inquiries highlighting service failures

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

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

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

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

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

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

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

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

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

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

4.1.2 Intense political and media interest in service provision

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

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

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

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

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

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

4.2.1 Service configuration creates safety concerns

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

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

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

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

4.2.2 Adverse consequences for primary and social care

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

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

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

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

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

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

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

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

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

4.2.4 Transformation efforts are moving slowly

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

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

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

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

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

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

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

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

4.2.5 An under-powered system of commissioning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.2.7 Clarifying the role of healthcare regulation

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

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

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

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

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

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

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

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

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

4.3.1 Clinical leadership

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

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

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

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

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

4.3.2 Cultural change

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

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

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

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

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

4.3.3 Data linked to goals

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

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

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

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

4.3.4 Standardisation

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

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

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

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

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

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

4.3.5 The recipe for success

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

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

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

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

4.4 EXTRACTING FULL VALUE FROM INCIDENTS AND COMPLAINTS

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

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

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

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

4.4.1 Incident reporting elsewhere

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

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

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

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

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

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

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

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

4.4.2 Incident reporting in Northern Ireland

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

An adverse incident is defined as:

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

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

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

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

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

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

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

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

4

Figure 1. Serious Adverse Incident reports: by Trust

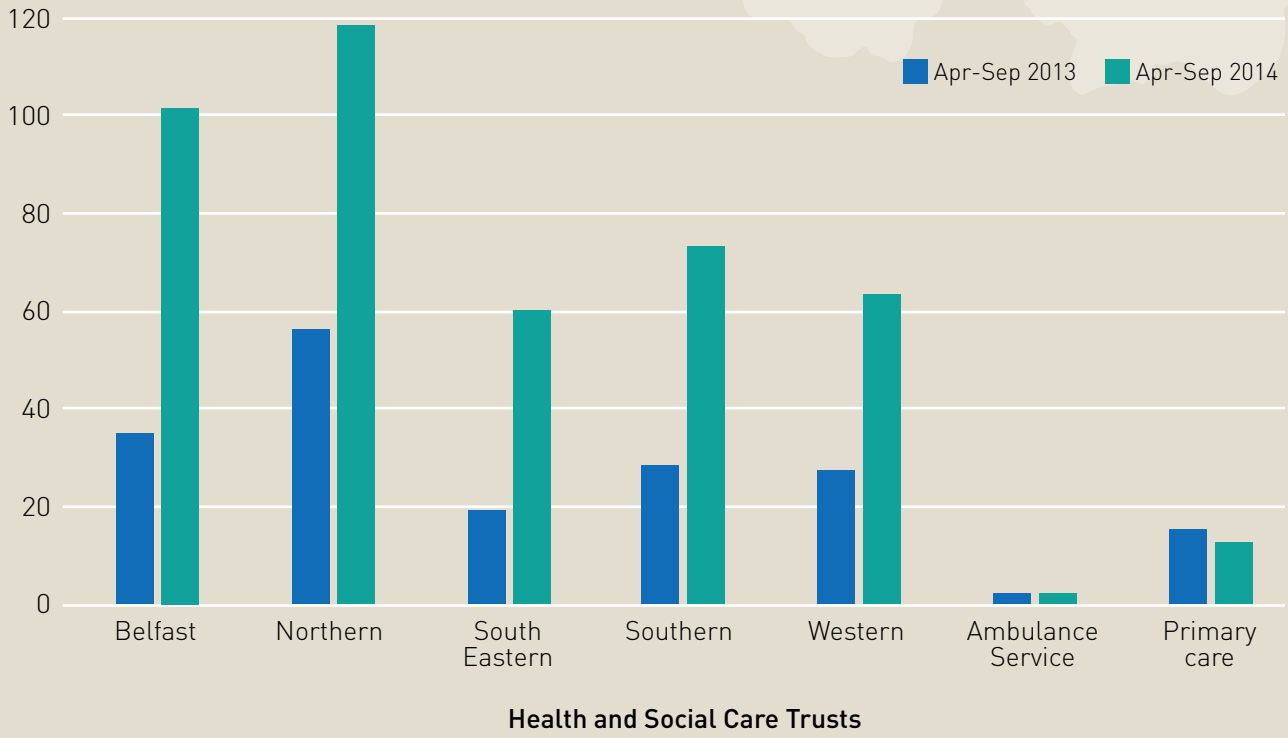
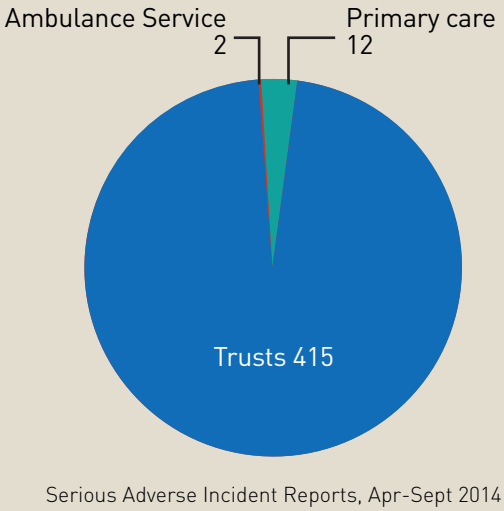
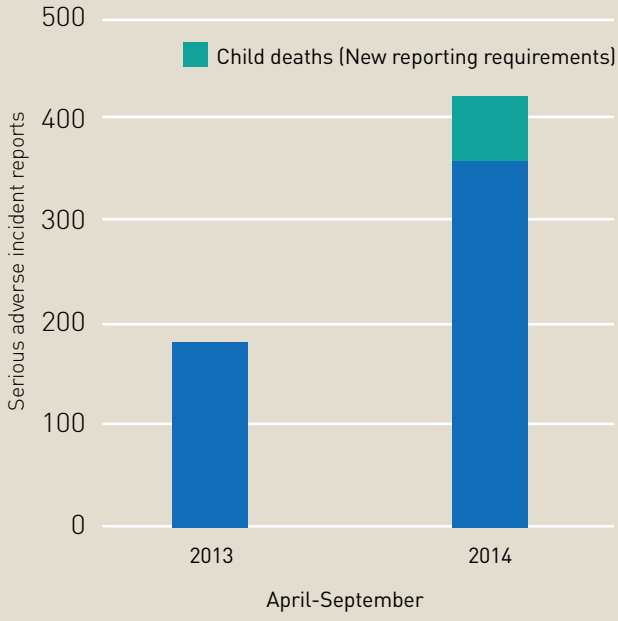


Figure 2. The great majority of Serious Adverse Incident reports are made by the Health & Social Care Trusts



Serious Adverse Incident Reports, Apr-Sept 2014

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



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

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

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

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

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

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

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

4.4.3 Frustrations with the incident reporting system

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

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

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

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

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

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

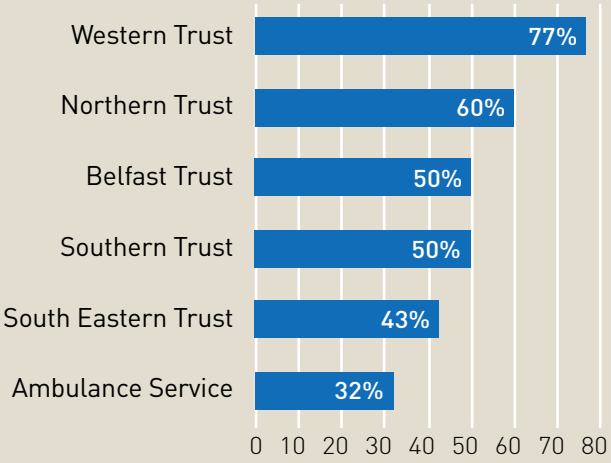
These cultural barriers to reporting and learning are not unique to Northern Ireland. Creating a culture where the normative behavior is learning, not judgment, is very much the responsibility of political leaders, policy-makers, managers and senior clinicians. This does not mean that no-one is ever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

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

4.4.4 The complaints system in Northern Ireland

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

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



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

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

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

4.4.5 Involvement of the coroner

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

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

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

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

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

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

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

4.4.6 Redress

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

4.4.7 The nature of learning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4

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

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

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

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

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

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

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

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

4.5 THE BENEFITS AND CHALLENGES OF BEING OPEN

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

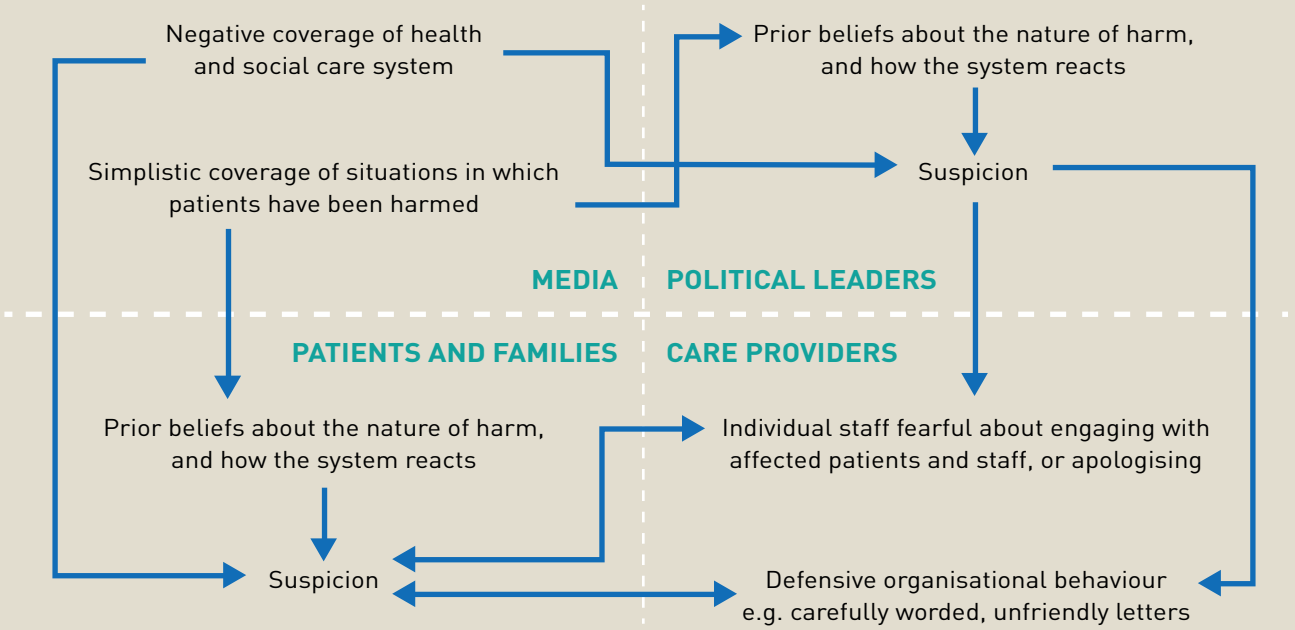
Openness is not something that can simply be demanded. It needs the right conditions in order to flourish. The enemy of openness is fear.

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

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

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

Figure 7. The vicious cycle of suspicion and fear



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

4.5.1 Governance arrangements to promote openness

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

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

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

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

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

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

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

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

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

4.5.2 Perceptions of openness

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

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

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

4.5.3 Duty of candour

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

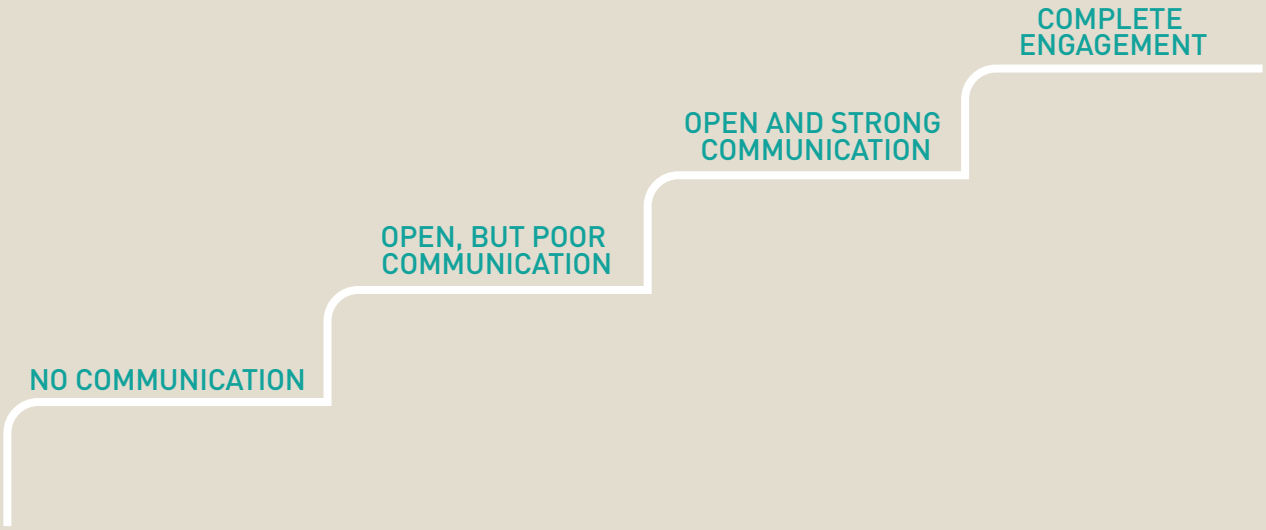
There are many potential themes for patient and family engagement in health and social care, for example:

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

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

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

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



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

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

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

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

5 CONCLUSIONS

5.1 RELATIVE SAFETY OF THE NORTHERN IRELAND CARE SYSTEM

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

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

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

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

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

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

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

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

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

5.3 FOCUS ON QUALITY AND SAFETY IMPROVEMENT

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

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

5.4 THE EXTENT TO WHICH SERIOUS ADVERSE INCIDENT REPORTING IMPROVES SAFETY

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

5.4.2 The Serious Adverse Incident process fulfils five main purposes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.5 OPENNESS WITH PATIENTS AND FAMILIES

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

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

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

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

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

6 RECOMMENDATIONS

Recommendation 1: Coming together for world-class care

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

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

Recommendation 2: Strengthened commissioning

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

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

Recommendation 3: Transforming Your Care – action not words

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

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

Recommendation 4: Self-management of chronic disease

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

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

Recommendation 5: Better regulation

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

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

Recommendation 6: Making incident reports really count

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

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

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

Recommendation 7: A beacon of excellence in patient safety

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

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

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

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

Recommendation 8: System-wide data and goals

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

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

Recommendation 9: Moving to the forefront of new technology

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

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

Recommendation 10: A much stronger patient voice

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

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

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

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

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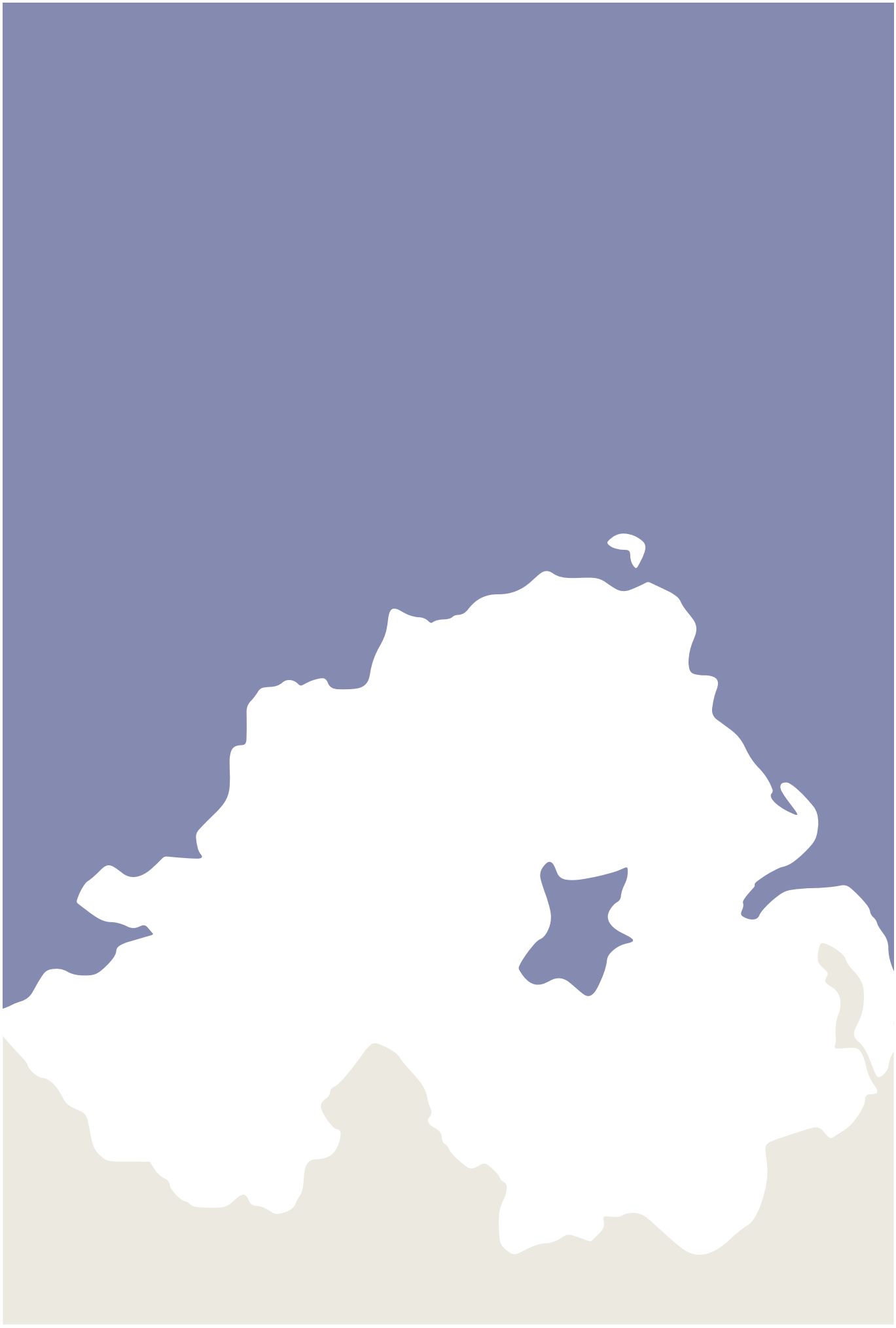

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Belfast Health and Social Care Trust
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ASSURANCE FRAMEWORK

COMMITTEE TERMS OF REFERENCE

COMMITTEE	**ASSURANCE COMMITTEE**
PURPOSE	The Board of Directors has approved the establishment of a Belfast Health and Social Care Trust standing committee whose purpose will be to have oversight of all aspects of integrated governance, excluding finance, and to ensure a robust assurance framework is maintained. The title of this standing committee will be the 'Assurance Committee'
MEMBERSHIP	**Chair:** A Non-Executive Director nominated and seconded by fellow Non-Executive Directors. **Membership:** Chairman and Non-Executive Directors of the Belfast Health and Social Care Trust. **In attendance:** ▪ Chief Executive ▪ Deputy Chief Executive/Director of Finance, Estates and Capital Planning ▪ Medical Director ▪ Director of Social Work / Children's Community Services ▪ Director of Nursing and User Experience ▪ Head of Office of Chief Executive/Co-Director Risk and Governance ▪ Corporate and Service Directors Other members of Trust staff may be required to attend meetings as the committee considers necessary. **Secretary:** The Co-Director for Risk and Governance/Head of Office, Chief Executive's Office will act as Secretary to the Committee. The Assurance Group assists the Assurance Committee in its work

DUTIES	Oversight of Corporate Governance and Assurance at the Belfast Health and Social Care Trust. The committee is responsible for ensuring that effective and regularly reviewed structures are in place to support the implementation and development of governance. The Committee shall seek to ensure that: ▪ Risks and opportunities are identified and managed; ▪ Controls both internal and external are in place; ▪ Local community, user group and staff input; ▪ Timely reports are made to the Board of Directors, including recommendations and remedial action taken or proposed if there is an internal failing in systems or services. The following existing activity will fall within the remit of the Assurance Committee: ▪ Quality, Safety and Standards in Health and Social Care; ▪ Corporate Parenting / Child Protection; ▪ Controls assurance and internal control; ▪ Complaints management; ▪ Litigation management; ▪ Maintenance of the reputation, image and integrity of the Belfast Health and Social Care Trust; ▪ Professional regulation; ▪ Research and education governance; ▪ Information governance; ▪ Other matters excluding finance that pertain to integrated governance and assurance. ▪ Regular review the Trust's Assurance Framework (AF) Principal Risk document and ensure any gaps in assurance are identified and highlighted to Trust Board. ▪ Regularly review the risks from the Corporate Risk Register, which are not included with the Principal Risk document ▪ Consider the appropriateness of the Mid-Year Assurance Statement and the Annual Governance Statement ▪ Consider Assurance sub-committees regular updates/annual reports
AUTHORITY	The Assurance Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. The Committee will be given the resources necessary to carry out its role. The Committee will be given full access to any information within the Belfast Health and Social Care Trust that it requires to fulfill its function. The Committee is authorised by the Board of Directors to obtain external professional advice and to invite outsiders with relevant experience to attend if necessary.

MEETINGS	**Quorum** A quorum is three members **Frequency of Meetings** The Committee will meet four times a year at the Belfast Health and Social Care Trust Headquarters. **Papers** Agenda and papers will be disseminated to Assurance Group members four working days before the date of the meeting and wherever possible electronically. **Meeting Arrangements** The Chair of the Assurance Committee in discussion with the Assurance Committee Secretary shall determine the time and place of meetings and procedures of such meetings. **Withdrawal of individuals in attendance** The Assurance Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of a particular matter.
REPORTING	The Committee Chair will call meetings of the Assurance Committee. The Committee has the right to conduct sensitive items of business in private session. The Committee shall report in writing to the full Board of Directors. Any business conducted in private session by the Assurance Committee will be reported to a private session of the Board of Directors. The Committee will make a formal Assurance progress report within the Belfast Health and Social Care Trust annual report.
CONFLICT/ DECLARATION OF INTEREST	The Chair shall seek and record any declaration or conflict of interest from members prior to every meeting of the group.
REVIEW	These terms of reference and operating arrangements will be reviewed on at least an annual basis by the group.

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Minutes of the Executive Team Meeting held on
3 February 2016 at 9.00am
Boardroom, Muckamore Abbey Hospital

Present:

Dr Michael McBride, Chief Executive
Mr Martin Dillon, Deputy Chief Exec/Director Finance/Estates/Capital Development
Miss Brenda Creaney, Director of Nursing and User Experience
Mr Shane Devlin, Director Performance, Planning and Informatics
Ms Catherine McNicholl, Director Adult Social and Primary Care
Mrs Bernie Owens, Director Unscheduled and Acute Care
Mrs Jennifer Welsh, Director Surgery and Specialist Services
Mr Cecil Worthington, Director Social Work/Children's Community Services
Mrs Bronagh Dalzell, Head of Communications
Mr Brian Barry, Director Specialist Hospital and Women's Health

Apology:
Dr Cathy Jack, Medical Director
Mr Damian McAlister, Director Human Resources/Organisational Development
Ms Claire Cairns, Head of Office, Chief Executive's Office

In Attendance:

Miss Marion Moffett Minute Taker

1. Minutes of Previous Meeting

The minutes of the previous meeting held on 27 January 2016 were considered and approved.

2. Matters Arising – Action Log

The contents of the Action Log from previous meeting was noted with specific reference to the following:

2.1 Minister's Visit to Critical Care Building

Mrs Dalzell advised she was still awaiting the Private Office to confirm a date for Ministerial visit to the Critical Care Building.

2.2 HCAI Update – Visit to Level 7 in RVH and Ward B, Mater Hospital

Dr McBride advised due to diary commitments he had not been able to carry out his planned visit to Level 7, RVH and Ward B, Mater Hospital had asked for it to be rescheduled.

2.3 Submissions to Expert Panel on Configuration of HSC Services

Mr Dillon undertook to co-ordinate a list of documents for submission to the Expert Panel and asked members to forward relevant information to him.

3. Chief Executive's Update

3.1 Restructuring Programme Board

Dr McBride briefed members on the membership of the Restructuring Programme Board the first meeting of which was scheduled for 10 February 2016.

3.2 Strategic Accountability Group

Dr McBride advised that the first meeting of the Strategic Accountability Group was scheduled for 22 February 2016 and Mr Dillon, as Deputy Chief Executive, would be representing the Trust.

3.3 Chief Executive's Forum

Mr McAlister had represented Dr McBride at the Chief Executive's Forum meeting on 1 February 2016.

Members noted that Mr Bingham had presented an update on the Shared Services feasibility work currently being undertaken by Deloitte in respect of ICT Services, Business Intelligence and E-Locum/Nurse Bank.

3.4 Interim Director of Specialist Hospitals and Women's Health

Dr McBride reported that Mr Aidan Dawson had been appointed as Interim Director of Specialist Hospitals and Women's Health and would take up post on 1 March, 2016.

3.5 Chief Executive, Our Ladies Crumlin, Dublin Visit

Dr McBride briefed members on a visit by Ms Hellen Short, Chief Executive, Our Ladies Crumlin and Ms Tracey Wall, Assistant Director to the RBHSC on 2 February 2016.

Mr. Dillon advised that the Business Case in respect of the Children's Heart Centre within the new Children's Hospital had been submitted to the DHSSPS as part of the overall Business Case for the establishment of the All-Ireland CHD Network.

3.6 Executive Team Workshop – 10 February 2016

Mr Dillon advised that the programme for the Executive Team Workshop on 10 February 2016 was being finalised and would be issued in the next few days.

Following discussion Mr Dillon asked that members give some thought to what the core priorities for 16/17 should be for discussion at the afternoon session of the workshop.

4. Resources

4.1 Finance

Mr Dillon thanked colleagues for submitting the reform/efficiency plans, these were currently being reviewed and a report will be presented to Executive Team in the near future.

Mr Dillon gave an update on the month 9 financial position .

Members noted a response was awaited from the HSCB in relation to the revised draft Financial Plan for 2016/17.

5. Safety and Excellence

5.1 HCAI Update and Recovery Plan

Miss Creaney presented an update on the HCAI performance indicators reporting a continuing improvement in respect of Cdiff, with MRSA remaining to a challenge.

Members noted the HCAI Recovery Plan report detailing actions being taken within Directorates to ensure improved performance.

Dr McBride emphasised the importance of continued focus across directorates in ensure improvement.

5.2 Unscheduled Care Update

Mrs Owens presented an update on the unscheduled care position which indicated 59% of patients had been seen within 4 hours with 48 patients waiting over 12 hours. She highlighted there continued to be significant improvement in the conversion rate compared to the same period last year.

In relation to the Mater ED the 4 and 12 hour performance had been maintained. Mrs Owens advised that Dr Mark Mitchell had been appointed as Clinical Lead in the Mater ED,

Mr Devlin advised that compared to January 2015 there had been 13% more attendances at RVH in January 2016.

Mrs Owens also pointed out that the number of Elective admissions for 2016 had increased compared to the same period in 2015.

Mrs Owens presented information in relation to the use of the Discharge Lounge which indicated the need for improvement to create ward bed capacity.

Mr McBride referred to the Patient Tracking system and the need for all wards to ensure up-to-date data was in-putted to in order that accurate information is available for Patient Flow.

Dr McBride asked that Directors ensure that all areas are using the Patient Tracking System and if necessary ensure training/IT support is provided.

Following a comment from Mr Barry regarding the use of telehealth to support early patient discharge, Mr Devlin undertook to follow up at a planned Trust workshop regarding the future of tele-monitoring.

Mr Barry also suggested that if AHP assessments were carried out in patient's homes following discharge it would be more appropriate.

Mr Barry gave an update on the performance within the RBHSC ED and reported 90% performance. He advised that there had been an incident over the weekend involving a sewage leak within PICU but there had been no impact on patient care.

In concluding the discussion Mr Dillon said that it would be useful to have a commentary prepared capturing all the improvements in January 2016 compared to same period 2015 i.e reduction in medical outliers, increase in Elective, occupancy/conversion levels, etc. Mr Devlin and Mrs Owens undertook to draft something for consideration.

6. Continuous Improvement

6.1 Performance Report – December

Mr Devlin presented the Performance Report for the period ending December 2015.

In noting the content of the report members discussed some areas reporting red which could be considered as core priorities for the Trust in 16/17.

Mrs Welsh advised that Cancer Services would be making a presentation at the April Trust Board Workshop to provide Non Executive Directors' with more detail in relation to targets.

6.2 Implementation of the National Living Wage Contract with Non Statutory Providers

Mr Devlin presented a paper outing a proposal for the Trust regarding the implementation of the National Living Wage (NLW) with regard to contracts with Non Statutory Providers in the community. He drew attention to the proposed approach being:

- The uplift to be applied to the Residential and Nursing Home sector could also be applied to the Community and Voluntary Sector
- Therefore if a 4% planning assumption is confirmed as a 4% pricing uplift, this uplift could be applied to the sector
- All contracts are reviewed by the relevant Directorate/Service purchasing the service to ensure that all levels of activity required by the contract are fulfilled via the contract monitoring and contract review processes.

Members noted the additional cost pressure associated with the NLW.

Following a lengthy discussion the approach outlined above was approved for submission the HSCB for further discussion.

7. Media/PR Round-Up

Mrs Dalzell gave an overview of recent and planned media coverage.

7.1 Social Media Incident Involving Patient

Dr McBride made reference to the video clip discussed at previous meetings which had since appeared on further social media site. Mrs Dalzell advised that the Communications Team had contacted the site requesting it be removed.

Mrs Owens advised that a review of the incident was being undertaken and a letter of apology had been issued to the patient's family.

Dr McBride asked that any learning be shared across Directorates.

Mrs Dalzell advised she would be issuing a poster to all Directors' and asked that they circulate it widely within their teams for display in all wards/departments indicating that there is no filming/photography allowed within patient areas.

7.2 Ministerial Visits

Mrs Dalzell gave an briefing in relation to planned Ministerial Visits to the Communications Advice Centre and Rheumatology Service on the Musgrave Park site on 4 March 2016.

7.3 Smoke Free

Mrs Dalzell briefed members on media coverage planned for 8 February when work would commence on the Smoking Shelter at the front of the Cancer Centre being demolished to make way for new bike racks in preparation for the launch of Smoke Free sites on 9 March 2016.

7.4 IHM Awards 2016

Ms McNicholl referred to the recent IHM Awards ceremony which she had attended and commented that there should be a process within directorates for co-ordinating entries to ensure Directors are aware of nominees.

8. Any Other Business

8.1 Social Care Committee Terms of Reference

Mr Worthington tabled draft Terms of Reference(ToR) in respect of the recently established Social Care Committee for consideration.

Following discussion Mr Worthington undertook to revise the ToR to include review of external inspection reports and further details in relation to the role of Executive Director of Social Work. Mr Dillon agreed to review the revised ToR.

9. Date of Next Meeting

Members noted that there would be a short Executive Team meeting at 9.00am on 17 February 2016 prior to the Assurance Group at 10.00am

Belfast Health and Social Care Trust

TRUST BOARD WORKSHOP

Thursday 2 July, 2015 at 10.00 am
Boardroom, Administration Building,
Muckamore Abbey Hospital

AGENDA

10.00am 1. **Chairman's Business**

1.1. Apologies
1.2 Conflict of Interest
1.3 Proposal for Non Executive Director Induction (Overview)

10.15am **2. Service Users' Stories** –
Community Learning Disability Services - Presentation
- *Aine Morrison Service Manager, Learning Disability Service*
- *Anne Marie Cooke and Manuel George, Service Users*

10.45am 3. **Chief Executive's Business**

3.1 **Emerging Issues**
a. Critical Care Building – Update

11.00am 4. **Director Adult, Social and Primary Care**

4.1 **Acute Care in the Home – The Frail Elderly Initiative - Presentation**
- *Dr Jan Ritchie, Consultant Geriatrician*
- *Gabby Tinsley, Service Manager, Older People's Services*

11.30am **6. Director of Human Resources/Organisational Development**

6.1 **IIP Mock Assessment Results -** Presentation

11.50 am **5. Director of Performance, Planning and Informatics**

5.1 **New Directions 2** – Discussion
5.2 **Performance Report**
5.3 **Trust Delivery Plan 2015/16 - Draft**

12.20pm **7. Deputy Chief Executive/Director Finance, Estates and Capital Development**

7.1 **Finance Report –** *to follow*

Belfast Health and Social Care Trust

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Belfast Local Adult Safeguarding Partnership (LASP)

Report 2015/2016

CONTENTS

SECTION 1: Introduction

Purpose

The Belfast Health and Social Care Trust is committed to ensuring the health, well-being and protection of all adults who are in receipt of residential care, nursing home care, supported living and respite care provided by or commissioned on behalf of the Trust.

The Local Adult Safeguarding Partnerships (LASPs) are located within each of the Health and Social Care Trust areas. The role of LASPs is to implement Northern Ireland Adult Safeguarding Partnership (NIASP) guidance, policy and procedures at a local level. Membership is drawn from local statutory, voluntary, independent and community sectors, including representation from Criminal Justice Agencies, Local Commissioning Groups, Local Authorities and the Faith Community. The Belfast LASP is chaired by the Co-Director for Older People and Physical and Sensory Disability Service Areas.

In order to progress the key priorities outlined in the NIASP work plan, the Belfast LASP has two work streams focusing on:

a) Prevention
b) Protection

The annual LASP work plan is reviewed under the seven NIASP themes. This Report includes an overview of assurance arrangements, audit activity, activity returns, commentary relating to the challenges for and achievements of each Service Area.

SECTION 2: Work-Plan for Reporting Period

Theme1: Leadership and Partnership Working

Over the last year the Belfast LASP has engaged in a number of ways in relation to partnership working:

Belfast LASP has continued to meet on a quarterly basis and has been relatively well attended. There is a strong commitment to LASP and the Work streams from all Trust partners and a small number of partner agencies.

The Department's Adult Safeguarding Prevention and Protection in Partnership Regional Policy 2015 has been issued at a time when many partner organisations and agencies such as local authorities and the PSNI have already embarked on a period of significant organisational re-structuring and in a particularly challenging financial climate. The need for effective partnership working is critical given the full spectrum of the Policy in terms of prevention and protection.

New definitions and thresholds and an emphasis on prevention, as well as new roles and responsibilities, mean that action will be required by all partner organisations and agencies to ensure that adults at risk and adults in need of protection receive appropriate support and, where necessary, protection.

1.2 Policing and Community Safety Partnership (PCSP)

Within Belfast there is the overarching Belfast PCSP and four district DPCSPs – North, South, East and West. The Belfast Trust Adult Safeguarding Specialist (TASS) is an active member of the South Belfast DPCSP and continues to raise awareness of adult safeguarding issues within this forum.

1.3 Non-Government Organisations (NGOs) Engagement Group on Human Trafficking

The NGO Engagement Group on Human Trafficking chaired by the Department of Justice (DoJ) is in its fourth year. The TASS continues to represent adult safeguarding at a regional level on this multi-agency working group. The Group continues to provide a forum for joint working between the Department of Justice, Police, HSC Trusts and NGOs on the issue of human trafficking and to inform the development of human trafficking strategies and annual action plans.

1.4 Acute Sector

Work in relation to raising the profile of adult safeguarding in the acute sector has continued this year. Designated Officers within hospitals have been tasked with the responsibility of raising the profile of adult safeguarding through awareness raising at local levels within wards. Work at a more senior level has taken place involving TASS and Governance leads in relation to thresholds for referral into adult safeguarding.

1.5 Multi Agency Risk Assessment Conference (MARAC)

The Belfast MARAC work-stream is chaired by the TASS and is part of the Belfast Domestic Violence Partnership. There continues to be regular meetings to look at operational and strategic issues associated with MARAC, with multi-agency partnership working being the cornerstone of this work. An action plan has been developed to progress the work of this multi-agency work stream. It will be important to consider the Department's Adult Safeguarding Prevention and Protection in Partnership Policy (July 2015) in the context of MARAC to ensure that the Trust's obligations are fully met.

Theme 2: Public Awareness and Prevention

2.1 Volunteer Now

Volunteer Now continues to be a core member of the Belfast Local Adult Safeguarding Partnership (LASP) and regularly provides updates in relation to training and developments. NIASP funds Volunteer Now to co-ordinate the delivery of Keeping Adults Safe training, free of charge to voluntary, community and independent sector organisations within each of the LASP areas. There is recurrent funding until 2018 working on the basis of five training sessions at least per Trust. In the Belfast Trust these continue to be facilitated through the Adult Safeguarding Strategic team and are very well attended.

2.2 Domestic Violence Partnership

The Belfast LASP recognises the importance of maintaining close links with other key partnerships. In terms of the Belfast Domestic Violence Partnership, adult safeguarding continues to be actively represented through the TASS membership of this group. This close partnership working has resulted in a shared understanding of respective roles and

responsibilities. Going forward it will be important to look closely at the Domestic and Sexual Violence Strategy - Stopping Domestic and Sexual Violence and Abuse in Northern Ireland – A Seven Year Strategy (March 2016) and to consider this in the context of the Department's Adult Safeguarding Prevention and Protection in Partnership Policy (July 2015).

2.3 "Keeping You Safe"

The "Keeping you Safe" programme continues to develop. A series of workshops have been facilitated with staff groups nominated to roll out the programme in a range of facilitates including voluntary sector partner agencies. An evaluation of the programme has endorsed its success.

2.4 Human Trafficking

Close communication and co-ordination Trust-wide will be required to deliver on the obligations as outlined in the Working Arrangements for the Welfare and Protection of Adult Victims of Human Trafficking, October 2012. The Trust Adult Safeguarding Committee will also need to consider the implications of the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (NI) 2015. This new legislation, the associated strategy and the DOJ annual action plans will be discussed in more detail in the Challenges section.

Theme 3: Access to Adult Safeguarding Service

3.1 Regional documentation is currently being developed in line with the new Protection Procedures.

3.2 Central point of contact for adult safeguarding referrals and human trafficking referrals

The Trust's Adult Safeguarding Gateway Team (ASGT) is the central point of contact for all external adult safeguarding referrals to the Trust. An operational pathway is in place to ensure that referrals are responded to by the appropriate Service Area. It has also been agreed that ASGT will act as the central point of contact for all external human trafficking referrals.

Theme 4: Effective Interventions

Regional Adult Safeguarding Prevention and Protection in Partnership Policy (July 2015)

4.1 Regional issues

The regional work being undertaken in relation to implementation of the Policy is well underway and detailed in the NIASP Implementation plan. The main areas of work can be summarised as follows:

- The development of Regional Operational Procedures
- The development and implementation of Joint Protocol
- The implementation of new definitions
- Requirement for each Trust to have an Adult Protection Gateway Service
- The roll-out of DAPO and Adult Safeguarding Champion roles.

4.2 Trust Issues

The main issues and challenges for the Belfast Trust in relation to implementation of the Department's new Policy can be summarised as follows:

- Scope of the Policy
- Adult Safeguarding/Protection Structures within the Trust
- Role of core teams in managing adults at risk and provision of professional assessments
- Role of DAPO within the Trust
- Significant implications for Trust-wide training
- Ensuring effective governance arrangements

These issues will be explored in detail in Section 5 relating to Challenges

4.3 Regional Joint Protocol

As previously stated, NIASP have developed an implementation plan in order to deliver on the requirements detailed in the new Adult Safeguarding Policy. TASS have been actively involved in this regional work. The new Joint Protocol has now been developed and approved by NIASP. The Joint Protocol updates the working arrangements between HSC Trusts and PSNI where an adult safeguarding concern constitutes a potential crime. The Trust welcomes the new Joint Protocol as it incorporates the recommendations from the joint RQIA and CJSNI inspection and learning from practice. Within Belfast we have worked closely with our colleagues in PSNI in developing this Protocol and have established strong partnership working. Regular bi-monthly meetings have been set up with adult safeguarding leads within the Trust and key personnel within PSNI (CRU/ PPU). These are chaired by TASS and offer an early opportunity to address emerging issues.

4.4 Prevention

The LASP Prevention work stream continues to meet on a quarterly basis and to deliver on agreed objectives. Key developments include:

- The Easy Read Leaflets have been reviewed and updated with new leaflets on Special Measures and Support in Court produced. These have now been issued by NIASP as regional leaflets.

- The Keeping You Safe project, a programme for educating service users about the nature of abuse, how to keep themselves safe from abuse and the reporting process continues to be delivered across a range of regulated facilities and in all service groups. The ethos of the programme is recognition that people generally need to be better involved, informed and have more control about safeguarding and their own individual safeguarding processes. The programme promotes a participative approach that is person-centred and inclusive. The programme is regularly reviewed and has recently been updated to reflect recent policy changes.

The second phase of the Keeping You Safe project has focused on identifying service users willing to act as co-facilitators. A number of services users have been identified willing to act as 'champions' and to co- facilitate the programme with a staff member. This participative and person-centred approach has been successful in enhancing service user self confidence and peer learning.

The third phase of the programme has commenced based on the ethos that safeguarding is everybody's business. Acknowledging that communities play a significant part in preventing, identifying, reporting and protecting people, progressing this initiative with a range of community groups is a priority for the Partnership.

Theme 5: User Experience

5.1 In 2014/15 the Northern Ireland Adult Safeguarding Partnership (NIASP) under took a baseline service user engagement audit, specifically in relation to the adult protection process. The purpose of the audit was to review service user involvement in adult safeguarding protection processes as evidenced by the user of the standardised adult safeguarding documentation; establish a baseline for future developments; and make any necessary recommendations for improvement. The audit identified a number of areas of good practice, for example, in extending written invitations to people to attend case conferences or discussions and in informing people that a safeguarding referral was being considered. It was found that more could be done to ensure that information on safeguarding was readily available to share with service users and that the content of training required to be reviewed to ensure the importance of service user engagement was emphasised throughout each stage of the process. The audit identified a need to build on these findings to extend our understanding of the service user and carers' perspective on the adult safeguarding express. In response to the audit, NIASP is currently conducting a Thematic Review of Service User Involvement in Adult Safeguarding.

The Adult Safeguarding 10,000 Voices Project will provide detailed qualitative information about the real experiences of service users and their carers. The Project aims to establish a baseline of experiences to improve and influence future development and delivery of services. This will be achieved by adopting the partnership approach which has been successfully used in the 10,000 Voices initiative, using a blend of qualitative and quantitative data through the use of Sense Maker methodology. The overall aim of this work is to identify how the adult safeguarding process can be improved to ensure that the service user's experience is rights based, empowering, consent-driven and as person-centred as possible.

5.2 The involvement of a new service user in the Prevention Workstream has been identified. The sub-group acknowledges that safeguarding adults is everyone's business and it is essential we continue to raise awareness and promote partnership working on all levels in partner organisations.

Theme 6: Training and Practice Development

6.1 The overall aim of the BHSCT Adult Safeguarding Training strategy is to provide a comprehensive range of high quality training to enable practitioners and manager

to have a good knowledge of the Regional and BHSCT Adult Safeguarding policies and procedures, thereby enabling staff to confidently and effectively carry out their role as defined within these policies. The Training Strategy acknowledges that all staff, in whatever setting and role, are in the front line in preventing harm or abuse occurring and in taking action where concerns arise. The training programmes are in keeping with the learning outcomes outlined in the NIASP Training Strategy and Framework 2013-2016.

The demands of the spectrum of training required to meet the adult safeguarding learning needs of the Trust's social care workforce present significant challenges to the Trust's Social Services Learning and Development Service.

The Trust has previously addressed with the HSCB the resources necessary to support training delivery in respect of the revised adult safeguarding policy. The implementation of the policy will require a huge training agenda which can only begin once the regional procedures are developed.

The Regional Training Strategy will need to consider the training needs of staff across sectors particularly given the responsibilities outlined in both the Adult Safeguarding Champion and the DAPO.

The training costs associated with implementation of the policy and procedures, which are yet to be developed, are likely to be significant. However, there have been no additional resources made available to assist the Trust and other key partners with implementation costs.

6.2 Adult Safeguarding Training Activity:

- Level 1 – Awareness Raising/Refresher
  40 courses with 773 staff attending

- Level 2 – Line Managers training
  2 courses with 63 staff attending

- Level 3 – Designated and Investigating Officers Training
  2 courses with 90 staff attending

- Level 4 – Joint Protocol training
  No activity during this period

- Court Room Skills
  3 courses with 72 staff attending

- Level 5 – Achieving Best Evidence
  1 course with 2 staff attending
  2 ABE refresher courses with 7 staff attending

- Designated Officers P.S Group
  3 workshops with 105 staff attending

- Investigating Officers P.S Group
  3 workshops with 134 staff attending

An Adult Safeguarding Awareness event was held for staff, community groups and service users. The event was well attended and feedback received was very positive.

The "Keeping You Safe" programme continues to develop. A series of workshops have been facilitated with staff groups nominated to roll out the programme in a range of facilities including Voluntary Sector partner agencies. An evaluation of the programme has endorsed its success.

6.3 Action 2016 - 2017

- To maintain our commitment to the development of staff competence in this complex area of practice.

- To secure additional funding for Adult Safeguarding Training to meet demand.

- To revise all training materials to comply with the new Regional Adult Safeguarding Policy.

Theme 7: Governance and Practice Assurance

7.1 Trust Governance Arrangements

The Executive Director of Social Work has accountability for the assurance of arrangements pertaining to the delivery of the Trust's statutory functions adult safeguarding services.

The Operational Directors are accountable for the service delivery response to safeguarding matters within their respective Directorates.

7.2 Trust Adult Safeguarding Committee

The Trust has established an Adult Safeguarding Committee. Its principal remit is to provide assurance with regard to the Trust's discharge of its stautory functions in respect of adult safeguarding service delivery.

7.3 LASP Governance Arrangements

The Belfast LASP has been successful in meeting Departmental requirements as set out in the 2010 Framework document. The Belfast LASP is chaired by the Co-Director of Older people and Physical and Sensory Disability Services. It is a multi-agency group which meets on a quarterly basis. The LASP delivers on strategic plans as detailed in the NIASP Strategy and Annual Action Plan.

SECTION 3: Activity Returns

The following statistical charts evidence a number of trends:

Chart 1: Belfast Trust Adult Safeguarding Referral Rate April 2011-March 2016.
This year has witnessed a decrease in referral rates across the Learning Disability, Older People and PHSD service areas. The Learning Disability Service has had an 18% decrease in referrals which reverses the trend over the last three reporting years. Both the Older People and PHSD Services have had a 15% decrease in referrals rates. This is the first full reporting years' data in relation to the Acute Sector with a 28% increase in referral rates. However at this point in the collation of data it is difficult to establish or comment on overall trends in this sector.

The Mental Health Service Area continues to demonstrate a significant upward trend in referral rates with an increase of 71%. This continues to reflect the significant and ongoing developmental work in relation to Adult Safeguarding in this Service Area.

Chart 2: Belfast Trust Quarterly Adult Safeguarding Referral Rates By Service Area.
The referral rates continue to fluctuate through all four quarters although there are slightly higher rates during the period October 2015 to December 2015 across all service areas except the Mental Health Service.

Chart 3: Belfast Trust Breakdown of Adult Safeguarding Activity by Service Area.
In comparing this reporting year's figures with the data from 2014/2015, there have been decreases in the number of investigations in the Learning Disability (17%), Older People (28%) and PHSD (40%) Service Areas. However there is a continued increase of 37% in investigations in the Mental Health Service Area.
There are similar trends in terms of protection plans with decreases in the Learning Disability (22%), Older People (26%) and PHSD (65%) Service Areas and an increase of 49% in the Mental Health Service Area.

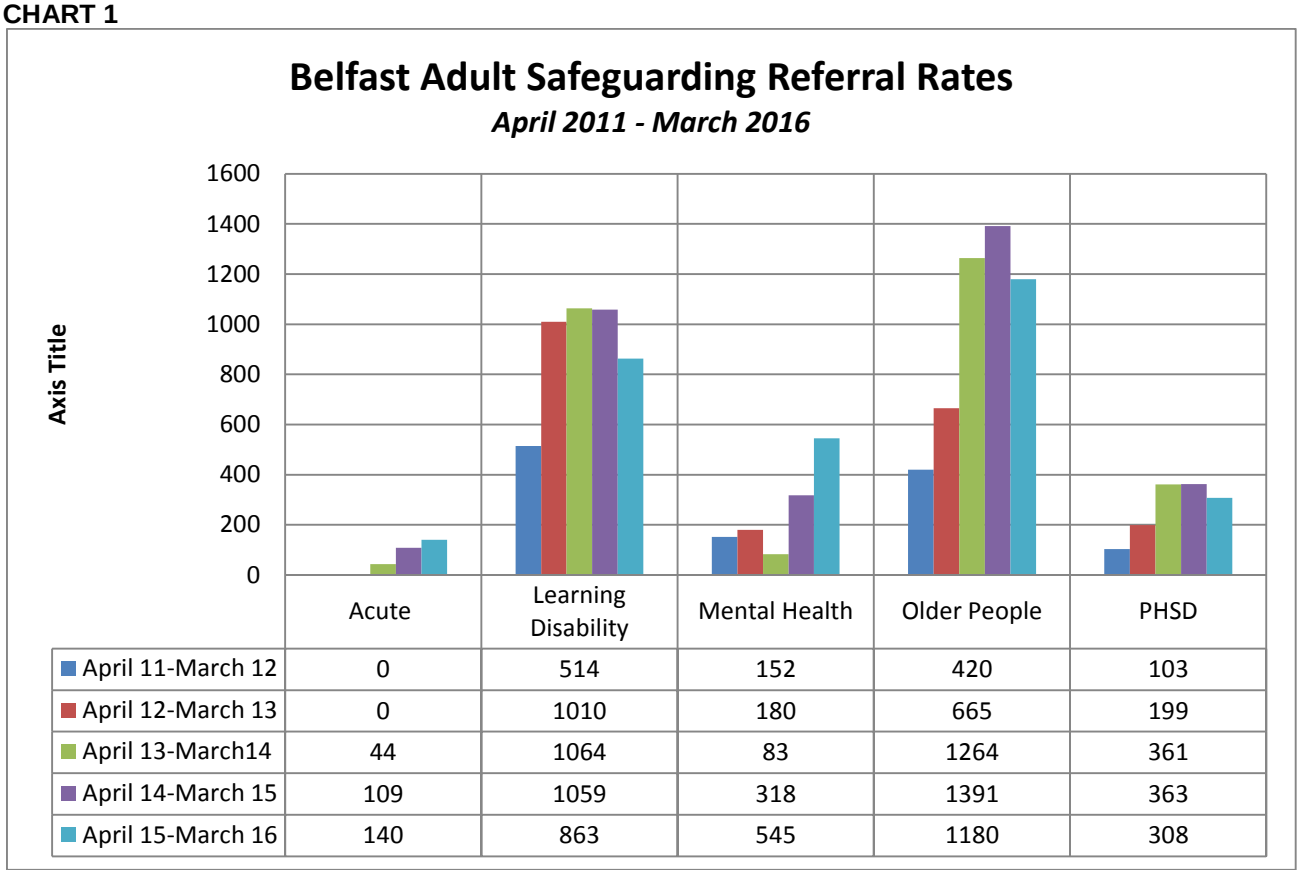
Chart 4: Belfast Trust Breakdown of Adult Safeguarding Referrals by Source
This reflects the first full year of referral source data which will form the basis for future analysis of trends

Chart 5: Belfast Trust Breakdown of Adult Safeguarding Referrals by Type of Abuse.
This evidences that the overall breakdown of percentages of types of abuse is similar to the previous reporting years. Physical abuse continues to be the most significant type of abuse at 58%. In terms of overall percentages, there is between a -2% and a +3% percent variation in the other types of abuse.

Chart 6: Belfast Trust Breakdown of Regulated Services Investigations by facility type.
This represents an overall decrease of 14% in investigations in regulated services from 2014/2015. Similar to the previous reporting year there are decreases in investigations in nursing homes (9%) and residential homes (31%), however nursing home investigations represent 26% of all regulated investigations. There has been an increase of 25% in investigations in statutory homes although this represents only 3% of overall investigations. Although there have been a significant decrease in the number of investigations in adult mental health units (18%), these also continue to reflect the highest percentage of regulated facility investigations at 48%

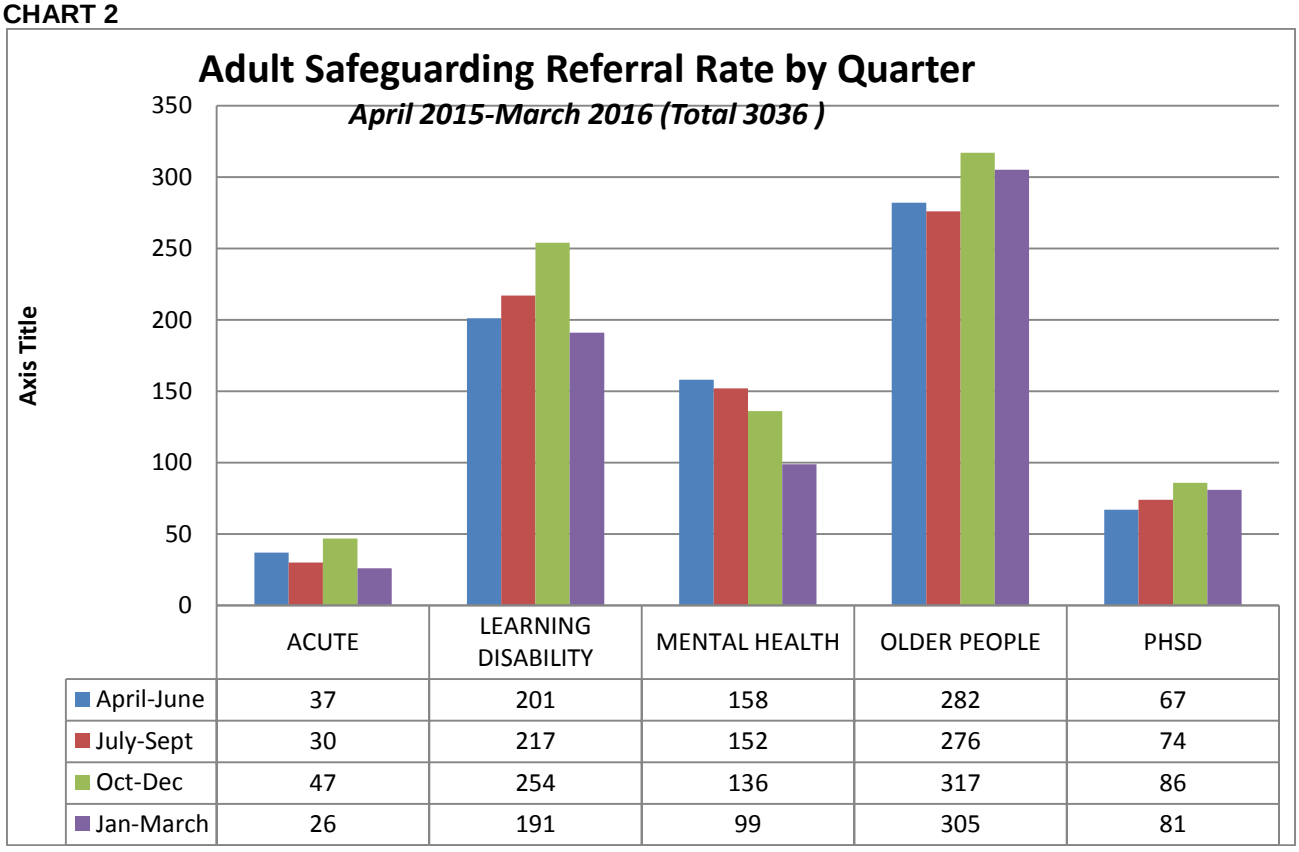
Chart 7: Summary of comparison figures from years 2014/2015 and 2015/2016.

CHART 1



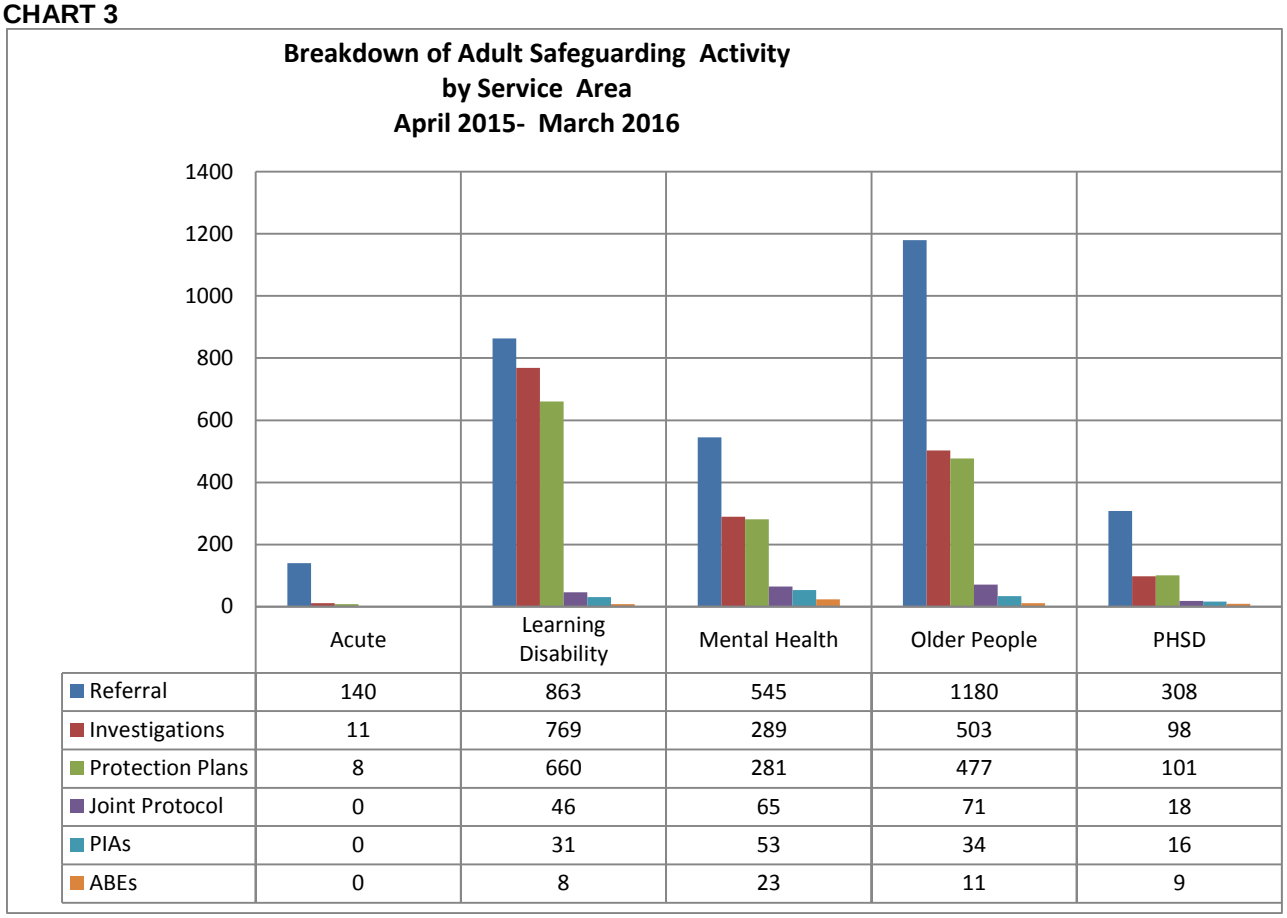
	Acute	Learning Disability	Mental Health	Older People	PHSD
April 11-March 12	0	514	152	420	103
April 12-March 13	0	1010	180	665	199
April 13-March14	44	1064	83	1264	361
April 14-March 15	109	1059	318	1391	363
April 15-March 16	140	863	545	1180	308

CHART 2



	ACUTE	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLE	PHSD
April-June	37	201	158	282	67
July-Sept	30	217	152	276	74
Oct-Dec	47	254	136	317	86
Jan-March	26	191	99	305	81

CHART 3



	Acute	Learning Disability	Mental Health	Older People	PHSD
Referral	140	863	545	1180	308
Investigations	11	769	289	503	98
Protection Plans	8	660	281	477	101
Joint Protocol	0	46	65	71	18
PIAs	0	31	53	34	16
ABEs	0	8	23	11	9

CHART 4

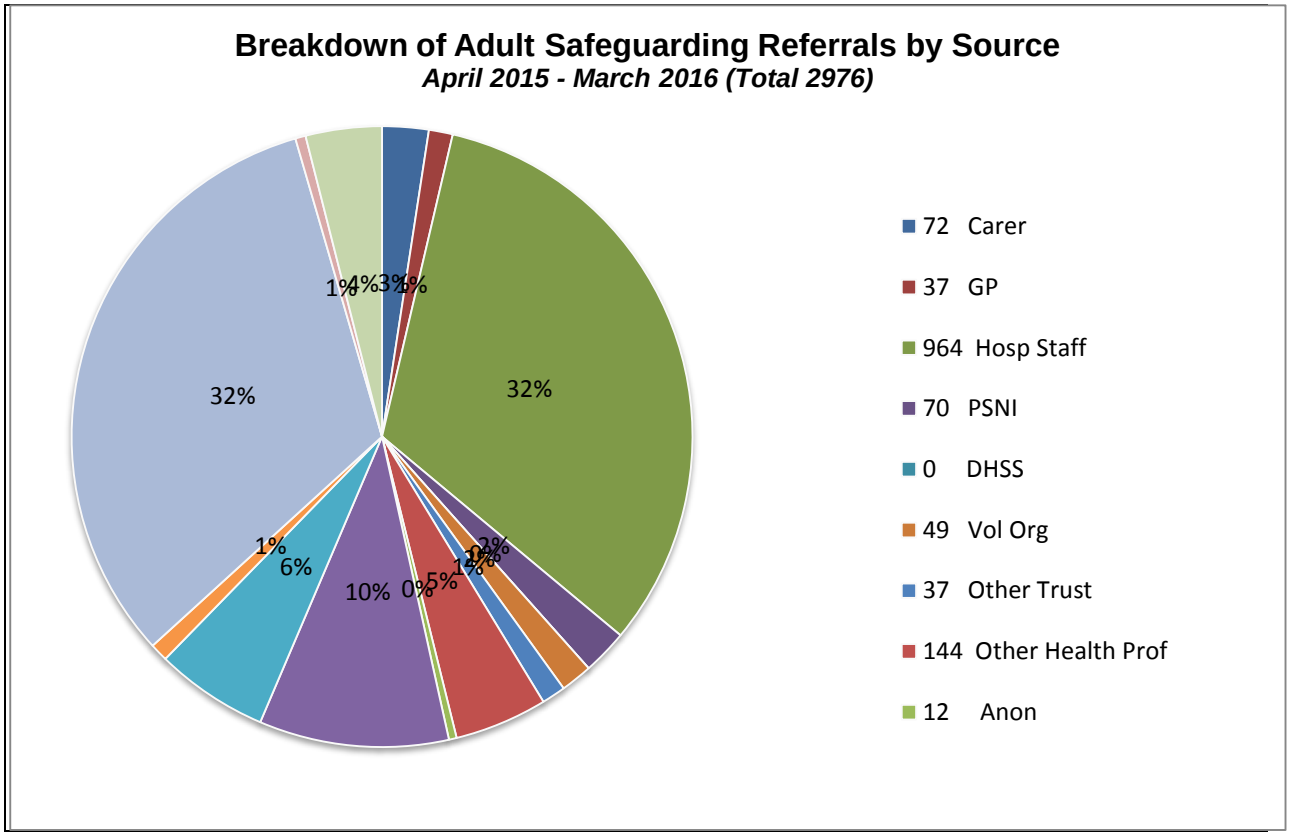


CHART 5

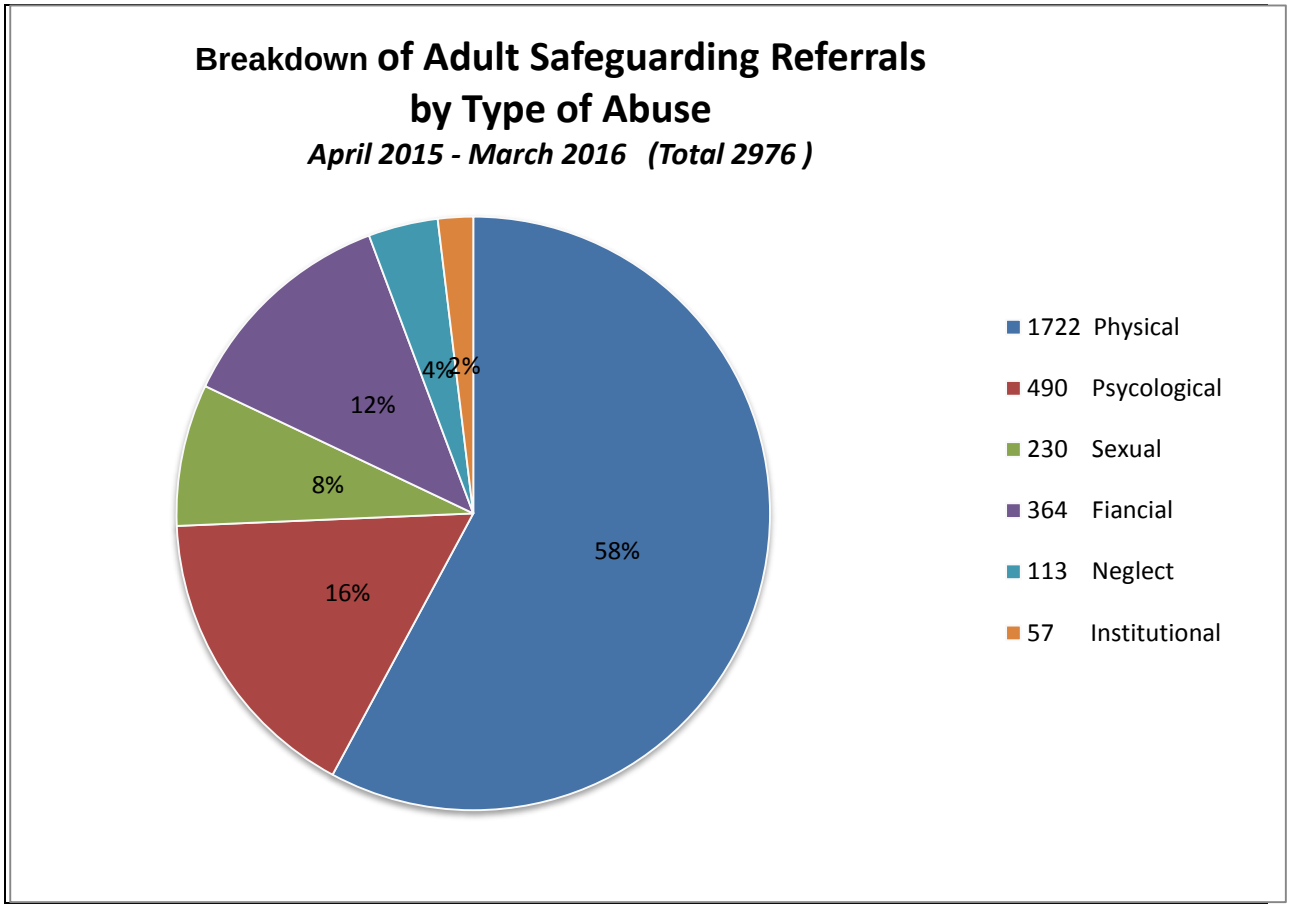


CHART 6

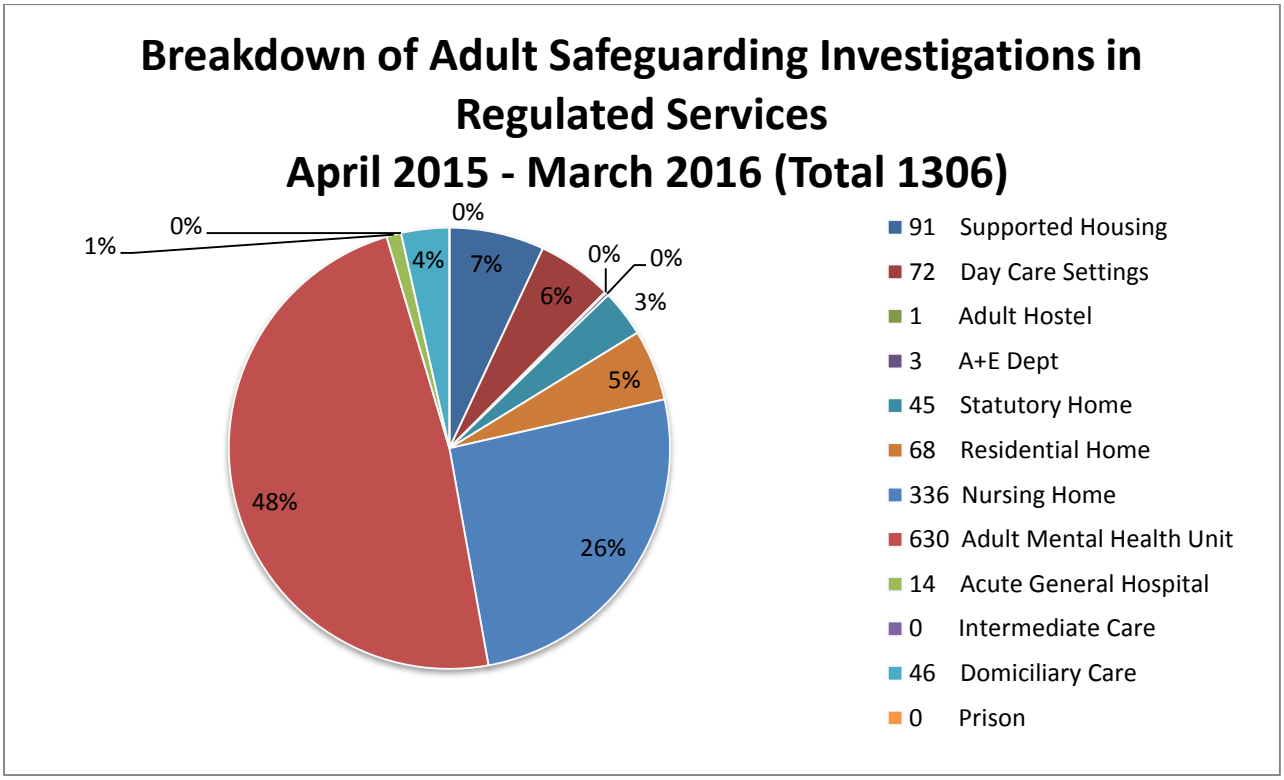


CHART 7

Table Of Percentage Increase/Decrease In Adult Safeguarding Activity From Years 14/15 to 15/16										
Service Area	**Referrals**		**Investigations**		**Protection Plans**		**PIAs**		**ABE Interviews**	
Years	14/15	15/16 **+/- %**	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16
Acute Sector	109	140 +28%	21	11 - 47%	13	8 -38%	0	0	0	0
Learning Disability	1059	863 -18%	933	769 -17%	847	660 -22%	34	31 -9%	12	8 -33%
Mental Health	318	545 +71%	210	289 +37%	188	281 +49%	41	53 +29%	30	23 -23%
Older People	1391	1180 -15%	697	503 -28%	644	477 -26%	62	34 -45%	23	11 -52%
PHSD	363	308 -15%	165	98 -40%	156	101 -65%	13	16 +23%	9	9 No change

SECTION 4: Service Area Reports

Physical Health and Sensory Disability

Within the reporting period there have been 139 safeguarding referrals relevant to the Physical and Sensory Disability Service Area. 78 of this activity were generated by the core Teams at Grove Health and Wellbeing Centre, Mount Oriel and Sensory Support Team, Bradbury. There were 116 investigation and protection plans at level two and three. Additionally 23 were screened out of the safeguarding process. The safeguarding administration frameworks were utilised to reflect consideration of the concerns, however the risks were then managed under alternative frameworks.

The activity attendant to the embedding of the safeguarding process has resulted in effective responses to heightened levels of complexity. 50% of the investigative responses were to level three interventions, initiating the Joint protocol Process.

In conjunction with the activity undertaken by the ASGT the core teams are significantly challenged in terms of delivering a timely response with effective co-ordination and development of safety plans. The operational activity in respect of strategy meetings and case conferences has also increased. These activities are critical to the safe and effective management of concerns and collaborative engagement in the delivery of protection planning. This process also ensures transparency in terms of the roles and responsibilities of the professionals involved. The demands on the availability of staff to attend the direct contact forums and the administrative workforce to support same require additional resources. The Trust has registered these risk issues and the attendant actions to reduce risks are continuously being monitored through the existing structures.

Additionally a review of administration across Older Peoples and Physical and Sensory Disability Services Areas has been commissioned. Included in this review is the role and function of administration support, a refocusing on the current demand and safeguarding specifically should be acknowledged in this review.

An analysis of the Team activity would indicate that there are particular areas that require greater availability of the professional resource. Within the Service Area, the North and West demography has around 50% greater safeguarding referrals and of the total investigations undertaken by the one Team, the North and West sector had approximately 66% more. Whilst this may be reflective of the Northern Ireland Multiple Deprivation Measure (NISRA) which indicates that 42 of the 100 most deprived wards are in North and West Belfast, it may not explain all the variables in activity.

The Sensory Support Team had a 50% increase in activity relative to the 2014/15 reporting period; however it was still significantly and proportionately lower than the core teams. Whilst an analysis of this information has not been undertaken, it is apparent that the standardisation of the application of detection, recognition and recording of safeguarding requires addressing by the Service Area.

Interestingly there has been a 34.5% increase in the reporting of quality concerns – this might suggest that professionals are managing safeguarding concerns through the quality monitoring process as it relates to regulated provision.
The Service Area continues to benefit from the social work Peer Support Forum and the Investigating Officer and Designated Officer Practice Fora. This enables staff to explore

professional dilemmas and challenges. These fora also ensure that the specific roles relating to Joint Protocol, Pre Interview Assessment (PIA) and Achieving Best Evidence (ABE) are addressed. In this reporting period there appears to have been less opportunity to undertake ABE interviews. It is critical that this opportunity is equally afforded to staff across all Services Areas to meet the standards required to sustain competence to practice. A system has been set up whereby staff can access ABE work through the Adult Protection Gateway service. It is anticipated that staff will be proactive in terms of meeting the standards required to sustain competency.

Cognisance of Human Rights continues to be critical to adults at risk and in need of protection. Within Physical and Sensory Disability this is foremost, the Service Area is assured that all staff attend mandatory training on Human Rights, utilise the individual, professional consultation forum and peer support mechanisms particular to the Service Area. One area of complexity, which is challenging for the service, is the access to capacity assessments. Within Physical and Sensory Disability there has been a proportion of referrals where the interface with Article 8, the right to private and family life, rights to self-determination, individual choice and freedom are compounded by the service user's fluctuating capacity or where capacity-specific decisions are required. This Service Area does not have the benefit of a resource to access capacity assessments in a timely manner and this can result in significant professional dilemmas wherein an individual wishes to go home to an abusive scenario. It is critical that this is addressed in order that safety planning is premised on sound evidence.

The documentation relating to safeguarding profiles the importance of practitioners taking cognisance of the engagement of Human Rights in all aspects of decision-making.

The Gateway model within the Service Area continues at times to present specific challenges. The threshold levels have been established to appropriately focus the protection work to the adult safeguarding team, however at times the professional perception of risks are enhanced and a sustained undertaking of the role and responsibilities of each element of the presentation and protective interventions need clarity and ongoing attention. This has been addressed through interface meetings with the safeguarding teams and core teams, however with the forthcoming changes to the model anticipated this will re-emerge as a concern. Effective training is imperative to ensure that there is seamless communication process, structures and governance arrangements around the interface. Furthermore, with the dissemination of the Adult Safeguarding Prevention and Protection in Partnership Policy, a range of expectations and attendant demands will emerge that will require good engagement if the professionals are to fulfil the obligations. Whichever model is adopted to best respond to the areas of risk and harm it must be inclusive and ensure that the professional responsibilities are not directed to those present in the safeguarding structures only. Further to consultation, it is anticipated that the operational protection procedures will be crucial to the discharge of service delivery responsibilities.

The Central Referral Unit and utilisation of secure messaging has become operational within this reporting period and it is anticipated that when this process is embedded it will enhance the clarity with which information is communicated and responded. At this time, the operational issues relate to the response times of the PSNI and clarity of the professional perceptions of significant harm. Additionally the application of process particularly as it relates to Joint Protocol and the application of individual choice by the adult at risk requires to be expedited. It is hoped the new Joint Protocol will resolve these issues. There have also been instances in domestic abuse situations where a single agency approach by the PSNI has been pursued. However, an Achieving Best

Evidence (ABE) interview would have possibly enhanced the quality of the management of the complaint. There have also been delays in response times from the PSNI in terms of domiciliary contacts. This has resulted in the persons in need of protection reconsidering whether to proceed and this has resulted in withdrawal of consent for an investigation. The Trust continues to have interface meetings with PSNI colleagues wherein these issues are addressed. All parties are motivated to improve the quality of the experience for the adult in need of protection.

Within this reporting period, all social work teams have been facilitated to access the Community Information Systems. Whilst this has been beneficial in terms of access to information relevant to the adult at risk, there are residual concerns. There continues to be restricted access to the ASP documentation when a level 3 investigation is on-going. There is the potential that all communication is not available upon which key decisions relating to protection/support planning are made. Furthermore the core teams are having to develop a shared folder for ASP(1)s as, when these are progressed to Adult Safeguarding Team, the core teams no longer have a copy. It is imperative that all documentation and minutes pertinent to investigations are shared with the core teams. Direct communication continues to be critical to ensure a co-ordinated, collaborative response and facilitate effective working relationships.

The implementation of self-directed support will present additional challenges in that the workforce employed will be regulated by the adults receiving services. Therefore it is critical that these individuals have access to knowledge of standards that they should receive from their employee and insight as to the constitution of risks, quality and harmful behaviours. It is hoped the Adult Safeguarding Champions will have a role in assuring the Trust in this regard akin to the role anticipated with the third sector.

Mental Health Service Area

The volume of referrals for Adult Safeguarding continues to increase steadily with a 71% increase from 2014/2015. Within mental health services ongoing improved awareness of adult safeguarding issues is now evident for this service user group. Referrals are received from a wide range of services, including hospital settings, medium secure facility, supported living facilities, nursing and residential settings, day care and from a range of community mental health services - within acute, primary and recovery teams. Given the overall increase in both referrals and adult safeguarding investigations there is a significant increase of 49% protection plans completed and a steady increase of PIA's completed within mental health services. The figures collated for 2015/16 would indicate a reduction of 23% in respect of ABE interviews completed within the Service Area. A possible explanation for this reduction in ABE returns is the PSNI interpretation of the DHSSPS Prevention and Protection in Partnership Policy. In particular the PSNI has interpreted the definition of an adult in need of protection as meaning that only those with a high level of vulnerability meet the criteria. It is the view of PSNI (CRU) that any patients in receipt of 24 hour care, for example hospital settings are not vulnerable adults in need of protection and their decision is for single agency PSNI investigation only.

The PSNI is also focused on the issue of intent and the targeting of vulnerable people. As a result, on receipt of AJP1s and PJI1s a high proportion have been assessed by the PSNI as only requiring a single agency investigation, e.g. PSNI now assess domestic violence cases, historical abuse, physical and sexual assaults as single agency investigations. The PSNI will only request ABE joint agency interviews following a failed PSNI single agency interview, when it becomes apparent that the victim has evidence of mental health difficulties. If this decision making by the PSNI continues there is a strong likelihood that the number of joint agency / ABE interviews will decline further in the future. It is hoped that with the introduction of the new Joint Protocol and the training pre-implementation that these issues will be addressed and resolved. In the interim the Trust has set up bi-monthly meetings with PSNI to discuss any ongoing issues. In addition direct liaison with senior staff within PSNI can take place in relation to individual cases.

Given the nature and complexity of mental health service users, IO and DAPO staff continue to challenge these decisions and raise ongoing issues with PSNI on a case by case basis. However, it has been our experience to date, despite the clear recommendation from mental health services for a joint agency interview, the PSNI will make the final decision.

With the introduction of the new Adult Safeguarding Policy July 2015 mental health services have reviewed and evaluated current safeguarding processes and structures. Currently mental health services have a Core Mental Health Adult Safeguarding team, comprising of Principal Social Worker and two WTE band 7 Senior Practitioners who are DAPO and ABE trained. There is a further band 7 Senior Practitioner who can on occasions provide sessions into adult safeguarding for DAPO, PIA and ABE. However, her substantive post is as social work development lead and Think Family lead.

A new Core Mental Health Adult Safeguarding team has been developed over the last year. This has provided the opportunity to introduce a more cohesive, streamlined structure within mental health services. This has improved the referral response, the quality of investigations and protection plans and in so doing improved outcomes for service users. The Core Mental Health Adult Safeguarding team provides a single point of access and support for the range of mental health services (40 teams / services).

There continues to be a high percentage of teams / service areas across mental health which do not have a DAPO. Part of the DAPO function is to screen the Adult Safeguarding referrals and subsequently allocate an IO officer within their team. There continues to be a high proportion of mental health services / teams where there is a marked deficit of trained DAPO / Investigation Officers. In these teams, the referral is forwarded to the Principal Social Worker who then screens the referral and allocates the case within the core Adult Safeguarding team. If the referral team has trained IO staff they will undertake this role in partnership with a DAPO from the core Mental Health Adult Safeguarding team. It is important that the line manager from this Service Area remains involved in respect of governance and accountability of the case.

All DAPO, IO and ABE work is undertaken by trained staff within mental health services. Within the core Mental Health Adult Safeguarding team, all staff are trained at ABE level.

Within the Belfast Trust Mental Health services, there are 3 main strands of service delivery – recovery, acute and primary. All 3 strands have different line management structures and therefore different reporting systems. Across the 40 teams / services across the Service Area a small number of team leaders are qualified social workers. As a result they are not trained as DAPOs and so this role and function falls on the Core Mental Health Adult Safeguarding team and / or other DAPOs in other mental health teams whose line manager is a social worker and DAPO trained. In addition there continues to be a considerable variation in respect of the number of staff trained as IOs again with only a very small percentage coming from non-social work staff. This significantly impacts on the workload of the social work trained staff within the teams, as they have to undertake the additional function of IO on top of carrying a high and complex caseload.

The setting up and development of the Core Mental Health Adult Safeguarding team within mental health services has provided the opportunity for the following changes:

- Core Mental Health Adult Safeguarding acts as a single point of contact for adult safeguarding referrals for mental health services who do not have trained DAPOs within their team
- Core Mental Health Adult Safeguarding team acts as a point of contact for external referrals via Adult Safeguarding team
- Core Mental Health Adult Safeguarding team screens all referrals received and identifies who will undertake IO role and DAPO function
- Core Mental Health Adult Safeguarding team screens out external referrals which do not meet the threshold for safeguarding and liaises closely with the referral agent in respect of action / management plans as required
- Core Mental Health Adult Safeguarding team provides an advisory and consultative role for all professional staff across the 40 teams / services
- Core Mental Health Adult Safeguarding team takes the lead in forwarding appropriate referrals to CRU
- Core Mental Health Adult Safeguarding team provides supervision / support to both DAPOs and IO staff across the teams / services, who are not line managed by a qualified social worker who is DAPO trained
- Core Mental Health Adult Safeguarding team takes the lead in joint protocol investigations and provides supervision / support to ABE trained staff

- Core Mental Health Adult Safeguarding team acts as a central point of contact for PIA / ABE interview requests and allocates accordingly within the Service Area
- Core Mental Health Adult Safeguarding team meet on a weekly basis to review and discuss Adult Safeguarding investigations and management of cases
- Core Mental Health Adult Safeguarding team provides a core link Band 7 senior practitioner for MARAC cases and referrals for the MARAC process
- Core Mental Health Adult Safeguarding team promotes and raises the awareness of Adult Safeguarding across the 40 teams / services by providing in-house training, supervision / support, weekly Adult Safeguarding meetings, provision of specialist working – MARAC cases, Human Trafficking, ABE cases and co-working regarding investigations and protection plans
- Core Mental Health Adult Safeguarding team continues to promote improved Adult Safeguarding practice across the disciplines and 40 teams / services and provides a standardised approach to reporting, documentation, decision making. The team continues to review processes and improve communication regarding Adult Safeguarding needs of service users
- Core Mental Health Adult Safeguarding team staff are fully trained in ABE / joint protocol. This has therefore improved the response rate to PIA / ABE request
- Core Mental Health Adult Safeguarding team has improved practices across the 40 teams / service areas in respect of reporting Adult Safeguarding cases, decision making, service user involvement and risk management

With the introduction of the new Adult Safeguarding policy July 2015 it clearly sets out the requirements of the DAPO as:

- A qualified social worker
- working at a minimum of Band 7
- having first line management responsibilities, or be in a senior practitioner role
- being suitably experienced: and
- having undertaken the necessary training

These requirements have greatly impacted on the Service Area as there is a lower percentage of band 7 senior social work posts across the 40 services / teams in comparison to the number of band 7 Nurse Team Leader posts. In addition within mental health services there are 9x band 7 senior practitioner staff who received their banding as a result of successfully completing the Approved Social Work (ASW) course and in so doing, fulfilling this function through inclusion on the ASW day rota. However, the additional role of acting as a DAPO is not currently incorporated into their job description and this is currently being addressed. For these existing band 7 senior practitioner staff to take on this role it will require a review of their workload as their current role as an ASW is very complex and demanding requiring staff to attend training forums, ASW supervision. As the majority of the band 7 senior practitioner (ASW) staff are employed within the primary and recovery community mental health teams, they already have a high and complex caseload. Therefore work force planning will be required to ensure that the needs of the service users will be met by giving consideration to the capacity of the current band 7 senior practitioners to not only meet the demand within the Service Area but also to fulfil the statutory requirements to undertake both the ASW and DAPO / ABE function.

There are principal challenges within mental health services with the introduction of the new Adult Safeguarding policy July 2015:

- Centralised one point of referral for all 40 mental health services / teams – Gateway Team
- Setting up robust IT systems and data collection processes
- Standardised defined timeframes re investigations protection plans and review processes across all services / team areas
- Ensure adequate amount of non-social work staff are trained as IO officers to undertake this role
- Provision of supervision / support for non-social work IO staff and ensuring clear governance arrangements are in place with non-social work line managers
- Clear accountability and governance process for all disciplines
- Joint agency working with PSNI, RQIA, professional bodies regarding procedures, protocols and practice issues

There is an ongoing training need for more staff across different disciplines to be trained as IOs. A number of nursing staff have refused to undertake the IO function and senior management is currently in negation with staff side in relation to this to ensure equity across all mental health teams and disciplines.

There are well established support groups for IO, DAPO and ABE trained staff across the Trust. Within mental health peer supervision and support and the opportunity for reflective practice have been developed. The Service Area requires all trained IO, DAPOs and ABE staff attend 75% of these support groups over a 12 month period.

The Service Area remains committed to the delivery of Adult Safeguarding, while recognising significant workforce pressures for the functions of the DAPO. In order to meet this requirement, the Service Area has to ensure there are sufficient numbers of staff trained as IOs across various disciplines to undertake this function.

Older People

Adult Safeguarding Gateway Team (ASGT)

Reporting Period	Referrals		Screened Out		Level 3 Investigations	
1/4/15 to31/3/16	*Older People*	*PHSD*	*Older People*	*PHSD*	*Older People*	*PHSD*
Q1	271	60	89	26	73	13
Q2	256	66	102	40	64	8
Q3	290	78	131	49	67	9
Q4	276	80	124	53	59	11
Totals	**1093**	**284**	**446**	**168**	**263**	**41**

Referral analysis

As highlighted above, the ASGT has received 1377 referrals for this reporting period which is approximately a 13% reduction on last year. There is a 29% decrease in overall investigations.

The Adult Safeguarding Gateway Team has been operational for 3 years now and maintains responsibility for providing a single point of contact for referrals and for the screening and management of level 3 investigations for Older Persons and Physical Disability Services. The ASGT also acts as a point of contact for referrals from members of the public and some voluntary bodies.

In screening referrals the ASGT will determine appropriate follow up for the management of safeguarding investigations while accepting allocation for those referrals deemed to be complex and high risk and which require protection measures to safeguard.

Prior to this reporting period there has been the necessity to revise and re-evaluate the criteria for level 3 referrals due to the increased pressure and volume of work placed on the Team. This has had a positive impact on reducing the number of investigations the team now conduct, which as a consequence has provided some leverage to direct staffing resources to manage the duty system. The duty desk, however, continues to be challenging and requires one third of the ASGT resource to ensure the appropriate management, screening, administration and allocation of referrals within the required 24 hour timeframe. The introduction of a 24 hour timeframe for turnaround and allocation of referrals has proved challenging for the Team, however, in terms of ensuring an obligatory governance and accountability structure it has proved essential. Screening that extends beyond the 24 hour period is captured within the monthly Team function report from which activity can be monitored.

Referrals from nursing and residential Homes

Pressure at the point of duty is compounded by the high level of “inappropriate” referrals, particularly from residential and nursing home sectors who remain unsure of the thresholds for safeguarding and quality of care issues.

Complex institutional investigations

As per previous reporting periods, ASGT continues to receive high volumes of referrals where there is a need to complete high risk complex institutional investigations requiring multidisciplinary and external agency input. Managing and co-ordinating complex investigations such as these has presented many challenges for the Team, particularly in relation to the roles and responsibilities of partner agencies, essentially when decision making has not been in keeping with that required under joint agency partnership working.

This was evident during this reporting period when escalation processes had to be initiated to address issues with PPU. Through escalation processes, the matter was quickly resolved at a senior management level. The New Joint Protocol goes some way to identify structures to support this and identifies the need to define the roles of partner organisations in complex institutional investigations.

With the introduction of the new Safeguarding Policy, the Trust Safeguarding Specialists have been tasked with working closely with Safeguarding Leads to determine what the best model will be for operational management of adult protection investigations as well as determine what the best Gateway model will be for the screening of referrals.

This will require significant contribution from Safeguarding Leads in order to agree the changes required and to review, devise and implement processes and procedures within their Service Areas and for the Trust generally as required by the Board. Given the amount of work that this will entail an Acting ASM within ASGT has been appointed in the interim with the specific remit of operational responsibility for ASGT as well as strategically contributing to safeguarding developments within the Trust.

Interfaces with Human Resources and Professional Bodies

Throughout this reporting period new challenges have presented for ASGT. These have been in areas such as interface working with HR, particularly in relation to professional bodies' engagement in disciplinary or conduct investigations. Increasingly more so ASGT are asked to provide reports to help inform outcomes in relation to decision making about staff. This is an area where regional guidance in the form of procedures of processes needs to be determined.

Added to this, protection planning with recruitment agencies where agency staff who work within the acute sector have been involved has also raised significant concerns. This is in relation to gaps within safeguarding processes where it has become apparent to ASGT that care workers within the acute sector are not aligned to professional bodies nor are required to be.

In working closely with the Safeguarding Specialists it is hoped that presenting issues such as these can be discussed and brought to the regional table where it is hoped guidance can be agreed and provided. This year close working relations with the Safeguarding Specialists has contributed to the development of new safeguarding processes in relation to pressure sore management. It is hoped that work in areas such as this will continue with particular focus also on MARAC and Human Trafficking management.

This reporting period has welcomed the introduction of the PSNI Central Referral Unit which has provided a central point of contact for Joint Protocol referrals.

The concept of a police central referral point is viewed by ASGT as a good one as it is recognised that this model of working will provide consistency in decision making and is a model which aligns itself also to that provided by ASGT. However, there have been problems encountered in terms of delays in receiving written confirmations around decision making from CRU, albeit that verbal communication has, on the whole, been met within agreed timeframes.

Other challenges across interfaces

Other challenges include joint working with the CRU in relation to decision making by them regarding domestic abuse referrals. In the majority of referrals made to CRU by ASGT decisions from them are made on the basis of 'intent'. For this reason CRU are allocating what the Trust perceive as a JP investigations to PPU for single agency police investigation. The Trust Safeguarding Specialists are aware of this and have addressed this issue with both the Board and PSNI Leads. This has been necessary given the impending introduction of the New Joint Protocol.

Joint Protocol working with PPU has also proved problematic in terms of significant time delays around completion of PIAs and ABE interviews and of the PPU's inability to attend home visits without uniform police presence in geographical areas where security concerns present. The ASGT have highlighted these concerns in a Risk Register which will be subject to regular review.

CRU, as with other external bodies, are now referring directly to Learning Disability and Mental Health Services given that ASGT no longer fulfils the need to act as a single point of contact for all external referrals.

This reporting period has also required ASGT to investigate a complex institutional abuse investigation in a Belfast Home. This raised significant issues in relation to the role of PSNI, as already discussed, and the role of RQIA given their regulatory responsibilities.

The Service Area remains concerned that RQIA are increasingly tending not to take as active a part in safeguarding investigations, protection planning and decision making although this does vary between individual inspectors. This is evident in the decreased number of strategy meetings RQIA now attend and in the number of safeguarding referrals they have received and have forwarded to Managers within the Homes to manage. ASGT, through the introduction of an audit cycle, will monitor and review activity in this area.

Within the ASGT arrangements are in place to support both DOs and IOs with reflective peer support group opportunities as well as benefit from in-house training which is provided by specialist teams within PSNI, PPS, NISCC and from many other professionals.

Professional Supervision Framework

Systems and processes are in place to facilitate supervision, reflection and continuous professional development given the specialist knowledge that is required from the

practitioners within the Team. ASGT continues to benefit from attendance at the Designated Officers, Investigating Officers and ABE support groups. There are 6 ABE trained interviewers within ASGT with the aim to have all staff trained to this level. Additional to the specialism that ABE interviewers bring to their safeguarding role, staff who are ABE trained have also engaged in Talking Mats training to further enhance practice in this area. With the implementation of the Post Qualifying Award in Adult Safeguarding staff have expressed their interest and commitment to completing this new course with 3 practitioners currently submitting assignments for the ABE module in this award.

Core Teams - Older People's Service Integrated Care Teams

ICTs deliver on what has been defined as level 2 adult safeguarding work, and also accept referrals from the ASGT where there is ongoing work/protection plans to be implemented and reviewed. Core teams also manage what would be considered level 1 adult safeguarding cases. Following the roll out of the DO role in the previous financial year to include care managers in the South and East locality who have a social work background, this year has seen a consolidation of the role by this group of staff.

Safeguarding activity in ICTs has added significantly to workloads of DOs, social workers and now care managers.

The professionalisation and modernisation of social care within ICTs is welcomed by Team Managers and Social Work Leads. The increased numbers of social workers anticipated is expected to have a positive impact in helping to address the demands of safeguarding work generated. However, there are a number of factors to be taken into account within the process of analysing new and appropriate staffing levels:

- Regarding the transitional phase (that is until full professionalization is achieved), the move of existing Care Managers who are Band 7 staff to other posts will need to be undertaken in a considered manner which will ensure the maintenance of adequate Designated Officer staffing levels within teams.
- The professionalisation will add to recording requirements for social workers who will be taking over high numbers of cases from Social Care Coordinators. These large numbers of cases will now require professional NISAT assessments, including many complex NISATS. There is also an expectation that more Carers Assessments are to be completed. Significant amounts of duplication will remain in the collation of assessment information unless this issue is addressed. All of the above will reduce the available staff resource to actively manage safeguarding.
- The levels of complexity in cases dealt with by ICT staff following transfer from ASGT has markedly increased and management have indicated that this trend is likely to continue as ASGT struggle to meet demands on their own service.
- Financial Abuse and financial management cases have resulted in social workers undertaking activity to protect service user's finances and manage finances on their behalf.
- The proposed Regional Adult Safeguarding Policy indicates a need for increased preventative work with users. This will have a significant impact upon workloads, responsibilities of staff and without any additional resource. At the present time as

part of the modernisation process the role of Band 4 social care staff is being reviewed.

- Adult Safeguarding statutory returns are difficult to compile and much reporting continues to be done on the basis of manually counted statistics.
- There are no minute takers within administration support to ICTs to assist with the significant increase in documentation and recording of strategy meetings / case discussions in relation to adult safeguarding staff

Challenges

Managing more work with the same staff level remains the primary problem:

As noted in last year's report an on-going challenge is the management of low level cases, for example the management of "one off" dementia management issues, where no injuries were sustained. These cases continue to be demanding of staff time. It is hoped that implementation of the new Policy will resolve this issue.

Strategic Direction

Strategic direction within Adult Safeguarding is inextricably linked to the process of modernisation of social care within ICTs and must be considered and managed within this context.

Learning Disability

Adult safeguarding remains a major area of work for the Service Area although there has been a reduction in referrals this year with just 810 referrals compared to 1059 last year.

The figures this year again show that the vast majority of referrals relate to physical assaults on a service user by other service users in regulated services. This reflects the fact that many service users in these settings display challenging behaviours including physical aggression towards others. These figures continue to emphasise the need for smaller scale, more personalised and individualised packages of care for service users. However, financial restraints mean that such packages are not deliverable in the majority of cases. Group care remains the norm for the majority of service users requiring day care or accommodation. As noted in previous reports, the Service Area has struggled to ensure adequate protection in some situations where both victim and perpetrator have learning disabilities and share the same space. This can occur both in hospital and community settings. While protection plans are put in place in these situations, the best protection would be alternative, more suitable placements which are not always available.

The Service Area continues to have significant on-going concern about the number of safeguarding referrals relating to staff in nursing, residential and supported living settings. These referrals have involved concerns about individual staff members but have also been about a number of staff members or the whole service. The issues have ranged from physical assaults to neglect to poor quality care practices. In this reporting year, there have been 25 referrals regarding staff and the Service Area has either led on or participated in 4 investigations where either the whole service or large parts of the service have been the subject of concern.

These figures and the outcomes of these investigations clearly show systemic concerns about how vulnerable people are cared for in these settings. The Service Area believes that many of these issues need tackled in a preventative fashion by good quality staff recruitment, retention, support and training processes. Staffing pressures in these settings, including the widespread use of agency staff, are often a contributory factor. The Service Area has also noted what appears to be an increasing tendency to manage staff absence by simply running with lower staff levels rather than bringing agency staff in.

The Service Area remains concerned that RQIA are increasingly tending not to take as active a part in safeguarding investigations, protection planning and decision making although this does vary between individual inspectors. The Service Area notes that RQIA are signatories to the Joint Protocol for Investigation and continues to believe that in certain circumstances a joint investigatory approach would be very helpful. The Service Area also believes that RQIA regulatory and quality improvement responsibilities require that they should necessarily be involved in the protection planning process including the design, enforcement, monitoring and review of these.

The Service Area would wish also to note the very significant resource implications in undertaking these large scale, challenging and complex investigations. During the course of an investigation into service user charges in a nursing home, the Service Area noted wide spread disparities between mileage rates charged by a range of different providers. The schemes met RQIA requirements in that they were transparent, individually applied to service users depending on their usage and signed up to be service users or carers but the Service Area felt that guidance on a reasonable rate

would be an important protection against abuse. The Service Area approached RQIA in relation to this but was informed that it could not offer such guidance. This matter is now with NIASP for further consideration.

The Service Area also continues to experience significant difficulties with anonymous whistle-blowing referrals about abuse in regulated services. Anonymous allegations are extremely hard to investigate and we have at times been left with the position of having considerable suspicion but lacking concrete detail and witnesses. We have also experienced difficulties with staff raising concerns but not being willing to express these openly. On occasions we continue to seek to enlist the support of professional bodies such as NISCC to emphasise a duty to disclose adult safeguarding concerns.

Support for whistleblowers is very important in this regard but we also believe that a professional duty to act on safeguarding concerns needs strongly emphasised to all staff in all sectors.

The Service Area also continues to experience some tensions with private sector care providers in the course of these large scale investigations in relation to the financial implications of having staff suspended during the investigation. The Service Area understands these difficulties but complex investigations usually do take considerable time and where the PSNI are involved, investigations can be very lengthy.

The Service Area has also encountered some tensions within the Trust between HR disciplinary processes and safeguarding processes and is engaging with HR to try to resolve these.

The Service Area continues to have a number of dedicated safeguarding staff. Muckamore Abbey Hospital (MAH) continues to have one Band 7 Designated Officer post although the post holder has just retired. Recruitment for a replacement is underway. The community service is now fully staffed with 1.5 WTE Band 7 staff although this has only recently been the case. This service takes referrals about abuse where a staff member is the alleged perpetrator or where issues of care quality in a group setting are such that they could be categorised as neglect. It is therefore this service which leads on most of the large scale complex institutional care investigations. The Service Area has benefitted greatly from the specialist dedicated resource but part of its strength lies in its very close working relationships with other Service Area staff who know the service users very well.

The Service Area is participating fully in Trust wide discussions about the future of safeguarding services following the publication of the new regional policy but is very keen to ensure that this aspect of its current service is not lost.

The Service Area continues to implement the new Joint Protocol for Investigation in MAH and is keen to extend this to all its services as soon as the Joint Protocol becomes operational for all. The Protocol continues to be very positively evaluated in MAH which welcomes the scope for increased professional discretion and judgement it allows.

The service area continues to work actively to engage service users effectively in safeguarding processes with particular emphasis on good communication methods.
The Service Area also continues to recognise the importance of helping service users to recognise and report abuse and remains actively involved in the ongoing roll out of the Keeping You Safe training workshop.

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SECTION 5: Challenges and Work-plan for 2015/16

Challenges for the Trust in relation to implementation of Department's new Policy

1. The Scope of the policy

The new definition extends the remit of the Trust beyond the current criteria and thresholds. An emphasis on prevention, as well as new roles and responsibilities mean that action will be required by all partner organisations and agencies to ensure that adults at risk and adults in need of protection receive appropriate support and, where necessary, protection.

The new policy extends to everyone, not just existing service users which is a major shift from the 2006 policy. For Trusts this poses a significant challenge in terms of potential increase in volume of work.

2. Adult Safeguarding Protection Structures within Trusts

There are three key messages relating to Adult Protection Gateway Service from the Department's Adult Safeguarding Prevention and Protection in Partnership Regional Policy. There can be summarised as follows:

a) All Health and Social Care Trusts must have a single point of access for receipt of referrals regarding concerns about adults who may be at risk and will promote and publicise contact arrangements within its area. Trust arrangements must accommodate referrals which do not obviously fit existing programme of Care structures, ensuring there are no safeguarding gaps.

   While the Trust does meet the DHSSPS requirement for a single point of contact for external referrals from the Public, via ASGT, current Trust structures mean that there are different Service Area arrangements for the management of Adult Safeguarding.

b) Each Trust will have an Adult Protection Gateway Service which will receive adult protection referrals. Referrals outside normal working hours should be made to the Regional Emergency Social Work Service (RESWS). Referrals will be accepted from any source, irrespective of Programme of Care boundaries.

c) HSC Trusts will be the lead agency in terms of the co-ordination of joint Adult Protection responses. Within each Trust accountability for Adult Protection service delivery arrangements rests with the Executive Director of Social Work and the lead profession within HSC Trusts is social work.

Delivering on the issues above poses significant challenges for the Belfast Trust given our current arrangements for the management of adult safeguarding

Current Arrangements and Key Challenges for Adult Safeguarding in each Service Area

Mental Health

There are 40 mental health teams in total within the Belfast Trust. Within Mental Health services adult safeguarding is integrated into the work of each core team. This is achieved by the alignment of DOs to each service. The Principal Social Worker and two Senior Social Workers within the Service Area co-ordinate Mental Health Gateway provision. This involves co-ordination and allocation of adult safeguarding referrals, including MARAC and Joint Protocol work. There are also regular weekly referral meetings and issues such as human trafficking are addressed within this mechanism.

Learning Disability

Similar to Mental Health Service Area, Learning Disability services operate within an integrated model where core teams are responsible for adult safeguarding. There are DOs and IOs in core teams and these staff are recognised as having significant expertise, skills and experience in terms of the service users that they work with and adult safeguarding. The nature of the Service Area, where most service users are known to the service for a long period of time, means that continuity of service is important. We are keen to ensure that existing knowledge and experience of service users is used effectively in the safeguarding process. The Service Area also has a number of specialist safeguarding staff.

Older People, Physical Health & Disability and Adult Safeguarding Gateway Team

The Adult Safeguarding Gateway Team has been operational for 3 years now and maintains responsibility for providing a single point of contact for referrals and for the screening and management of level 3 investigations for Older Persons and Physical Disability Services. Core Teams investigate Level 2 safeguarding referrals

The ASGT also acts as a point of contact for referrals from members of the public and some voluntary bodies.

In order to examine how the Trust will meet the Department's requirement for one Adult Gateway Protection service, TASS have facilitated a number of consultation workshops with safeguarding leads in all service areas. This included:

- Monthly meetings with Adult Safeguarding Leads
- Adult Protection Structures Workshop with Leads and Senior Managers
- Workshop with core teams in Older Peoples services

The Adult Safeguarding Committee is currently considering the feedback from the Trust consultation process in addition to the NIASP Commissioning document.

3. The role of Core teams in terms of managing adults at risk and provision of Professional assessments.

The new Policy sets a clear requirement that Core Teams (targeted services) provide a professional assessment where there is a safeguarding concern and manage adult at risk of harm cases which do not meet the threshold for Adult Protection Gateway service. The higher threshold for Adult Protection Gateway service is beneficial in terms of clearly defining Gateway's role and is welcomed. This does mean, however, that a lot of the work previously managed by adult protection services will need to be managed by Core Teams. Within Older People services there has been an identified shortfall in relation to professionally qualified social work staff. The expectation

outlined in the Policy regarding professional assessments and management of adults at risk by Core teams will be a major challenge. Senior management are examining this issue under workforce planning but have highlighted that this will potentially impede full implementation of the Policy.

4. The role of Designated Adult Protection Officer (DAPO) within Trusts

The role of DAPO is specified as first line Social Work Manager or Social Work Senior Practitioner. The Trust will need to review the existing complement of current DAPOs and their distribution across Directorates/services to ensure it has sufficient numbers of staff in the right location to be able to undertake this function. A transition period will be required to allow Trusts to phase out non-social work DAPOs currently in the system.

5. The significant implications for Training Trust-wide

The implementation of the new policy requires a huge training agenda which can only begin once the regional procedures are developed. The regional training strategy will need to consider the training needs of staff across sectors particularly given the responsibilities outlined in both the Adult Safeguarding Champion (regulated services) and the DAPO. The Belfast Trust Social Services learning and Development Team is represented on the NIASP training work stream and will be the lead to take forward all training requirements for the social care workforce arising from the new policy and associated procedures within the Trust. At this point there is no additional funding allocation.

6. Ensuring effective Governance arrangements

The Trust will be required to review governance and audit arrangements in line with the new Policy. There are a number of specific requirements which include contracts, targeted services and protection service. The Belfast Trust has and will continue to undertake audits in relation to staff compliance with adult protection. Consideration will need to be given to how a similar audit in relation to the quality of decision making within the Trust at team manager level in relation to ‘Adult at Risk’ referrals.

The nature of the accountability of the Executive Director of Social Work within the Trust for adult safeguarding will require to be delineated.

Challenges for the Trust associated with Service delivery:

1. Complex investigations in Regulated Facilities

As per previous reporting periods, the Trust continues to receive high volumes of referrals where there is a need to complete high risk complex institutional investigations requiring multidisciplinary and external agency input. Managing and co-ordinating complex investigations such as these have presented many challenges, particularly in relation to the roles and responsibilities of partner agencies.

There are significant challenges in relation to timescales for completion of large scale challenging and complex investigations and the very significant resource implications required to undertake them.

2. Interface with RQIA

The Trust remains concerned that RQIA are increasingly tending not to take as active a part in safeguarding investigations, protection planning and decision making although this does vary between individual inspectors. It is noted that RQIA are signatories to the Joint Protocol for Investigation and that in certain circumstances a joint investigatory approach would be very helpful. The Trust also believes that RQIA regulatory and quality improvement responsibilities means that they should necessarily be involved in the protection planning process including the design, enforcement, monitoring and review of these.

3. Interface with Central Referral Unit (CRU)

This reporting period has welcomed the introduction of the PSNI Central Referral Unit which has provided a central point of contact for Joint Protocol referrals.

The introduction of a PSNI Central Referral Unit has been viewed as a positive development as it will provide regional consistency in decision making and facilitate good communication. CRU has requested that Trusts provide a central point of contact in relation to referrals and exchange of information. Unfortunately given the current adult safeguarding structures within Belfast Trust, it has not been possible at this point in time to facilitate this. Each service area has identified key contacts and these have been shared with PSNI CRU.

As detailed earlier in this report, there have been challenges in terms of interpretation of new definitions and this has had an impact on operational issues. It is important to note that with the introduction of the new Joint Protocol it is anticipated that these issues will be addressed through training and guidance, as detailed in the Protocol. In the interim arrangements are in place where concerns can be escalated to the Police and regular joint agency meetings are occurring.

4. Regional Joint Protocol

NIASP have set tight timescales for implementation of the new draft Joint Protocol. It will be critical that all relevant Trust adult safeguarding staff receive appropriate training pre-implementation of the Joint Protocol. The Trust training team are represented on the NIASP regional training group and are currently in the process of developing the relevant training material. In the absence of additional funding to resource the training requirement training needs will need to be accommodated from within core funding and work schedules amended to meet deadlines for implementation.

5. Domestic Violence / MARAC

The 'Adult Safeguarding Prevention and Protection in Partnership 2015' policy identifies domestic violence as a related definition and highlights the importance of adult safeguarding, taking into consideration domestic violence strategies. In March 2016 'Stopping Domestic and Sexual Violence and Abuse in Northern Ireland – A Seven Year Strategy' was issued. The Strategy also recognises the need to strengthen links across a range of policies and services. It specifically references the new 'Adult Safeguarding Prevention and Protection in Partnership 2015' policy. Going forward there will be a need to develop a clear understanding of the roles and responsibilities of key agencies involved in domestic violence work. There is a particular need in terms of the new Definitions of an adult at risk of harm and an adult in need of protection to understand the Trust's obligations and have clear pathways in place.

With regard to MARAC the Trust currently adheres to the regionally agreed MARAC Operational Protocol and the regional Information Sharing Agreement. There are operational arrangements in place whereby each Service Area has identified staff who deliver on their MARAC obligations, as detailed in the MARAC Operational Protocol. As detailed above the definitions in the new Adult Safeguarding Policy extend the scope of those who traditionally meet Service Area criteria and this poses a significant challenge for the Trust in terms of possible new work. To date the Trust has a protocol in place where abuse cases which do not meet the current service area criteria can access Trust adult safeguarding support. The number of cases responded to in this context has been fairly low but with changes in definition it is anticipated this could potentially rise significantly. Clarification will be required in terms of Trust responsibility to high risk victims of domestic abuse who do not currently meet service area criteria. A position in relation to the Trust role in MARAC with regard to these cases will need to be considered.

6. Interfaces with Human Resources and Professional Bodies

The complexities in adult safeguarding investigations have resulted in increased challenges in relation to the interface between adult safeguarding and HR processes.
In situations where an allegation relates to a staff member there can be multiple investigations required to include adult safeguarding, disciplinary and possible Police investigations. In addition there are reporting requirements in relation to professional bodies and increased requests for adult safeguarding reports to be provided to support the other investigative processes. To date the Trust has been addressing these on a case by case basis and have been seeking HR and legal advice as required. The Trust is currently considering the regional Protection Procedures and welcomes the plans to include a section to address this complex area of work. The Trust is currently looking at this draft section and would hope to work with colleagues regionally to agree content.

7. Acute Sector

The interface between adult safeguarding and acute sector continues to present challenges. Work in relation to identification and management of adult safeguarding cases within this sector is ongoing. Targeted training is taking place to support key personnel and to raise the profile of this work.

8. Human Trafficking

The 'Working Arrangements for the Welfare and Protection of Adult Victims of Human Trafficking' document outlines the requirements placed on HSC Trusts in relation to

adult victims of human trafficking. As a named first responder Trusts have an obligation to recognise and respond to potential trafficking cases. Where a potential adult victim is identified and consent to a referral into the National Referral Mechanism has been given, the Trusts have a role in relation to making this referral. DOJ have a contract in place to support potential victims during a period of reflection and recovery. For those who are being supported by DOJ the Trust's role is to meet, identify healthcare needs and provide additional support to adult victims where there is an identified need, i.e. counselling or community service provision.

In the absence of specific funding for human trafficking and with competing demands at a time of austerity, it has not been possible to develop a specific training session dedicated to human trafficking and to deliver this in a consistent manner to all Trust staff. The Trust has been proactive in trying to meet its obligations in a number of ways:

- a slide on human trafficking is included in the Trust Corporate Induction
- human trafficking is included in all five levels of adult safeguarding training

Also this year the Trust organised a human trafficking awareness week where eight awareness raising seminars were delivered across a range of social care, health and hospital settings. In addition there were six information stands set up in Trust venues. Within this reporting period there were also a small number of specific human trafficking sessions organised within the adult services directorate. These sessions were targeted at adult safeguarding and social work staff. The Trust has been supported in raising awareness of human trafficking with Trust staff by NGO partner agencies who have delivered presentations and shared knowledge and learning.

The Trust has structures in place to respond to human trafficking referrals. In relation to adult victims the central point of contact for all external referrals is the Adult Safeguarding Gateway service. Regional statistics demonstrate that the number of reported cases of human trafficking is relatively low with 45 potential victims identified in Northern Ireland in 2014.

The Trust welcomes the introduction of the 'Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (NI) 2015' with its clear focus on responding to this very complex area of work. With the regional strategic plan and the development of regional annual action plan now enshrined in legislation, the Trust recognises the need to continue and enhance our focus on this area of work. 'Adult Safeguarding Prevention and Protection in Partnership 2015' policy reinforces the Trust obligations to address issues associated with human trafficking. Going forward the Trust will continue to work in partnership with the NGO Engagement Group chaired by DOJ in the development of annual action plans. The Trust also plans to review its current arrangements in relation to training and service delivery.

9. Financial Abuse Work

In this reporting period extensive work has taken place in relation to financial abuse issues. The DHSSPS set up a working group to look at issues of management of patients' finances in residential and nursing home settings, including supported living. The Belfast Trust has been an active member of this regional group and has contributed to the development of both the 2015 and 2016 DHSSPS Circular outlining requirements in relation to these settings. Action plans were developed with an aim to ensure more effective co-ordination and accountability in relation to the management of service users' finances in these settings. The Belfast Trust has made significant progress in relation to

delivering on the regionally agreed action plan. Within existing resources it is difficult to deliver fully on all requirements identified in the action plan but the Trust has made strenuous efforts to achieve compliance.

10. Adult Safeguarding Training

The demand for awareness raising training from the social work/social care workforce is considerable and constant with managers prioritizing the need to equip frontline staff to recognise and identify signs of abuse or neglect. Meeting this demand continues to be challenging for the learning and development service given the current level of resources.
Requests for Adult Safeguarding training continue from the Acute Sector with approximately 25 requests for bespoke training from AHP and Nursing teams received and declined.

Whilst awareness of the abuse and neglect of vulnerable people continues to be a key priority for acute sector staff, meeting these identified training needs by the Social Services learning and Development Service is not feasible.

11. Resources

The Trust would suggest that there is a need to address with the Commissioner the current and resourcing of adult safeguarding service delivery in the context of the exponential rise in service volumes and complexity over the last number of years and the implications for service delivery of the implementation of the revised Adult Safeguarding Policy.

BELFAST LASP WORKPLAN 2016-2017

The Belfast LASP work plan for 2016-17 is based on the core themes contained in Adult Safeguarding: Prevention and Protection in Partnership (2015).

Agreed Actions	Responsible	Timescale
Prevention		
Belfast Domestic Violence Partnership TASS is an active member of Domestic Violence Partnership and will continue to raise the profile of adult safeguarding within this forum, ensuring that any action plans reflect relevant issues	Belfast LASP	ongoing
Access to Adult Safeguarding Services Implementation and roll out of the regional documentation in relation to new Regional procedures	Belfast LASP	September 2016
Regional Adult Safeguarding work - TASS's will continue to work in partnership with NIASP to deliver on objectives	TASS	ongoing

Protection		
- The development of Regional Operational Procedures - The development and implementation of Joint Protocol - The implementation of new definitions - Requirement for each Trust to have an Adult Protection Gateway Service - The roll-out of DAPO and Adult Safeguarding Champion roles.	TASS-LASP	March 2017
Acute Sector Continue to promote adult safeguarding within the acute sector through a process of targeted training and support to key personnel	TASS	ongoing
Governance Continued facilitation of the Trust-wide Adult Safeguarding Committee	TASS	March 2017
Facilitation of Regional 10000 voices Audit re adult safeguarding	TASS	March 2017
Development of effective engagement with PARIS recording and statistical returns on a Trust wide basis	TASS	March 2017

Agreed Actions	Responsible	Timescale
Partnership		
Belfast LASP will continue to meet on a quarterly basis and continue to promote partnership working with LASP members. Belfast LASP work-streams will continue to meet regularly and deliver on agreed objectives	Belfast LASP	March 2017
Development and implementation of Regional Adult Safeguarding Procedures & Guidance Document in keeping with the Draft Policy	Belfast LASP	September 2016
Development and roll out of the Regional Joint Protocol following the evaluation of the Joint Protocol Pilot	TASS	September 2016
Development of effective partnership protocols with RQIA in relation to investigations in regulated facilities. This is particularly required in complex cases where there are issues relating to disciplinary and criminal procedures, breach of regulation and large scale intuitional abuse	TASS	September 2017
MARAC - Work in partnership with key relevant personnel within the Trust to ensure effective service delivery - Work in partnership with colleagues on a regional basis to review adult safeguarding MARAC arrangements and address operational issues	Belfast LASP	September 2016
Human Trafficking Trust will continue to work with the Department of Justice through attendance at the Human Trafficking Engagement group and will seek to deliver on the action plan as specified in 2015/2016	Belfast LASP	Ongoing
Work with NGO and Regional Adult Safeguarding Officer to consider the recommendations set out in a number of reviews and in particular the review of the National Referral Mechanism	TASS	Ongoing
User Experience Continued roll out and evaluation of adult safeguarding training for service users	Belfast LASP	March 2017
Review the outcomes of the Regional Service User 10000 voices audit	TASS	March 2017
Training and Practice Development The LASP will continue to facilitate a Conference and other safeguarding prevention/awareness raising workshops throughout the year	Belfast LASP	March 2017
Continued facilitation of IO, DO and ABE practice development fora and introduction of another forum specifically for social care staff	Belfast LASP	March 2017

Belfast Health and Social Care Trust

caring supporting improving together

BELFAST HEALTH & SOCIAL CARE TRUST

REGIONAL REPORTING TEMPLATE FOR DELEGATED STATUTORY FUNCTIONS

For Year end 31 March 2016

REPORTING TEMPLATE INDEX

SECTION 1 – INTRODUCTION

- to be completed by Executive Director of Social Work

SECTION 2 – EXECUTIVE SUMMARY

- to be completed by Executive Director of Social Work (inc signature & date)

SECTION 3 – GENERAL NARRATIVE & DATA

- to be completed for each Programme of Care by the Social Work Leads for that Programme
- the data returns 1-6 & 8-9 for each programme should follow the narrative
- all Programmes must complete an individual Data Return 1-6 & 8-9 inclusive
- Data Return 9 (Mental Health) can be compiled by the ASW Lead but should have a separate data set for each Programme
- Data Return 10 is only to be completed by the Family & Child Care Programme (this is for the 6 month period 1st October – 31st March)
- Data Return 11 replaces the Training Accountability Report
- please ensure complete reporting of all Data Returns **(nil returns or non-applicable should be reported)**

DATA RETURNS

1 General Provisions (Returns 2-9 below relate to specific statutory duties, the data returned therein constitutes a sub-set of this return)
2 Chronically Sick and Disabled Persons
3 Disabled Persons (NI) Act 1989
4 Health and Personal Social Services Order
5 Carers and Direct Payments Act 2002
6 (Safeguarding Adults)
7 (Social Work Teams and Caseloads)
8 Assessed Year in Employment
9 Mental Health
10 Family and Child Care specific returns (CC3/02)
11 Training Accountability Report

CONTENTS SHEET

1. Introduction

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

The Trust, as a corporate entity, is responsible in law for the discharge of statutory social care functions delegated to it by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. The Trust is accountable to the Health and Social Care Board (HSCB) for the discharge of such functions and is obliged to establish sound organisational and related assurance arrangements to ensure their effective discharge.

The following are central to the delivery of statutory services are:

- A focus on the assessed needs of the individual service user.
- Promoting and supporting the service user's engagement as fully as possible in decisions about their care.
- A commitment to seamless, multi-professional, integrated working across all Trust service settings.
- The optimising of available resources to provide high quality, effective and efficient services.
- The promotion of inclusive partnerships with community, statutory and voluntary sector organisations in the development and delivery of accessible and inclusive services.
- Person centred service delivery approaches.
- A skilled, knowledgeable and highly competent workforce.

The Scheme for Delegation provides the overarching assurance framework for the discharge of statutory social care functions. It outlines:

- The powers and duties which are delegated to the Trust.
- The principles and values which underpin the delivery of statutory services.
- The policies, circulars and guidance to which the Trust must adhere in the discharge of such functions.
- The organisational assurance arrangements in respect of same.

The Scheme for Delegation requires the Trust to produce an annual report addressing how it has discharged those statutory functions pertaining to social care services.

The Trust's exercise of these functions, in particular those relating to the protection and care of children and vulnerable adults and restrictions of personal liberty, give rise to significant levels of public and media interest and scrutiny.

The Executive Director of Social Work is professionally accountable for and is required to report to the Trust Board on the discharge of statutory social care functions. An unbroken line of professional accountability runs virtually from the individual practitioner through the Service Area professional and line management structures to the Executive Director of Social Work and onto the Trust Board.

This Report has been prepared on an HSCB regional template and is sub-divided into the following sections:

SECTION 1: An introduction to the Report.

SECTION 2: An overview of the Trust's performance in relation to the discharge of its statutory functions across the respective Service Areas by the Executive Director of Social Work.
SECTION 3:

Individual Service Area reports, each of which addresses a range of key themes including: a review of the Service Area's engagement with external regulatory agencies with regard to the discharge of statutory social care functions; challenges with regard to the delivery of statutory social care services; workforce issues; and areas of emerging significance.

The individual Service Area reports include a number of information returns relating to statutory social care service delivery.

APPENDICES:

BHSCT Assessed Year in Employment (Social Workers) Annual Overview Report.

BHSCT Social Services Workforce Learning and Development Accountability Report

The Belfast Local Adult Safeguarding Panel (LASP) Report 2013-2014

I would like to take this opportunity to recognise the role and contributions of Trust staff across all professions and Directorates in the discharge of statutory functions.

The discharge of statutory functions is complex, demanding, highly skilled and rewarding work. In particular, I would wish to express my appreciation of the professionalism and dedication of the Trust's social care workforce in this regard.

Cecil Worthington
Executive Director of Social Work

May 2016

EXECUTIVE SUMMARY

2 GENERAL

Executive Director of Social Work:

2.1 Statement of Controls Assurance

(Brief statement is sufficient, however any gaps / breaches in terms of compliance should be highlighted and the action taken to resolve these)

Reference to RQIA should be included.

Reference to NISCC and the Trust's mechanisms for monitoring registration status should be included.

The Trust has achieved satisfactory compliance with the requirements specified in the Scheme for Delegation.

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

In the context of a particularly challenging operational and budgetary environment characterised by significant resource and capacity pressures, enhanced levels of public expectation, related scrutiny and an on-going drive for modernisation and service improvement, the Trust has continued to prioritise the safe discharge of its statutory social care functions.

The Trust has co-operated fully with the Regulation and Quality Improvement Authority (RQIA) in the discharge of its functions.

The Trust is compliant with NISCC's Code of Practice for Employers. With regard to the registration of the workforce, the Trust has robust organisational arrangements in place to monitor and assure compliance with registration requirements. The trust is currently preparing for the compulsory registration of the social care workforce. The Trust is engaged in regular formal and informal contacts with NISCC.

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

This must include confirmation that all Social Work staff receive formal and regular professional supervision from a professionally qualified social worker who can function in this supervisory role. Please state when this is not the Social Work Line Manager.

The Executive Director of Social Work is professionally accountable for the discharge of statutory functions by the social care workforce and related assurance arrangements pertaining to same across all Service Areas. These arrangements are underpinned by an unbroken line of professional accountability from the individual practitioner through the Service Area professional and line management structures to the Executive Director of Social Work and onto the Trust Board.

The Trust's social care workforce is operationally and professionally managed within two Directorates-Adult Social and Primary Care and Childrens Community Services. The Trust's Executive Director of Social Work also holds the post of Director of Children's Community Services. The Co-Director of Social Work and Social care Governance supports the Executive Director in the discharge of his responsibilities.

The Associate Directors of Social Work have a key organisational role in providing assurance with regard to the discharge of statutory functions. They have responsibility and are accountable for:

- The professional leadership of the social care workforce within their respective Service Areas.
- The provision of expert advice within their Service Areas on the discharge of statutory functions and professional issues pertaining to the social care workforce.
- Ensuring organisational and assurance arrangements are in place within their Service Areas to facilitate the discharge, monitoring and reporting on the discharge of statutory functions.
- The completion of the individual Service Area Annual and Interim Statutory Functions Reports.
- Ensuring that arrangements are in place within the Service Area to monitor compliance with NISCC workforce regulatory requirements.

The Trust's Adult Social Services Professional Social Work Supervision Policy (January 2014) and the Regional Supervision Policy Standards and Criteria (Revised November 2013) provide the framework for the delivery of professional social work supervision to social work staff in adult and childrens services. The Trust's Supervision Policy and Procedures for Social Care Staff in Adult Services October 2011outlines the processes and standards informing supervision delivery to social care staff.

Compliance with supervision standards is monitored through Service Area and Trust-wide audit processes. A Trust-wide professional social work supervision monthly exception reporting system has been implemented to monitor

compliance with the frequency of supervision delivery and to identify and address any areas of non-compliance. (Please see individual Service Area Reports).

Under the auspices of the Regional Social Work Strategy, a Draft Regional Adult Social Work Supervision Framework has been developed which is about to be disseminated for consultation. The Draft Framework seeks to establish regionally agreed standards for the delivery of social work supervision in adult services.

The securing of a sufficient base of designated operational management and professional social work posts at Band 7 and above is of particular significance in integrated service structures to facilitate the delivery of professional social work supervision.

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

(Narrative should be specific. Trusts should take the opportunity to append their Adult Safeguarding Report).

Within the individual Service Areas the Trust has sought to consolidate and develop monitoring and assurance mechanisms in relation to its discharge of statutory functions. These are detailed in the individual Service Area reports.

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

The Executive Director of Social Work is responsible for assuring the arrangements underpinning the discharge of statutory social care functions. She/he is required to report directly to the Trust's Assurance Committee and the Trust Board on the discharge of these functions. The Annual Statutory Functions and six-monthly Corporate Parenting Reports are presented to Trust Board for its consideration and approval.

The Executive Director of Social Work:

- Provides professional leadership to the Trust's social care workforce.
- Provides expert advice to the Trust Board on all matters pertaining to the discharge of statutory functions.
- Is accountable for the assurance of all issues pertaining to the social care workforce's compliance with professional and regulatory standards.

The Trust has recently established a Social care Committee. The Committee is chaired by a Non-Executive Director, Ms Anne O'Reilly. The other three members of the Committee are also Non-Executive Directors Ms Miriam Karp, Dr Martin Bradley and Mr Stuart Elborn. The Committee is a sub-committee of the Trust's Assurance Committee. It is authorised by the Trust Board to review the Annual and Interim Statutory Functions Reports, the six-monthly Corporate Parenting

Reports and miscellaneous other reports pertaining to the discharge of statutory functions which are present to Trust Board.

The Social Care Steering Group (membership of which is made up of the Associate Directors of Social Work Group) is a sub-committee of the Trust's Assurance Committee with responsibility for the monitoring of and reporting to the Assurance Committee on the discharge of statutory functions.

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

The Trust has established an Adult Safeguarding Committee which mirrors the remit and structures outlined in respect of the Children's Safeguarding Committee from an adult safeguarding perspective. In the context of the dissemination of the Revised Regional Adult Safeguarding Policy, the Adult Safeguarding Committee will have a substantial focus on assuring the implementation of and compliance with the Regional Policy.

Each Service Area has its local Risk Register which informs the populating of the Directorate and Trust's Corporate Risk Registers and Principal Risks Document respectively.

The Trust has developed interim compliance arrangements in response to the limited assurance findings of a BSO audit of data collation and assurance processes in respect of the returns included in the Annual Statutory Functions and six-monthly Corporate Parenting returns for the period ending 31 Marche 2014. The full implementation of the PARIS information system in childrens services and the optimising of the system's reporting functionality across both adults and childrens social care services will provide the substantial future assurance in relation to social care data management and assurance arrangements.

The recent RQIA regional review of professional regulatory structures and assurance processes commented positively on the Trust's social care arrangements.

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

Trust should where appropriate include brief descriptions and cross references when the matters being reported are dealt with in detail in other sections of this report. Where such cross referencing is not appropriate the failure to discharge any statutory function must be reported in this section.

This has been a challenging year for the Trust as a consequence of the overarching financial context, the complexity of need, the ongoing drive for

modernisation and reform of service delivery processes, caseload volumes pressures across all Service Areas and the enhanced levels of public expectations and scrutiny.

The Trust has continued to prioritise investment in its workforce knowledge and skills base; to consolidate and enhance service user engagement; to strengthen its partnerships with local communities and voluntary, private and statutory agencies; and to promote community capacity building and the creation of social enterprise initiatives within localities. Within this context the Trust achieved IIP Bronze accreditation

The following is an overview of a number of areas which have generated particular challenges in relation to the discharge of statutory functions over the reporting period. The individual Service Area reports provide detailed commentaries on the issues as they relate to their respective service delivery responsibilities.

Deprivation of Liberty:
As noted in a number of the Service Area reports, the Trust's Legal Adviser has commented on the Trust's need to review all those situations in which service delivery arrangements have given rise to a deprivation of a service user's liberty and has recommended that, on the basis of prioritisation of the nature and extent of the deprivation, the Trust should engage with the Courts to progress applications for Declaratory Orders in relation to all such deprivations. This is potentially a huge task from logistical, professional and workforce perspectives with the likelihood of substantial direct costs related to legal proceedings. The Trust has addressed this matter previously with the DHSSPS and the HSCB.

Revised Regional Adult Safeguarding Policy:
The implementation of the Regional Policy will significantly enhance the scope and service delivery responsibilities of the Trust in relation to adult safeguarding. While the Trust is fully supportive of the thrust and aims of the Policy, it will require a substantial investment in training and awareness raising across the Trust's workforce, and a significant investment in adult social work service delivery capacity in light of the specific workforce requirements in relation to the role of social workers as prescribed in the Policy.

PARIS
The implementation of PARIS within childrens services is progressing. However, in view of the need to develop system software to facilitate current and projected reporting functionality, the Trust would suggest that additional investment will be required to support the implementation process. The Trust recognises the need at both Trust and regional levels to substantially develop information management capacity and infrastructure within community services as a whole and particularly in relation to the discharge of statutory functions.

Other areas referenced in the individual Service Area reports include:

- Challenges associated with the delivery of the Trust's daytime ASW Rota.

- The current “freeze” in Supporting People funding with significant implications for the development of specialist accommodation across all Service Areas.
- The overarching financial context. While the Trust has continued to prioritise the discharge of statutory functions, it has minimal capacity to do so on an ongoing basis without impacting directly on statutory service delivery.
- Implications for the discharge of statutory functions of the restructuring of commissioning arrangements.

2.5 Progress report on Actions taken to improve performance, including financial implications. This section should make specific reference to last year’s report (sect 2.4), actions arising and progress made.

Statutory Functions Action Plans:
The HSCB in consultation with the Trust has established a schedule of meetings and related action planning and review processes to address performance with regard to the discharge of statutory functions. Progress on the action plans emanating from the Annual and Interim Statutory Functions Reports and on-going difficulties and emerging challenges are addressed within the individual Service Area meetings with HSCB staff and reflected in the current Action Plan.

There are no specific outstanding actions as such arising out of the Interim Statutory Functions Report (November 2015) although a number of the areas addressed will be included on the agenda for the annual review meeting in June 2016.

Workforce:
The Trust has continued to promote the development of its social work and social care workforce through on-going investment in learning and development in line with the Regional Workforce Development and Training Strategy. The Trust has achieved relative stability across its social work and social care workforce. As noted above, the Trust was recently reviewed and re-accredited as an IIP Bronze Award organisation.

Finance:
As previously noted, this has been a challenging year in relation to the discharge of statutory functions across all Service Areas in the context of the complexity of need, pressures associated with referral and caseload volumes, the intensity of public and media scrutiny and the overarching budgetary constraints.

In relation to the discharge of statutory functions, the Trust has continued to prioritise service delivery and has addressed on an on-going basis with the HSCB those areas where demand, resources and capacity issues have been most difficult. The Trust is committed to progressing its modernisation and reform agenda which is predicated on further developing partnerships with key stakeholders in the development, delivery and reform of services and the strengthening of community infrastructures and capcity.

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

The individual reports provide a synopsis of risks listed on Risk Registers.

The following risk pertaining to the discharge of statutory functions is presently listed in the Trust's Principal Risks Document:

Maintenance of controls and assurance processes underpinning the discharge of statutory functions within each Service Area.

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

This should include a summary (more detailed information should be provided within the relevant sections of this report) of Audits, Service Improvement evaluations etc, conducted by the Trust or by others, including Recommendations and progress.

The Trust is engaged in an on-going focus on the effectiveness of its assurance processes with regard to discharge of statutory functions. Details of audits are listed in individual Service Area reports.

- RQIA independent thematic and facility inspections.
- RQIA and the Mental Health Review Tribunal statutory duties to scrutinise the Trust's discharge of its statutory functions under the Mental Health (NI) Order 1986.
- The Trust is publicly held to account by the Courts with regard to its discharge of its statutory social care duties.
- The Trust is publicly held to account by the Assembly's Committee for Health Social Services and Public Safety. This involves written submissions to and appearances before the Committee of Trust staff to address thematic and specific issues of interest/concern relating to statutory social care services delivery.
- External and internal performance management and accountability arrangements facilitate scrutiny of the Trust's performance in respect of the provision of statutory services.
- The following are core reports prepared by the Trust for the HSCB and the DHSSPSNI related to the discharge of its statutory functions: the Trust's Annual and Interim Statutory Functions Reports; six-monthly Corporate Parenting Report; the Trust's Annual Self-Assessment Report (Section 12 Audit) to the Safeguarding Board for NI (SBNI); the Belfast Local Adult Safeguarding Partnership (LASP) Annual Report; the Annual Accountability Report in respect of Social Services learning and development activity; the Annual Assessed Year in Employment (AYE) Audit; the Annual Social Services Workforce Return; and ad hoc reports as and when required.

- The Trust's Serious Adverse Reporting and Children's Services Untoward Events arrangements afford a process for Departmental and HSCB monitoring and related learning from significant events.
- The Trust's arrangements for the investigation and management of compliments and complaints and the Trust's interface with the Office of the Commissioner for Complaints.
- The Trust's discharge of its statutory duties to co-operate with the SBNI-in particular its responsibilities with regard to Case Management Reviews (CMR) and related children's safeguarding inquiries.
- The Trust's engagement with the NI Adult Safeguarding Partnership and its discharge of its responsibilities in relation to Case Management reviews and related adult safeguarding inquiries.

CONCLUSION:

The financial context has presented substantial challenges to all Service Areas during the reporting period. The requirement to make the levels of savings delivered to date processes through service improvement, modernisation and efficiencies while retaining service continuity and quality has proved hugely challenging in light of the range and complexity of need, the increases across Directorates in service delivery volumes and the rapidity and scale of organisational change.

2016-2017 will in all likelihood prove even more demanding. While the Trust will continue to prioritise the discharge of its statutory functions, the scale of the financial challenges for Service Areas will inevitably give rise to further service delivery pressures.

The Service Areas are progressing innovative modernisation and improvement initiatives to maximise service delivery performance and outcomes. The importance of flexible, person centred social care services in obviating unscheduled admissions to hospital and facilitating timely discharges and the Trust's central role in the development of community capacity and resilience through partnerships such as those centred on the operationalising of Family Support and Mental Health Hubs, the Recovery College and the Trust's support for and commissioning of locality-based schemes to support vulnerable adults.

The Older Peoples Services Workforce Review is an ambitious service improvement initiative which seeks to re-profile the importance of professional social work's contribution to provision of qualitative and innovative service delivery to older people. It is predicated on a commitment to professional excellence-evidence-based, outcomes, person centred and rights based provision which promotes the social dimension to wellbeing.

It is essential that the investment in workforce development to enhance skills, knowledge and capacity within a practice culture which promotes and values their engagement, expertism and the exercise of professional discretion within robust accountability and assurance arrangements is consolidated.

The promotion of personalisation and Self-directed Care, service user participation in the development, planning and review of services, outcomes-led

practice which accentuates qualitative measures of effectiveness located within a coherent evidence base are pivotal to optimising overall performance.

The Social Work Strategy is moving through into its second phase of implementation. *Putting improvement at the heart of social work* captures its emphasis on the dynamism and drive of the profession providing a strategic framework and related priorities which will inform the development of social work over the next number of years.

The social care workforce has a crucial role in the delivery of community services. In the Trust's view, compulsory registration of the social care workforce will consolidate the importance of their work; enhance their profile and status while strengthening workforce assurance.

The discharge of statutory functions related to the development of safeguarding arrangements and practice in both adults and children's services; the securing of seamless service pathways across acute and community settings to reduce unnecessary hospital admissions and facilitate safe, person centred discharges; and the resettlement of long stay patients from mental health and learning disability hospitals will present substantial challenges.

The maintenance of vulnerable adults and children with complex health and social care needs within their own communities with enhanced levels of risk will require a sustained investment in community infrastructure and community capacity and the engagement and support of communities and service users and the wider public. Strong partnerships with statutory, voluntary, community and private sector organisations will be pivotal to maximising of available resources and capacity to deliver improved outcomes for service users.

The social work and social care workforce will have a key role in the delivery of the Trust's vision. Their values, skills and knowledge base will be central to the effective delivery of integrated person centred care, the optimising of personal choice, the management of risk and the promotion of healthy, inclusive and enabling communities.

Cecil Worthington
Executive Director of Social Work
May 2016

3. GENERAL NARRATIVE

OLDER PEOPLES SERVICE AREA

3.1	Named Officer responsible for professional Social Work
	Mrs Katie Campbell, Service Manager for Older Peoples Services (Acting) is the Associate Director of Social Work within the Service Area. The Associate Director of Social Work has responsibility for professional issues pertaining to the social work and social care workforce within the Service Area. She is accountable to the Executive Director of Social Work for the assurance of organisational arrangements underpinning the discharge of statutory functions related to the delivery of social care services within the Service Area. The Associate Director of Social Work is responsible for: ➢ Professional leadership of the social care workforce within the Service Area ➢ The establishment of structures within the Service Area to monitor and report on the discharge of statutory functions. ➢ The provision of specialist advice to the Service Area on professional issues pertaining to the social care workforce and social care service delivery, including the discharge of statutory functions. ➢ The collation and assurance of the Service Area Interim and Annual Statutory Functions Reports ➢ The promotion and profiling of the discrete knowledge and skills base of the social care workforce ➢ Ensuring that arrangements are in place within the Service Area to facilitate the social care workforce's learning and development opportunities. ➢ Ensuring that arrangements are in place within the Service Area to monitor compliance with NISCC registration requirements. An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through the Service Area line management and professional structures to the Executive Director of Social Work and onto the Trust Board. The Associate Director of Social Work has assured the Service Area report which meets the requirements of the prescribed audit process in respect of the discharge of statutory functions.
3.2	**Supervision arrangements for social workers**
	Trusts must make reference to: Assessed Year in Employment (AYE) and compliance and Caseload weighting arrangements. The Service Area has had five social workers undergoing their Assessed Year in Employment on the 31 March 2016. Assurance can be given that AYE social workers have a protected case load and receive the mandatory training and supports required as well as a comprehensive induction and appraisal process. The social workers are able to avail of

	the peer support from the AYE support group within the Trust. The Service Area's professional social work structure is regularly reviewed to ensure on-going continuity of the unbroken line of professional accountability. In those cases where vacancies would impact on this continuity, immediate actions are put in place to address the gap. The structure provides clear lines of professional reporting and accountability for all designated social work staff within the Service Area. The Service Area continues to take full cognisance of the findings and recommendations identified by the BSO audit of professional social work supervision. The Service Area continues to audit performance around professional supervision and, where appropriate, develops action plans to address issues and provide assurances around meeting the requirements of the revised policy. There has been an annual supervision audit within the Service Area in this reporting period. The audit evidenced the Service Area's satisfactory compliance. Supervisors are required to report monthly on instances where staff have not received supervision and identify actions in place to address this. These returns are monitored by the Principal Social Worker for the Service Area with patterns or trends analysed. The Service Area is increasingly concerned that the model of one to one supervision has become a task focused case management process, and that it does not adequately create space for discussions in relation to reflective practice or personal development. In this forthcoming year, the Service Area intends to review its supervision framework to develop a more enabling and supportive framework to encourage reflective practice, peer support and best practice, yet ensuring that professional requirements in relation to supervision are maintained. Supervision affords a mechanism for addressing organisational engagement, performance and accountability and a vehicle for feedback and reflection which are fundamental dimensions to learning and development. Under the auspices of the Regional Social Work Strategy a revised regional adult social work supervision policy and standards is being developed with a strong evidence based-focus, linking investment in supervision delivery with enhanced workforce knowledge and skills and improved service delivery outcomes. The revised policy will incorporate a range of supervision delivery options incorporating group and peer supervision models within a strong emphasis on reflective approaches. Regulated services have demonstrated through RQIA inspections that they are compliant/substantially compliant with the Trust's social care supervision policies in this reporting period. At senior management level the Service Area has a Social Work Leads (ASM) Forum which meets quarterly and where social work issues, developments and requirements are discussed.

	A Band 7 Social Work Leads Forum, chaired by the Principal Social Worker, meets quarterly to discuss social work issues and requirements. This enables the Service Area to share best practice, strengthen social care governance and provide professional leadership in an increasingly demanding and challenging work environment. As stated last year, the Service Area does not currently have a bespoke case load weighting system and eagerly awaits any guidance on this from the work being undertaken through the Regional Social Work Strategy Workstreams.
3.3	**Report on processes, audits, reviews, research and evaluations undertaken during the year, that measure performance against delegated statutory functions, identifying emerging trends and issues (may include cross references to other sections to this report).**
	Social Care Workforce Review The Service Area completed its review of the social care workforce in October 2015. The aim of this review was to address the organisational pressures and challenges experienced in delivering against statutory functions to achieve the desired social care outcomes. The Service Area has consistently highlighted in previous reports the pressures and challenges it faces within the current structures and resources available to meet in full its statutory responsibilities. This is evidenced in the low levels of professional social work assessment, difficulties in meeting NISAT targets, undertake and review the level of carers assessments expected, and delivery against Personalisation and Self Directed Support. Within this current structure and under-investment in social workers, the professional resource at this time has to rightly focus on complex cases, high risk and adult protection, in what is a reactive rather than a proactive, preventative approach. The workforce is currently ill-equipped to promote and deliver services that are necessary to support a culture of prevention, focussed on enhancing wellbeing and building resilience. The breadth of the Review has been substantial in relation to the number of teams, services, and roles that fell within its scope, encompassing fifteen teams and nine job roles across hospital and community settings. This included professional social work in hospital and community settings, the range of social care roles; care managers social care assessors, and assistant care managers. Key to the Review has been a drive to promote professional social work, improve standards of practice and articulate social work's discrete contribution to health and social care in the context of the Social Work strategy and TYC as well as the incoming mental capacity legislation. A draft report setting out recommendations on a way forward was circulated amongst all staff in October 2015 for consultation. At the core

of these recommendations, is a vision to develop and implement a model of social work and social care for older people, which recognises old age as a distinct part of the developmental life cycle; to address the specific challenges of aging by promoting independence, autonomy, and dignity in later life; and to develop a professionally led service that works in partnership with Older People, to promote independence and resilience, maximise social inclusion and citizenship, reduce risk and avoid harm.

The recommendations of the Review are wide-ranging and will represent transformational change for the Service Area.

Key recommendations are:

- Older People's Social Care services are to be professionally led, whereby all case holders will be Band 6 social workers, with all initial assessments and reviews being undertaken by social workers.
- The management and review of long-term placements will be transferred from the Integrated Care Team structures to a newly-established Older Persons Care and Placement Review Team.
- The Care Management assessment and care planning functions are to be undertaken by the core Band 6 social worker role in the Integrated Care Teams and this will result in the phasing out of current Care Management structures and roles
- The Band 6 social worker role should be considered the mainstream role in social care in Integrated Care Teams. Therefore current levels of skills mix within Integrated Care Teams should be redressed to ensure adequate levels of Band 6 social workers are available
- Agreed standardised social work and social care standards are to be implemented across Hospital Social Work and community services.
- Community and hospital social work will be managed under a unified professional and operational line of accountability in the form of a single senior manager

The draft report has been circulated widely amongst staff and key stakeholders. There has been significant consultation by senior managers with all groups of staff affected. The consultation period has now ended and the Service Area has commenced a process of implementation, involving engagement and participation from all grades of staff and representatives for carers and service users.

This transformational change in social care will not be realised without the necessary investment in the required professional social work staff. At present the Service Area is developing a business case outlining the anticipated investment required.

Professional Supervision

In this reporting period, the Service Area has undertaken an annual supervision audit. There is evidence of sustained improvement in frequency of recorded supervision in line with the policy. Findings also indicate that in areas of high pressure, delivering regular recorded

supervision remains a challenge. As well as a system of continued audit, local action plans are in place to address this.

NISCC Registration
The Service Area contributes to the Trust's assurance arrangements underpinning compliance with NISCC registration in respect of the social care workforce. A Bank-Staff checklist and guidance around registration requirements have been developed and used to ensure full compliance.

Regulation Quality and Improvement Authority
Overall the Service Area is achieving levels of reasonable to full compliance in most standards. All services inspected have demonstrated compliance with requirements around safeguarding and overall compliance with quality Improvement plans. Annual service evaluations are maintained and shared with service users and carers.

Risk Register
The Service Area has a process in place that ensures the Risk Register is regularly reviewed and updated. All risks are reviewed at least annually and this process is fully integrated into the Service Area's corporate governance arrangements.

Accidents and Incidents
These are monitored and reported on at the Service Area's governance meetings and at local level through the social care audit cycle.

Reflective Practice
There are a number of reflective practice fora within the Service Area to support staff practice, such as support groups for Investigating Officers, Designated Officers, ABE trained interviewers, Approved Social Workers as well as social work leads meetings.

A social work forum at the practitioner level also meets twice yearly to discuss current issues within social work. In this reporting period there has been a focus on Carers Issues and Self Directed Support (SDS). There has been the development of an SDS reflective group to support the implementation of SDS.

Enhancing Nursing Home Support / Quality Assurance
Within the area of adult safeguarding there continues to be a significant level of referrals originating from Nursing and Residential Homes. Homes have been increasingly supported to recognise concerns and to report these, through the Service Area's Quality Assurance Team (QAT) for commissioned services. A Service Area-wide governance group with representation from safeguarding, quality assurance, complaints and care management continues to monitor complaints, patterns and trends in the independent sector.

Contracts with Independent Domiciliary Providers
The Service Area meets at least annually with all independent domiciliary providers to ensure that contractual obligations are met and to assure the Trust that the commissioned service is providing value for

	money**.** There are significant pressures currently in relation to shortages in the availability of domiciliary care packages, particularly in the South and East sector. This alongside an absence of robust reviews of care packages is causing substantial delays for some service users in accessing appropriate care packages and is having an impact upon flow through reablement and intermediate care provisions. This is having a major impact on these services' productivity and ability to meet Commissioner's targets. The Trust is currently working to finalise a domiciliary care procurement process that aims to bring stability to the domiciliary market.
3.4	**Report on the Programme of Care's interfaces with other statutory agencies including for example: NISCC; RQIA; PHA (in relation to social care)** **Trusts should include references to Judicial Reviews or other significant Court Judgements that directly impact on the discharge of statutory functions.**
	NISCC The Service Area is compliant with the regulatory requirements in relation to the registration of the social work and social care workforce. The Trust has worked collaboratively with NISCC throughout the year to progress the registration of the domiciliary care workforce. **RQIA** The Service Area complies fully with reporting on all notifiable incidents in accordance with regulations and in working to address issues identified through inspection processes. **Joint Protocol Partnerships** There continues to be significant challenges for the Service Area in the context of an extensive and complex institutional abuse investigation in a Belfast care home. This again highlighted the challenges of such investigations and, in particular, those related to interfaces with other Joint Protocol partners, the PSNI and RQIA. Joint Protocol working with PSNI has proved problematic in terms of significant time delays around completion of PIA's, ABE interviews and investigations. Whilst the development of a Central Referral Unit within the PSNI has assisted in developing improved and timely interfaces between the Trust and the PSNI, there continues to be significant delays in the PSNI's investigation processes. This can leave victims and their families distressed and frustrated. It is becoming increasingly apparent that RQIA take a less active role in joint agency strategy or investigation work within regulated facilities. This is evident in the decreased number of strategy meetings RQIA now agree to attend and their perceived reluctance to become

	involved in safeguarding processes. This places the Trust in a very challenging position. In the absence of safeguarding legislation to support the Trust in its investigation role, the Trust has been challenged on its authority to undertake such investigations. Whilst there are contractual obligations on the independent sector to work with the Trust in matters of safeguarding, there is no right of access to facilities to view their records and there is no authority to interview staff, should the facility fail to co-operate fully. It is imperative that the new joint protocol arrangements clearly define the roles and responsibilities of partner organisations in complex institutional investigations and also in the management of whistleblowing allegations. **Regional Dementia Strategy Group** The Service Area continues to have representation at senior management level on the Regional Group for the implementation of the NI Dementia Strategy. **MARAC** The Service Area has representation on the MARAC group. The number of referrals made to MARAC by the Service Area has remained consistent. **Judicial Reviews and Significant Court Judgements** The Service Area is increasingly challenged in relation to those cases which involve both a Guardianship and a Deprivation of Liberty. The Service Area has had one case in this reporting period which has met this threshold. The Mental Health Review Tribunal are not dealing with these types of cases and have made a recommendation that Trusts obtain a Declaratory Order from the High Court giving approval to the Deprivation of Liberty. Guardianship cases are being adjourned pending the relevant Trust obtaining a Declaratory Order. This process has proved to be lengthy with the Department of Legal Services being slow to bring these to the Court and they are being deemed non-urgent by the Court. The Trust has been left vulnerable in this position, whereby the Trust has faced allegations of failure and delay in bringing procedures where the applicant might challenge their deprivation of liberty.

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	ADULT SAFEGUARDING During this reporting period 1385 referrals have been screened by the Adult Safeguarding Gateway Team (ASGT). Whilst, this is a reduction of approximately 13% on previous years, it reflects that referral rates to the team have remained at a high level. This continues to have significant implications for the ASGT in terms of managing this pressure of work as a central point of referral. This is a highly pressurised work environment for staff and the maintenance of a stable workforce continues to be a challenge with a high turnover of staff. Lengthy scrutiny processes and delays associated with the HRPTS recruitment process have exacerbated these pressures. It is noted that 44% of the referrals that have been made to the team in this period were screened out, as not being a safeguarding concern. This screening process is a time consuming function of the ASGT which across any week absorbs approximately one-third of the staffing resource. All referrals must be subject to administrative and governance processes regardless of the outcome and this is a staff-intensive process. There is continued concern about the use of such a level of staff resource to manage a high level of *"inappropriate"* referrals to the ASGT.	It is anticipated that the implementation of the new Regional Adult Safeguarding Policy will assist in better definition of protection and adults in need of protection cases and that this will in turn reduce the levels of inappropriate referrals made to the team. The Service Area is acutely aware of the impact this will have on its core services. This will be taken into consideration during the implementation of the recommendations within the Workforce Review and the investment required. The Trust is currently reviewing its adult safeguarding service delivery model and structures across all Service Areas to ensure that the arrangements put in place can deliver the best possible outcomes for adults at risk or in need of protection and the best use of available resources.	These risks are recorded on the Directorate Risk Register

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	Upon further analysis of the activity levels, it is apparent, that it is in the area of nursing and residential home, and domiciliary provision that there continues to be a significant need for investigation. These investigations are complex, require a significant time commitment and often involve multiple service users. Furthermore, the investigations can involve PSNI and may have to run parallel with various organisations' disciplinary processes. However, the ASGT encounter issues in relation to the progression of investigations, particularly in those which are being led by the Public Protection Unit. This can manifest as delays in terms of the identification of investigation officers, commencement of investigations, delays in witness and ABE interviews.	The Trust has met with the PSNI to share concerns in relation to these issues. Staff in the ASGT are pro-active in addressing such delays with the PSNI, albeit that this can be labour-intensive. The implementation of the new Joint Protocol should reduce the number of referrals to the PSNI, which in turn has the potential to reduce some of these difficulties.	These risks are recorded on the Service Area Risk Register
	AVAILABILITY OF DOMICILIARY PACKAGES The domiciliary care market remains challenging. The slow pace of the procurement process has been a contributory factor. In addition, the Service Area feels that procurement is focused on task orientated service delivery models and has not taken full cognisance of the personalisation agenda	The Service Area has developed a single point of access for domiciliary care packages in the form of the roll out of the Community Access Centre. This allows the Service Area to access contemporaneous information to inform prioritisation based upon identified risk. The waiting list for domiciliary care is reviewed on a daily basis to identify risk and review availability of services to enable the Service Area to reduce delay and understand demand.	These risks are recorded on the Corporate Risk Register

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	CAPACITY There is a continual decrease in the capacity of community services providers to meet demands for domiciliary packages due to increased need from hospitals and a shortage in available hours. This is particularly felt in the South and East sector where there are increased demands from the Ulster Hospital with limited services available in certain areas. On 22 March 2016 there were 287 clients awaiting a care package and the overwhelming majority of these were people living in their own homes Pressures are also particularly felt in Community Rehabilitation and Reablement services, where patient flow is reduced due to pressures and long waits in accessing domiciliary packages for those exiting these services. This significantly impacts on these services' length of stays and in their current failure to achieve commissioning targets. The Service Area undertook an audit of services commissioned. Findings highlighted an unacceptable level of 15 minute calls being commissioned with a task focussed approach based on assessments that are undertaken by non-professionally qualified staff.	Reducing the over reliance and over prescription of domiciliary care packages is a key area for improvement for the Service Area which it expects to bring about with the implementation of the Workforce Review through professional social work assessment and review and meaningful engagement with service users and carers in relation to meeting their assessed needs.	

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	REABLEMENT CHALLENGES The Service Area has been particularly challenged in its delivery of a Reablement Service in this reporting period. In October 2015 additional funding was received from the Commissioner to increase the capacity of the Service to take 200 referrals per month. Progress on this has been hampered by a number of factors; ➢ Limited capacity in the domiciliary care market ➢ Blocks at the exit stage for service users assessed as requiring a domiciliary care package leading to long lengths of stay. ➢ Inability to manage and control demand for domiciliary care due to low levels of professional review. ➢ Unprecedented high levels of absenteeism amongst rehabilitation support workers ➢ Difficulties and additional demands associated with HRPTS and Shared Services implementation/processes. The difficulties and frustrations associated with HRPTS and Shared Services are concerning. To date managers have had to repeat the recruitment exercise three times and are now entering a fourth period of recruitment. During this process it has been noted by managers involved that each advertising event attracts significantly fewer	As well as the remedial action discussed around domiciliary care challenges, the service area is working with HR on all these issues, including the management of absence. The Service Area feels disempowered in making improvements to these processes however recruitment processes will continue until the full complement of staff are in post and a waiting list developed These issues are being raised through the Trust's HRPTS user group.	

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	applicants than ever before for Band 3 posts. There is empirical evidence to suggest that having an electronic application process is impacting adversely on those applying due to difficulties in navigating the on line application process. Whatever the reasons, the recruitment process in this case has proved to be labour and resource intensive and ineffective and has had a significant negative impact on the Service's expansion and ability to meet targets.		
	CHALLENGES IN DELIVERING STATUTORY EMI PROVISION The Trust currently has five EMI residential homes. One of these homes, Ballyowen was the subject of a public consultation proposal to re-provide as a supported housing scheme for people with dementia in the West Belfast lower Fall's area. Ballyowen is now closed to permanent admissions and currently has occupancy of eight permanent residents. Work has commenced on the new supported housing scheme which will provide thirty dementia specific apartments. The expected completion date for the scheme is December 2017. Not surprisingly the demand for EMI homes continues to reduce. This is reflected in the occupancy levels which are currently 53% across the five homes. Taking out Ballyowen the		

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	occupancy across the other four homes is currently sitting at 62%. A number of factors are having an influence on demand as follows: ➢ Increase in numbers of people with dementia being supported at home for longer ➢ Increase in supported housing options- currently there are 90 places across three schemes ➢ The ageing stock of homes is out-dated in design. As such the built environment has significant limitations in compensating for disabilities associated with dementia and are not in keeping with best practice in dementia care in terms of promoting independence meaningful occupation, social inclusion, quality of life and citizenship ➢ They are all locked environments and as such deprive all people who live in them of their liberty In addition over the last three years, the Service Area has struggled to appoint and retain permanent managers in these homes. Providing professional and managerial leadership to this sector is a significant challenge. Currently all four EMI homes have interim managers in post all of which are designated managers of other Day Care Centres. This is having a destabilising effect on the Service and service delivery.	The Service Area is undertaking an internal review of these homes. The terms of reference are as follows: ➢ To review the underlying and situational factors impacting on the current difficulties in complying with regulatory requirements in relation to the recruitment and retention of permanent registered managers in line with the Residential Care Homes Regulations (NI) 2005 and minimum care standards ➢ Identify areas where service development and service improvement is necessary and outline how this might be achieved ➢ Determine and clarify the EMI homes long-term future role in dementia care The Service Area has also made an application to the DHSSPS requesting approval for a temporary "Recruitment and Retention Premium" to attract managers to the posts and is working towards temporarily appointing deputy managers to support the registered manager.	The risks associated with the recruitment of registered managers is on the Corporate Risk Register

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	SKILLS MIX WITHIN INTEGRATED CARE TEAMS As referenced in previous reports, in this Service Area the mean percentage of social care staff that are professionally qualified social workers is approximately 30%. This would be significantly lower than in other service areas. This has an impact on the service area's capacity to discharge delegated statutory functions in a timely and equitable way. There are particular pressures around the completion of NISAT assessments, Carers Assessments, adult safeguarding, reviews and the management of complex cases.	The Social Care Workforce Review has identified that there needs to be a rebalancing of the current skills mix within Social Care in Integrated Care Teams and significant investment in the professional workforce. It is acknowledged that the Service Area has not been in a position to invest sufficiently in the training and development of Band 4 staff. The Service Area is currently working towards the development of a training profile for this group of staff. However, the Service Area will face challenges in resourcing this additional training requirement and will be seeking additional funding to support this as part of a wider funding application for training and development.	These risks are recorded on the Service Area Risk Register
	CARE MANAGEMENT Within the Service Area, the care management function has traditionally been delivered by the designated roles of Care Manager and Assistant Care Manager. With increasing demands, overtime this role has significantly changed from the vision set out in People First. This had led the Care Management role towards a	As a result of the Workforce Review, the care management assessment, care planning and review functions will be undertaken by the core Band 6 Social Worker role. This will result in the phasing out of current care management structures and roles. To facilitate this, current levels of skills mix within Integrated Care Teams need to be urgently addressed, to ensure that there are adequate numbers of social workers to carry out professional tasks and undertake the care management function.	**These risks are recorded on the service area's risk register.**

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	more bureaucratic and task focused process which has undermined the therapeutic relationship between staff and service user. Whilst acknowledging the commitment and dedication of care management staff, it is felt that the current role of care management is no longer the best model to move forward with.	The Service Area recognises that this will require social workers to undertake a new range of skills and knowledge. It is critical to maintain stability within the Service Area, that social workers receive training in relation to new areas of working and that they are supported through this transition. The management and review of long term placements, is to be moved from the Integrated Care Team structures to a newly established Older Person's Care and Placement Review Team. This team will be a multi- disciplinary team and will aim to enhance the quality of life and protect the rights, of people in long term care.	
	INSTABILITY OF THE INDEPENDENT NURSING AND RESIDENTIAL SECTOR There has been significant instability and turbulence within the Nursing and Residential Home sector which has led to a number of home closures which have affected Belfast Trust residents. These include: Stormont Nursing Home (closed Feb 16) Victoria Park EMI Nursing Home (closed Feb 16) Stewart Memorial Home Bangor – (closing April 16) one resident affected due to home closure Hollygate Nursing Home – due to close on 2nd July		**These risks are recorded on the service area's risk register.**

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	2016. There are thirteen permanent residents. Oakmount Nursing Home in Bangor – whilst this is not closing, the home is being re-categorised which means that current residents need to move to EMI Nursing Care A recent audit which looked at the outcomes for people transferred to another nursing home as a result of the above closures, revealed an unusually high level of deaths within a short period of time. Whilst there were multiple reasons for this, it does highlight the impact of home closures upon residents and the importance of well-planned transitions This did not reach the threshold of a serious adverse incident, however the service area considers that it is significant and warrants a Significant Event Audit to be undertaken to inform and share learning. In addition, evidence is emerging to indicate a profile change in people being admitted to nursing care in that 25% of people die within three months of admission with a significant number dying within the first year. Clearly many of these people are in the End of Life stage which challenges the concept of the statutory annual review. There is a clear need for more	A Significant Event Audit will be undertaken to ensure that the learning is shared and implemented across the Service Area. The Workforce Review's recommendation in relation to a specialist multi-disciplinary Older Persons Care Placement and Review Team will ensure that people	

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	frequent reviews to review and re-assess frequently changing needs, protect the rights and ensure best interests, quality of life and the quality of their death.	are reviewed in accordance with their assessed needs and that rights are protected with increased assurances around quality of care and quality of life and death. Information will also be collated to inform trends, learning and practice development and the taking of appropriate actions to continually enhance service delivery.	
	SELF DIRECTED SUPPORT AND DIRECT PAYMENTS The uptake of Direct Payments within the Service Area remains comparatively low. The envisaged benefits of this model of service delivery have yet to be felt widely across the Service Area. The personalisation agenda which is envisaged within Transforming Your Care will be challenging to deliver within the Service Area.	The Service Area is working closely with the Trust Self- Directed Support Implementation Officer to ensure that staff are kept appraised of developments in this area and to develop strategies to address the challenges that exist. The appointment of a senior manager to develop and operationalise the concept of Older Peoples Community Hubs, working to integrate the community and voluntary sectors, is expected to support the development of an infrastructure that will support and assist personalisation.	

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	HRPTS HRPTS continues to place increased demands on managers' workloads, as they continue to spend lengthy periods of time undertaking administrative tasks. Processes are complex and at times unreliable and this has made recruitment and selection processes more cumbersome. This has been exacerbated by the further implementation of Shared Services, as it can be challenging to staff to access appropriate support. To date the system has failed to deliver overall benefits for the Service Area.	A working group has been set up to address concerns but progress on the issues raised has been slow.	
	MANAGEMENT INFORMATION SYSTEMS The Service Area has achieved the full implementation of the Central Information System across all its services. However, a key issue for the Service Area remains its capacity to provide key, assured service data to measure performance, activity and outcomes. An under-developed information culture within the Service Area is now recognised as a major constraint to understanding demands, pressures and outcomes.	The Service Area has appointed an Information/Business Manager and a Business Support worker to progress the Service Area's capacity to improve information availability and quality. It is expected that this will introduce a robust information management, collation and assurance processes to provide qualitative data to inform levels of demand, activity, performance, outcomes and future service delivery investment and development. Already these posts are assisting the Service Area to understand the breadth of the challenges in this area.	

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
		They have identified as a key issue for the Service Area as the inconsistency in the information loaded onto CIS which causes significant variance in reports from CIS. To address this issue, the Service Area is currently recruiting a Band 6 Training Officer for CIS to review current staff practices and to support staff to achieve consistency across the Service Area.	

3.8	**Key Social Work Workforce issues, including recruitment, retention, flexible working arrangements, workforce continuity etc. Information provided should include level and type of vacancies and any vacancy control systems in place.**
	The Social Work and Social Care Workforce review represents a restructuring of staffing roles and responsibilities across the Service Area, in both Integrated Care Teams and Hospital Social Work. **Investment in the professional workforce** As previously identified the issue of skills mix, remains a critical issue within Integrated Care Teams. The envisaged development of the social work role in Integrated Care teams will require significant numbers of additional social workers to ensure that the Service Area has the correct skills mix to deliver the vision set out in the Workforce Review. Historically, investment in professional social work staff has been low across community services. To achieve the goal of a professionally led service in which access to service delivery is informed by a professional assessment, the Service Area will need substantial additional investment. Identifying this additional funding is proving challenging in the current financial climate, yet it is essential to ensure that the Service Area is in a position to meet the complexity and volume of its statutory service delivery responsibilities. As the Service Area undergoes this period of change, a number of vacancies within the workforce are to be held for those staff affected by organisational change. As highlighted before there is a risk of significant instability as the Service Area moves through this change process. **Gerontological Model of Social Work** At the core of the Service Area's vision is the development and implementation of a model of social care service delivery to older people which recognises old age as a distinct part of the developmental life cycle and addresses the specific challenges of aging by promoting independence, autonomy, and dignity in later life. To that end the Service Area is keen to develop a model of Gerontological Social Work promoting a strengths-based approach that focuses on the specific needs of Older People. The Service Area is currently developing a training strategy in relation to this but recognises that they will be unable to move forward within current training resources and will require additional investment in this area. **Career Pathway for Social Care Staff** A key theme arising during the consultation for the Social Care Workforce Review is the limited opportunities for Band 4 social care staff to access a pathway to professional qualification within an employment based route. In this context the development of a social care career pathway which linked to accredited learning opportunities and career progression at both practice and managerial levels is a pressing issue.

	All applications for flexible working arrangements are considered under the Trust's Work Life Balance Policy and facilitated in accordance with Service Area needs.
3.9	**Trusts should provide a copy of their charging policies and provide explanation of what aspects of service provision you apply this to.**
	Home help Service – The Trust operates in accordance with the Model Scheme for the Provision of a Home Help Service **Residential & Nursing Homes Charging** – The Trust operates in accordance with the DHSSPS April 2015 Charging for Residential Accommodation Guide (**CRAG)** to determine charges.
3.10	**Social Workers that work within designated hospitals? Give an account of how these duties are fulfilled by Social Workers working in these designated hospitals**
	Hospital Social Work Teams are located within the Trust's three main acute hospital sites. There are also dedicated social work teams based at Meadowlands and Musgrave Park Hospital. The Service Area has organisational and professional management responsibility for the Trust's entire services social work workforce in these service locations (with the exception of the RBHSC and Royal Jubilee Maternity Hospital). Social workers within the Community Mental Health Team for Older People take a lead role in the assessment of need and co-ordination of the discharge of all patients from the Dementia Inpatient Service at Knockbracken and older patients in ward L, Mater Hospital, receiving POA services. Social workers work across a range of diverse multi-disciplinary wards and departments. These include ED, Medical and surgical wards, specialist services and inpatient treatment units i.e., Neurosciences, Spinal Injury Unit, Regional Acquired Brain Injury Unit, Stroke Unit and mental health services for older people wards including dementia. Child and adult safeguarding referrals are screened and assessed by hospital social work staff. Hospital social workers are trained and act as Designated and Investigating officers in adult safeguarding investigations. Hospital Social Work has faced unprecedented challenges in recent years through the growth of the unscheduled care agenda, re-location of services and the high level of scrutiny associated with hospital performance and discharges. Hospital Social Work has at times struggled to define its role and priorities within this context. This has significantly impacted upon core functions, such as assessment and timely case closures. Increasingly hospital-based social workers are undertaking a screening function as opposed to carrying out

assessments. The challenge for the Service Area is how to best allocate resources so that the service can best respond to those service users whose social needs are non-complex and those that require a professional social work service.

The Service Area intends to review the levels of screening, assessment, recording and intervention required in complex and non–complex social work referrals. This will assist the Service Area to decide the level of skills mix necessary across all parts of hospital social work service delivery including specialist areas. However, it is anticipated that an increased skills mix of Band 4 social care staff will be required across hospital settings to manage non- complex social care referrals.

Despite the constant focus on hospital discharges, the identification and reporting of complex discharges continues to be poorly understood within the hospitals. Factors that continue to hinder effective and timely discharge are:

- Multiple discharge pathways to community care services in other Trusts.
- The constant pace of internal organisational change within the Trust's hospitals that affect wards and which require ongoing reconfiguration of social work alignment.
- Challenges in discharging older patients with a dementia, delirium or alcohol related dementia.
- Relatives refusing discharge on the basis of waiting on a home of choice.

A Rapid Access Primary Care Service (RAPS) has been introduced by the Service Area. This social care service provides assistance for patients in Belfast who require a home from hospital service. It is available seven days per week between 8.00am and 10.00pm and will respond to patients in Emergency Departments, Clinical Assessment Units, BCH Direct and inpatient wards in the Royal, City, Mater and Ulster Hospitals. The Service assists patients with practical supports for up to a maximum of three days including transport home, personal care, practical support, assistance with meals provisions and medication administration. The impact of this Service to date has been positive and initial evidence indicates that, since inception in November 2015, 173 hospital bed days have been saved by the availability of the RAPS service. The Service Area intends to undertake a review of the service model.

Moving forward the Service Area will have to consider the benefits of new models of discharge including "Discharge to Assess" models.

3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	Human Rights principles are mainstreamed and central to the design, development and practice of all Belfast Trust policies and proposals. One of the Trust's five core values is to treat everyone with respect and dignity – including colleagues, patients and clients. Cognisant of the intrinsic link between human rights, equality and disability, Belfast Trust policy makers and managers, when screening a policy, use a template which incorporates the human rights dimensions alongside the prescribed statutory equality and disability considerations. **Training** Mandatory Human Rights training is provided on an ongoing basis by the Learning and Development Team. This is targeted at all social work and social care staff. The Service Area works to promote a human rights approach in all social work and social care interventions and service delivery. Documentation is being reviewed and updated on an ongoing basis to ensure that consideration of the human rights of service users is inculcated into everyday practice and evidenced in decision making and recording. The Service Area has recently secured funding as part of the Social Work Innovation Scheme, to develop a toolkit for hospital-based social workers undertaking "Best Interest" decision making for those people who lack the capacity to make decisions about future care placements. In addition, this project aims to develop specialist knowledge amongst hospital social workers in balancing risks, human rights and the least restrictive options while facilitating the discharge process focused on the person's quality of life and best interests. The service area continues to fund the Alzheimer's Society for the provision of an advocacy service, for those service users who lack an independent voice, particularly those on the cusp of, or in receipt of institutional care.

HUMAN RIGHTS

3.12	Identify any challenges encountered in the balancing of Rights.	3.13 What action have you taken to manage this challenge?	3.14 What additional actions (if any) do you propose to manage any on-going challenges?
	ADULT SAFEGUARDING There continues to be a tension between the obligations placed by the Joint Protocol upon the Trust to report all incidents of suspected or alleged abuse to the PSNI and the right of an individual to choose not to pursue Police action. This is particularly relevant when dealing with victims of Human Trafficking.	Staff are supported to discuss these challenges within the Designated Officers and Investigating Officers support groups. The Service Area looks forward to the implementation of the new regional joint protocol procedures which should promote the individuals autonomy and choice, yet ensure that those at risk of the most serious of crimes are protected.	Ongoing
	DEPRIVATION OF LIBERTY ISSUES Further to the Cheshire West judgment (2014) in relation to deprivation of liberty issues, the Trust has been advised by DLS, that every person, either placed by or with assistance from the Trust, for example in an EMI unit will be likely deemed to have been deprived of their liberty. They have predicted that it is possible that Belfast Trust could be involved with well in excess of 1,000 persons who will be deemed deprived of their liberty. DLS have advised that the Trust will be required to bring forward a Declaratory Order application for each of these cases. Accordingly, the Trust will be required to pay Court fees in each case and will be liable for the fees of Counsel. In the most straightforward of cases which are dealt with without issue there is likely to be a cost to the Trust	The implications of this advice are significant in terms of financial and staff resources. The situation is exacerbated by the lack of up to date Deprivation of Liberty Safeguards guidance from the DHSSPS. Current guidance does not take cognisance of the Cheshire West ruling. The Service Area is currently seeking guidance from the Executive Director of Social Work who intends to raise it as a regional issue. The Service Area is currently seeking Declaratory Judgments in relation to 2 cases.	Ongoing

	of approximately £2000. In cases with added complexity the costs could be many times more. To date the Court has failed to issue guidance as to the practical way forward in DOL cases. Therefore DLS are now recommending that applications should be brought in all cases where there is a deprivation of liberty but mindful of the expenditures both financially and in terms of staff time it may be appropriate to prioritise cases which should be brought before the Court at first instance.		

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**

Hemsworth Court Community Integration Project

Through work on a community integration project, Hemsworth Court was integral in leading a project of working towards the development of a dementia friendly community in the Shankill area. Key aims of the project were to work in partnership with local statutory agencies and community groups to promote and secure the integration of Hemsworth Court into the wider Shankill community, raise awareness and address stigma associated with dementia.

Since commencing the project last year, 30 local businesses have signed up to become "Dementia Friendly" and their staff have received dementia awareness training, all of which has been hosted in Hemsworth Court. The contribution and excellence of Hemsworth Court has been recognised by a number of awards that the Service has received in this reporting period as follows:

In the Dementia Friendly community awards 2015, Hemsworth Court was recognised in the following categories:

- Best Community Initiative - Hemsworth Court Community Integration Project.
- Best Dementia Friendly involvement initiative in association with Spectrum Arts Centre - Social Sofa at Hemsworth Court.
- Best Dementia Friendly project - Spectrum Arts Centre – Social Sofa at Hemsworth Court.
- Best Dementia Friendly Educational Initiative with Glenwood Primary School Social Sofa Project at Hemsworth Court.
- Best Dementia Friendly educational initiative for work with the Hammer Youth Club - Take a Step in Someone Else's Shoes Project at Hemsworth Court.

Hemsworth Court was awarded the Epic Award – (April 2016) UK and Ireland Voluntary Arts Awards for excellence in work with people with disabilities.
The scheme also received runner up in Elevator Award – (Dec 2015) for Building Dementia Skills Capacity (Dublin City University and Health Service Executive)

Hemsworth Community Integration Project was also runner up in the Trusts Trust's annual Chairman Awards "Partnership Approach" category.

CLARE Project Mount Vernon

The Service Area has worked closely with the CLARE project to develop a network of support for older people in the Mount Vernon area of North Belfast. CLARE is a community led voluntary organisation that enables vulnerable adults and older people to maintain their

	independence and reduce feelings of isolation and loneliness. The project connects older People to existing support services and resources, provides help with practical tasks within the home and offers befriending opportunities that improve peoples' lives for the better. The CLARE project was recognised in the Trust's annual Chairman Awards, receiving first place in the "Partnership Approach" category.
3.16	**SUMMARY**
	This report has provided the opportunity to reflect on and review the challenges of social care service delivery to older people while also affirming a transformational vision underpinning the future delivery and development of services predicated on person centred, strengths based, needs led and empowering service delivery models. Within current integrated models social workers have struggled to understand and articulate their role. It has been difficult to sustain professional standards, particularly around the areas of assessment in the hospital setting and care management reviews. The Workforce Review has identified that outdated models of service delivery focused on the prescribing of domiciliary care and institutional care are no longer fit for purpose. The predominance of non-professional staff in the delivery of social care has marginalised the professional role and weakened the quality of services delivered to older people. This Service Area, through the lens of the Workforce Review, has been able to articulate a vision for social care service delivery to older people which is informed by: partnership and co-production; a robust and dynamic outcomes centred evidence base promoting resilience, inclusion and rights of older people; and is predicated on enhancing the workforce's skills, knowledge base and drive for quality and service improvement. The development of a Care Home Review Team will bring into sharp focus the needs of Older People in care and will enable the Service Area, to deliver on statutory obligations in relation to reviews. The development of a Gerontological model of social work will demand a focus on the holistic needs of older people, in particular, the importance of their social world-their own sense of personal esteem, inclusion and participation- as fundamental to their wellbeing and quality of life. However, the Service Area recognises that whilst this is an exciting time for Social Work with Older People, this transformational change will be challenging and complex in the delivery. The Service Area needs to ensure that service stability is maintained throughout implementation and to enable service users, carers and staff to be involved in and influence the development of services. The low number of professional social workers in the Integrated Care Teams means significant investment is required to develop professional social work capacity in older people's community services and related learning and staff development opportunities. If the Service Area is to face future demands and deliver on its vision, additional financial investment is crucial.

DATA RETURN 1
OLDER PEOPLES SERVICE AREA

1 GENERAL PROVISIONS			
		<65	65+
1.1	**How many adults were referred for assessment of social work or social care need during the period?**	**0**	**6121**
1.2	**Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?**	**0**	**4865**
1.3	**How many adults are in receipt of social work or social care services at 31st March?** This figure includes: a) Service users in receipt of intermediate care receiving Social Work support (9) b) Number of carers in receipt of a service (5.4) (363) c) The figure for 1.3a d) Total figure for 1.4	**0**	**7718**
1.3a	**How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?**	**0**	**621**
1.4	**How many care packages are in place on 31st March in the following categories:**		
	i. Residential Home Care	**0**	**699**
	ii. Nursing Home Care	**0**	**1853**
	iii. Domiciliary Care Managed	**0**	**3321**
	iv. Domiciliary Non Care Managed	**0**	**744**
	v. Supported Living	**0**	**108**
	vi. Permanent Adult Family Placement	**0**	**0**
1.4a	**For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular.** Care Management policies and procedures in the Service Area have been updated and reviewed in this period, to reflect the DHSSPS Care Management Circular. A new review proforma has also been developed to reflect the Circular and strengthen the focus on Human Rights Issues.		
1.4b	**Please describe how the Care Management process is being managed in this programme with particular reference to decision making levels, review and care**		

	planning, highlighting any particular difficulties being experienced and how they are being addressed. The Service Area aims to complete reviews within ten weeks of the commencement of a care package or placement, followed by annual reviews for care placements and six-monthly reviews for people in receipt of domiciliary care. As has been highlighted previously, compliance with these standards remains challenging for the Service Area. It is this context that the Service Area intends to move responsibility for the review of service users in long term placements to a newly-established Care and Placement Review Team. Furthermore, care management functions within Integrated Care Teams will be transferred to Band 6 Social Work staff who will ensure that reviews, decision making and care planning are professionally led.		
1.4c	**Please articulate how the views of service users, their carers and families are included in the decision making process, review and care planning.** Service users and carers are central to the care management process. Within the Service Area there is recognition that a number of service users have significant cognitive impairments which can act as a barrier for effective communication and involvement in decision making. The Service Area intends to develop a tool kit in relation to best interests decision-making and maximising service user and carer involvement. The Service Area commissions advocacy services for service users who lack capacity to contribute to their care in a meaningful way.		
1.5	**Number of adults provided with respite during the period**	*PMSI return*	PMSI return
1.6	**Number of adults known to the Programme of Care in receipt of Centre based Day Care** ***These figures relates to the number of service users registered with the day centre on 31 March 2016**		
	- Statutory sector	**0**	**839**
	- Independent sector	**0**	**462**
1.6a	**Number of adults known to the Programme of Care in receipt of Day Opportunities**	**0**	**79**
1.7	**Of those at 1.6 how many are EMI / dementia** ***This figure relates to the number of service users registered with the day centre on 31 March 16**		
	- **Statutory sector**	**0**	**193**

	- **Independent sector** There are no specifically commissioned EMI places in the independent sector but there could be service users with varying degrees of dementia attending. The Service Area is unable to disaggregate this information		
1.8	**Unmet need (this is currently under review)**	**X**	**X**
1.8a	**Please report on Social Care waiting list pressures** There are a substantial number of people awaiting domiciliary services for which they have been assessed. All assessed services are at a critical or substantial level of need. This is creating significant pressures and risks within the Service Area and resulting in an increased number of complaints by service users. There are a significant number of people awaiting a carer assessment across the Service Area. This is symptomatic of the impact of low numbers of professional staff across Integrated Teams who have limited resource to undertake the professional task of carer assessments. However, despite these pressures, the Service Area's performance in relation to Carers Assessments has improved over the reporting period.		
1.8b	**Please identify possible new service innovations that are currently supported by non-recurrent funding** The Service Area has been successful in securing £5000 from the Social Work Innovation Fund for the development of a toolkit to support hospital social workers to: ➢ Identify and where appropriate undertake an assessment of mental capacity. ➢ Develop best practice guidance to support best interest decision meetings and care planning. ➢ Develop standardised proformas to support staff in undertaking capacity assessments, recording of best interest decisions and developing person centred discharge plans. ➢ Develop a bespoke training programme which will equip staff with new knowledge in relation to how to safeguard the best interest of people with dementia or delirium		
1.9	**How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?**	**0**	**4**

1.10	**Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations.** ➢ Development of guidance in relation to best interest decision making and risk management across multi-disciplinary Teams to ensure integrated working in complex high risk cases. ➢ Guidelines have been developed for the management of those cases, where there is a dispute over the termination of services. ➢ Guidelines for the sharing and agreeing of the minutes of adult safeguarding strategy meetings with families.	~~*Board return*~~	~~**Board return**~~

Data for 1.5, 1.8 and 1.10 will be sourced by Board officers from existing returns.

DATA RETURN 1
HOSPITAL
OLDER PEOPLES SERVICE AREA

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	**How many adults or children were referred to Hospital Social Workers for assessment during the period?**	**94**	**3695**	**9804**
1.2	**Of those reported at 1.1 how many assessments of need were undertaken during the period?** The Service Area is not able to provide this information, as increasingly social workers are undertaking screening for discharge, rather than assessments. The system is currently not able to disaggregate these activities. The service area is working to develop an understanding of the levels of complexity in hospital social work and the appropriate levels of assessment.			
1.3	**How many adults or children are on Hospital Social Workers caseloads at 31st March?** The Service Area has been unable to disaggregate this figure by age group in this reporting period			**6837**

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

DATA RETURN 2

OLDER PEOPLES SERVICE AREA

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	**Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65**	**0**	**N/A**
2.2	**Number of adults known to the Programme of Care who are:**		
	Blind	**0**	**933**
	Partially sighted	**0**	**413**
2.3	**Number of adults known to the Programme of Care who are:**		
	Deaf with speech	**0**	**76**
	Deaf without speech	**0**	**48**
	Hard of hearing	**0**	**3486**
2.4	**Number of adults known to the Programme of Care who are:**		
	Deaf Blind	**0**	**127**

DATA RETURN 3

OLDER PEOPLES SERVICE AREA

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

DATA RETURN 4
OLDER PEOPLES SERVICE AREA

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

4.1	**Number of Article 15 (HPSS Order) Payments**	**22**
	Total expenditure for the above payments	**£696.02**
4.2	**Number of TRUST FUNDED people in residential care (123 people were self funding on 31 March 2016)** Figure relates to those in residential care on 31 March 16	**576**
4.3	**Number of TRUST FUNDED people in nursing care (557 were self funding on 31 March 2016)** Figure relates to those in nursing care on 31 March 16	**1296**
4.4	**How many of those at 4.3 received only the £100 nursing care allowance?**	**557**
4.5	**How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?**	**5**

DATA RETURN 5
OLDER PEOPLES SERVICE AREA

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+
5.1	**Number of adult carers offered individual carers assessments during the period.**	**0**	**1264**	**680**
5.2	**Number of adult individual carers assessments undertaken during the period.**	**0**	**493**	**156**
5.3	**Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?**		**0**	**0**
5.4	**Number of adult carers receiving a service @ 31st March** The Service Area has been unable to disaggregate this information by age of carer.			**363**
5.5	**Number of young carers offered individual carers assessments during the period.**			**0**
5.6	**Number of young carers assessments undertaken during the period.**			**0**
5.7	**Number of young carers receiving a service @ 31st March**			**0**
5.8	**(a) Number of requests for direct payments during the period 1st April – 31st March 16** As the Service Area did not anticipate the inclusion of this additional category in this year's return, it does not currently have in place a system for capturing this information accurately			**0**
	(b) Number of new approvals for direct payments during the period 1st April – 31st March 2016			**29**
	(c) Number of adults receiving direct payments @ 31st March			**115**
5.9	**Number of children receiving direct payments @ 31st March**			**0**
5.9.a	**Of those at 5.8 how many of these payments are in respect of another person?**			**0**
5.10	**Number of carers receiving direct payments @ 31st March**			**0**

5.11	**Number of one off Carers Grants made in-year.**	**437**
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		

Commentary

During this period 437 carer grants have been awarded and the Service Area has funded 350 complementary therapies. The Service Area has also supported carer support groups, a carers' pamper morning, carers' outings and a carers' residential.

The Service Area has contributed to the development of the Trust's Carers Strategy and is advocating for the rights of older carers and carers of older people. The Service Area is undertaking a carer assessments improvement project involving hospital services to increase the number of carer assessments offered in hospital settings as well as reviewing the information provided to carers. This is following an audit undertaken by the Service Area which centred on the identification of and information on supports to carers proffered in hospital settings.

DATA RETURN 6
OLDER PEOPLES SERVICE AREA

6 SAFEGUARDING ADULTS

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

DATA RETURN 7
OLDER PEOPLES SERVICE AREA

7 SOCIAL WORK STAFF

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 8
OLDER PEOPLES SERRVICE AREA

8 Assessed Year in Employment

TRUST RETURN SUBMITTED BY SOCIAL SERVICES LEARNING AND DEVELOPMENT SERVICE AND APPENDED TO THIS REPORT

DATA RETURN 9
OLDER PEOPLES SERVICE AREA

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

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	**Total Number of Assessments made by ASWs under the MHO**	**32**	Reported by RESW
9.1.a	**Of these how many resulted in an application being made by an ASW under (Article 5.1b)**	**25**	Reported by RESW
9.1.b	**How many assessments required the input of a second ASW (Article 5.4a)**	**0**	Reported by RESW
	Comment on any trends or issues in respect of requests for ASW assessment or ASW applications There has been an increase in the number of people who have been assessed under the Mental Health Order. The reasons for this are unclear. The Service Area intends to analyse this trend further with a view to informing its understanding of the reason for this.		
9.1.c	**Number of applications made by the nearest relative (Article 5.1.a)**	**0**	
	Comment on any trends or issues in respect of Nearest Relative applications for admissions		
9.1.d	**Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge?** Discharges within the Service Area are planned and involve the nearest relative as standard practice. The Service Area takes all practicable steps to inform the nearest relative at least seven days prior to discharge.		

Use of Doctors Holding Powers (Article 7)		
9.2	**How many times did a hospital doctor use holding powers?**	**5**
9.2a	**Of these, how many resulted in an application being made?**	**5**
ASW Applicant reports		
9.3	**Number of ASW applicant reports completed**	**32**
9.3.a	**How many of these were completed within 5 working days**	**32**
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken.	
Social Circumstances Reports (Article 5.6)		
9.4	**Total number of Social Circumstances reports completed.** *This should equate to number given at 9.1c. If it does not please provide an*	**0**

	explanation.	
9.4.a	**Number of completed reports which were completed within 14 days**	
	Please provide an explanation for any Social Circumstances Reports that were not completed within the requisite timescale, and / or any discrepancy between the number of Nearest Relative applications accepted and the number of Social Circumstances Reports completed, and what remedial action was taken.	**0**

Mental Health Review Tribunal

9.5 **Number of ~~referrals~~ applications to MHRT in relation to detained patients**

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**1**	**1**	**0**	**0**	**1**
Patient	**0**	**0**	**0**	**0**	**0**
Nearest Relative	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**
Total	**1**	**1**	**0**	**0**	**1**

Comment on any trends or issues in respect of Mental health Review tribunals

9.5.a This is intentionally blank

Guardianships (Article 18)

9.6	**Number of Guardianships in place in Trust at period end**	**0**
9.6.a	**New applications for Guardianship during period (Article 19(1))**	**1**
9.6.b	**How many of these were transfers from detention (Article 28 (5) (b))**	**1**
9.6.c	**How many were Guardianship Orders made by Court (Article 44)**	**0**
9.6.d	**Number of new Guardianships accepted during the period (Article 22 (1))**	**1**

9.6.e	**Number of Guardianships renewed during the reporting period (Article 23)**	**1**
9.6.f	**Number of Guardianships accepted by a nominated other person**	**0**
9.6.g	**Number of MHR hearings in respect of people in Guardianship**	

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**1 Case adjourned**	**0**	**0**	**0**	**0**
Patient	**0**	**0**	**0**	**0**	**0**
Nearest Relative	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**
Total	**1**	**0**	**0**	**0**	**0**

9.6.h	**Total number of Discharges from Guardianship during the reporting period (Article 24)**	

Discharges as a result of an agreed multi-disciplinary care plan	**2**
Lapsed	**0**
Discharged by MHRT	**0**
Discharged by Nearest Relative	**0**
Total	**2**

Comment on any trends or issues in respect of Guardianship

As stated previously, the Service Area is increasingly challenged in relation to those cases which involve both a Guardianship and a Deprivation of Liberty through the residency requirement. The Mental Health Review Tribunal are not dealing with these types of cases and have made a recommendation that Trusts obtain a Declaratory Order from the High Court giving approval for the Deprivation of Liberty. Guardianship cases are being adjourned pending the relevant Trust obtaining a Declaratory Order which is proving to be a lengthy process. The Trust is vulnerable in this position. The Trust has faced allegations of failure and delay in bringing procedures where the applicant might challenge their deprivation of liberty.

Approved Social Worker (ASW) Register		
9.7	**Number of newly appointed Approved Social Workers during period**	**0**
9.7.a	**Number of Approved Social Workers removed during period**	**4**
9.7.b	**Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)**	**3**

CORPORATE COMMENTARY

There has been a steady decrease in the number of ASWs available to participate in the Trust's Day Time Rota over the past number of years. There are concerns that the Trust, under the present arrangements, will not have capacity to meet the statutory requirement set out in Article 115 of the Mental Health (NI) Order 1986 (the Order) in respect of the availability of ASWs to discharge the range of statutory functions as specified in the Order.

While four social workers from the Trust are currently participating in the Regional ASW Training Programme and hopefully will be assessed as competent, they will not be available for appointment by the Trust until October 2016 and will then be required to undertake a period of "shadowed practice" before they can operate as autonomous practitioners. Therefore this could result in them not being on the Daytime Rota until January 2017.

The potential addition of these four social workers will not fully offset the number of ASWs lost through retirement/those who have moved to other posts/other Trusts/ RESWS. Of the cohort of twenty-eight, one has already indicated that, due to demands of work as a Team Leader, they will be withdrawing and another has indicated they will be retiring in June 2016.

The Trust has twenty-eight ASW trained staff currently on the Daytime Rota. Training of additional ASW staff has been identified as a priority within the Service Area. Nominations for the 2016/17 Regional ASW Training Programme are presently being collated.

Additional ASW duties include Guardianship-related functions and inputs into MHRT cases in light of their knowledge, skills and experience in this area. ASWs also provide a consultation role to those teams/services which do not have ASWs or social workers. Service Area ASWs participate in refresher training throughout the year and re-approval training every three years.

Due to the pressures of the ASW rota the 'floater' has been replaced as a third member on the ASW rota. This is because it is a regular occurrence that all three ASWs on the Rota on a daily basis are called out to assess patients. On a regular basis there can be multiple ASW assessments requested on the same day.

It is now a regular occurrence that ASWs on the Daytime Rota have to wait substantial lengths of time for the ambulance and PSNI to support the conveyance of service users to hospital in those circumstances in which significant risks to the service user or others are extant. These situations are exacerbated by difficulties in accessing beds in the Trust's area. This results in ASWs having to accompany those requiring admissions to hospital to units across the region. Such episodes can significantly impact on the ASWs' ability to fulfil the requirements of their core posts.

	An inter-agency group involving representatives from the PSNI, the NI Ambulance Service and Trust's Unscheduled Care, GP Out of Hours and ASW Services has been established to address interface matters relating to their respective responsibilities and pathway processes pertaining to assessments for admission under the Order. The Trust has completed a review of ASW activity. The Review highlighted a number of key organisational, logistical and professional issues impacting on the delivery of the ASW Daytime Rota including: the diminution over a number of years of the complement of designated social work posts in the Mental Health Service Area; the increase in demands on available social work resources of the exponential increase in adult safeguarding activity and, in particular, the projected and current impact to date of the Revised Adult Safeguarding Policy determination that social work will be the lead profession in safeguarding service delivery; the increasing complexity of ASW-related activities; the impact of the difficulties of out- of -Trust admissions; the difficulties associated with interfaces across the PSNI, Ambulance Service, Unscheduled Care and ASWs in respect of assessments for admission; the need to develop a robust workforce planning approach to social work requirements in Mental Health (including ASWs) incorporating the implications of the Mental Capacity legislation; and the resourcing of and supports for staff engaged in the Regional ASW Training Programme. The Review's proposal for the establishment of a hybrid ASW core team to address the immediate pressures on service delivery and to ensure the Trust's capacity to discharge its statutory functions has been agreed and is currently being actioned. The Principal Social Worker (PSW) in Mental Health with operational responsibility for the co-ordination of the Rota works closely with the Regional ASW Group in relation to the review of documentation to ensure a consistent approach across the region. In addition, the PSW has also revised local ASW documentation relating to alternative care planning for patients who have been assessed as not requiring detention for assessment under the Order. Breakaway training has also been scheduled for June 2016 for all ASWs on the Daytime Rota. In-house bespoke training has also been completed on the Regional Interagency Protocol in February 2016. ASWs have been appraised of the PSNII risk assessment process for thresholding and prioritising referrals and have been advised of the importance of providing clear and factual information in respect of assessed risks when requesting PSNI assistance. The PSW has reviewed as a priority the provision of reflective practice supervision sessions for ASW staff. These are now "up and running" and take place on a 6-8 weekly basis. The PSW has also re-launched the ASW Forum which meets twice a year. Attendance at the ASW Forum alternates with the reflective practice groups and attendance is mandatory (i.e. 75% attendance). The Trust will continue to review and develop supports to its ASW workforce. The Regional Audit of Assessments for Admission under the Mental Health (NI) Order 1986 was launched in March 2016. The Report will contribute to an ongoing Trust focus on improving ASW organisational and service delivery arrangements and the management of internal and external interfaces. Trust senior management are reviewing a number of interface issues across the RESWS and the Daytime Rota. The Trust has robust administration structures in place to monitor ASW

	numbers, accreditation and re-accreditation arrangements.	
9.8	**Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If so please provide detailed explanation for each and every instance including their age and relevant powers used.** NO	
9.9*	**How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?**	**16**
	Issues or trends relating to notifications to the office of care and protection and on-going management of such arrangements There continue to be ongoing difficulties for those service users who have no capacity/ no family members to assist in the management of monies. The Trust is no longer able to manage the financial affairs of service users as per the direction of the Office of Care and Protection. The cost of appointing a professional controller is £1000 per year which is a significant additional expense for service users. Staff who were to assist service users could be open to allegations of misappropriation of service users' funds. The Office of Care and Protection has provided two question and answer sessions for staff during this reporting period	
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). **Schedule 2A Supervision and Treatment Orders.**		
9.10	**Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March**	0
9.11	**Of the Total shown at 9.10 how many have their treatment required as:**	
	Treatment as an in-patient	**n/a**
	Treatment as an out patient	**n/a**
	Treatment by a specified medical practitioner.	**n/a**
9.12	**Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)**	**n/a**
9.13	**Of the total shown at 9.10 how many of these supervision and treatment orders were *made* during the reporting period.**	**n/a**

PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

3.1	Named Officer responsible for professional Social Work

The person's role and responsibilities and their direct line of accountability to the Director of Social Work should be explained.
Trusts must provide assurance that the prescribed audit of the application of this scheme has been carried out by the lead Social Worker.

Ms Bernie Kelly is the Associate Director of Social Work for the Physical and Sensory Disability Service Area (PSD). She is accountable to the Executive Director of Social Work for the assurance of organisational arrangements underpinning the discharge of statutory functions related to the delivery of social care services within the Service Area.

The Associate Director of Social Work is responsible for:

- Professional leadership of the social work and social care workforce within the Service Area;
- The establishment of structures within the Service Area to monitor and report on the discharge of statutory functions;
- The provision of specialist advice to the Service Area on professional issues pertaining to the social care workforce and social care service delivery, including the discharge of statutory functions;
- The collation and assurance of the Service Area Interim and Annual Statutory Functions Reports;
- The promotion and profiling of the discrete knowledge and skills base of the social care workforce within the Service Area;
- Ensuring that arrangements are in place within the Service Area to facilitate the social care workforce's learning and development opportunities;
- Ensuring that arrangements are in place within the Service Area to monitor compliance with NISCC registration requirements.

An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through the Service Area line management and professional structures to the Executive Director of Social Work and onto the Trust Board. With the exception of the Community Brain Injury Team and the Care Management Team, all of the first line manager posts within the Service Area have designated social work status.

The Associate Director of Social Work has assured the Service Area Report which meets the requirements of the prescribed audit process in respect of the discharge of statutory functions.

3.2	Supervision arrangements for social workers

Trusts must make reference to: Assessed Year in Employment (AYE) and compliance and Caseload weighting arrangements.

Assessed Year in Employment
The Service Area has no social workers currently undergoing their Assessed Year in Employment (AYE).

Supervision
The Service Area has achieved satisfactory compliance with supervision requirements and ensures each social work practitioner has regular one to one supervision. The four regulated day care services are inspected by RQIA and through their inspections they continue to demonstrate that they are compliant with the Trust's supervision policies.

The Service Area participated in a Trust-wide audit of social work supervision during the reporting period evidencing satisfactory compliance with the requisite standards. The Service Area continues to submit exception returns on a monthly basis to monitor its ongoing compliance with the delivery of professional social work supervision.

Supervision affords a mechanism for addressing organisational engagement, performance and accountability and a vehicle for feedback and reflection which are fundamental dimensions to learning and development. Under the auspices of the Regional Social Work Strategy a revised regional adult social work supervision policy and standards is being developed with a strong evidence based-focus, linking investment in supervision delivery with enhanced workforce knowledge and skills and improved service delivery outcomes. The revised policy will incorporate a range of supervision delivery options incorporating group and peer supervision models within a strong emphasis on reflective approaches.

As well as staff having access to supervision they have access to peer support groups. Social workers also attend Investigating Officers fora, Designated Officers fora and Achieving Best Evidence Support fora. Day Care staff have opportunities to shadow their peers in other centres. All of these initiatives enable and promote reflective learning, facilitate opportunities to address practice and service delivery challenges and to enhance staffs' professional and personal development.

In addition to the above, the Service Area, together with the Older Peoples Service Area (OPS) participates in joint social work fora. These provide staff with structured space to consider practice and service delivery issues. Areas addressed areas have included the Regional Social Work Strategy, the OPS Workforce Review, out of hours working arrangements for social work and social care staff, Human Trafficking and Self Direct Support.

	The senior management of PSD and OPS hold a quarterly Social Work Leads Forum to discuss social work issues and developments. These processes reflect the Service Area's commitment to sharing best practice and to continuous improvements in service delivery. **Caseload Weighting Arrangements** The Trust does not currently have a bespoke caseload weighting system for social work in adult services. Social work staff in one of the Physical Disability Teams has participated in the regional workload management pilot as part of the Social Work Strategy and this will be evaluated in the next reporting period. Currently the Service Area utilises supervision as a method to provide a regular, focused opportunity to review the supervisee's caseload and to determine allocation of work.
3.3	**Report on processes, audits, reviews, research and evaluations undertaken during the year, that measure performance against delegated statutory functions, identifying emerging trends and issues (may include cross references to other sections to this report).**
	Duty Referral and Allocation Procedure/Process The Service Area ensures that each team adheres to its duty, referral and allocation procedures which detail the screening and allocation processes and related professional responsibilities. The Sensory Support Service complies with the Regional Sensory Services Guidelines and Procedures. Team leaders and Senior Practitioners are responsible for assuring compliance with the Procedures. The Day Care sector within the Service Area adheres to the Trust's Procedures for Day Care Services which are compliant with RQIA standards. **Audits Reviews and Evaluations** **Community Brain Injury Team (CBIT)** Following the RQIA Review of Acquired Brain Injury Services in September 2015, the Trust established an Action Plan Working Group to take forward the twenty-three recommendations of the Review. The Service Manager is a member of the Working Group. The Trust held an event for brain injured service users, their carers and the voluntary sector on 15 April 2016 in an effort to improve engagement. The Assistant Service Manager with responsibility for CBIT is currently undertaking a regional quality improvement programme with a view to improving service user engagement. The Community Brain Injury Team continues to maintain access to service within the target of thirteen weeks from referral. There have been no breaches. The Service Area is undertaking service improvement within CBIT which includes better pathways and interfaces with the Regional Acquired Brain Injury Unit and appointing a Clinical Lead and a Band 8A

managerial post following the departure of the Clinical Lead in December 2015.

Review of Day Care Services
The scoping exercise and review of day support services which commenced in the previous reporting period, continues to be a key action for the Service Area as it has identified the need to modernise how services are delivered. Working groups continue to focus on communication, service profiling and re-design and outcomes and standards. It is envisaged that this work will progress throughout the next reporting period.

Monthly audits of day centre files continue to be completed and service user feedback is sought on a monthly basis as directed by RQIA standards for Day Care.

Recurrent funding has been secured for the continuation of two Community Access Worker posts. The role of community access is integral to the modernisation of traditional day care provision. The Community Access Workers to date have provided support to 128 individuals. This model is a driver to achieving the targets set for Self Directed Support, delivering day opportunities to promote service user independence. Individuals referred to the programme benefit from greater opportunities as a result of working in close partnership with local community, voluntary and public sector agencies.

Review of the needs of People with Sensory Loss (RSIG)
As referenced in last year's report, the Regional Sensory Implementation Group (RSIG) of the Physical and Sensory Disability Strategy reviewed the communication needs of people who are profoundly deaf. An option appraisal for future working was identified and it is proposed that this will go to public consultation in the next reporting period.

Following the reporting of a regional analysis of the needs of deaf/blind service users, the Service Area will be recruiting a Rehabilitation Assistant to support the Sensory Team and other Service Areas to take forward the recommendations of the Review's findings.

Carers
A strategy planning group was formed to develop a new Carers Strategy for the Belfast Trust. This group was made up of Trust staff from across services and carers from the Carers Reference Group. It examined carer strategies from across the British Isles and relevant policy documents in detail. In this reporting period the group also carried out a review of all carer engagement activity carried out by service groups. From this research the group determined key themes which would form a basis for the new strategy and best practice to form a framework for this document.

Specific focus groups were facilitated with Roma, Traveller and other ethnic minorities by workers specific to their communities to ensure

"lesser-heard" voices of marginalised groups of carers had the opportunity to contribute to the strategy development.

In February 2016, a Trust-wide workshop was held which brought together carers, Trust staff from all levels and services, and representatives from voluntary and community sector organisations. The aim of the workshop was to reflect on the engagement work carried out by the Trust and to further refine key objectives and actions for the new Belfast Trust Carers' Strategy.

Vascular Rehabilitation Beds

A regional review of vascular services in Northern Ireland was undertaken in 2012 and the Review Report is currently out for consultation. Demand for this service has increased and acute services have noticed that the patient group most affected by a delay in their care pathway are those who have undergone limb and toe amputation.

Whilst the Trust awaits the outcome of the regional vascular review, the Service Area has agreed to participate in a pilot for a regional vascular rehabilitation bed service which is available to all adults who have undergone amputation. The Service Area has secured two rehabilitation beds in a nursing home to enable those patients deemed medically fit to be discharged to continue with their on-going rehabilitation treatment. This service commenced late into this reporting period and will be closely monitored over the next reporting period to determine if it is fit for purpose and value for money.

NISAT

On-going review of NISAT has identified that a Version 4 of the electronic assessment tool is ready to be rolled out within the Trust. The Service Area is pleased to report that it will commence implementation of Version 4 NISAT in June 2016. Staff welcome this as they envisage that the changes will be more user and staff friendly.

Generic Reviews, Audits and Evaluations

Service user engagements via specific working groups or forums continue to be utilised and are seen as an integral part of service development as their feedback is vital in modernisation initiatives. These are undertaken in all departments within the Service Area.

The Service Area continues to audit and review service delivery to improve and sustain good practice. Team leaders carry out random case file audits during each supervision session and Assistant Service Managers complete audits to ensure supervision standards are met.

Each team and Day Care facility is required to complete a wide range of statistics which include caseloads, referral and closure numbers together with carer, direct payments and adult safeguarding activity. These figures are monitored and analysed by the Service Area to identify any emerging issues or trends.

	The Service Area continues to monitor issues related to quality, adverse incidents, Departmental queries, complaints and compliments via quarterly Governance meetings which are chaired by the Service Manager and supported by the governance lead for the Service Area. The purpose of these meetings is to identify key themes and trends and discuss the learning which is shared and disseminated to staff via team meetings and professional support forums. The Governance meeting also has processes in place to review and manage the Risk Register. The Service Area is pleased to report that there have been no Serious Adverse Incidents in this reporting period. **Contracts with Voluntary Sector** All contracts are monitored by staff at managerial level. Key staff hold regular meetings with the voluntary agencies throughout the year to ensure targets are met and quality of service and value for money secured. Any concerns are raised with the Service Manager who will participate in at least annual reviews to agree performance and to determine the appropriateness of contract renewal. Voluntary agencies also complete their internal audits to ensure that service user satisfaction and outcomes are achieved. **Contracts with the Independent Domiciliary Care Organisations** The Service Manager meets with all commissioned providers at least annually to ensure value for money through a qualitative and quantitative scrutiny process. **Reflective Practice Groups** As previously mentioned in 3.2 above, the Service Area promotes a peer support model within individual Teams, managers groups and social work fora. These groups are invaluable in terms of communicating and discussing lessons learned from research and considering implications for practice.
3.4	**Report on the Programme of Care's interfaces with other statutory agencies including for example: NISCC; RQIA; PHA (in relation to social care)** **Trusts should include references to Judicial Reviews or other significant Court Judgements that directly impact on the discharge of statutory functions.**
	NISCC The Service Area is compliant with the regulatory requirements in relation to the registration of the social work and social care workforce. The Service Area promotes and facilitates staff access to training and other learning opportunities so that they are able to complete their NISCC PRTL re-registration requirements. The Service Area is engaged in Trust-wide preparations for the extension of the regulation of the social

care workforce.

RQIA
As referenced in 3.3 above, RQIA completed a regional review of compliance with the pathway and standards required for service users with acquired brain injury. This was published in September 2015 and the Trust has established a Working Group to take forward the recommendations. Day Care services continue to be compliant with the RQIA standards and are subject to on-going inspection and monitoring.

The Physical and Sensory Disability Strategy 2012-2015
In this reporting period the Service Area continues to be engaged in the Strategy's workstreams. These involve representatives from all statutory and voluntary bodies and key stakeholders including service users, the DHSSPS, HSCB, PHA and OFMDFM.

With the appointment of a new Project Lead, workstreams have been re-configured into two workstreams, one focusing on sensory and one focusing on physical disability. The Service Manager co-chairs one of the workstreams and an Assistant Service Manager is actively involved in the other workstream.

Community Emergency Response Team (CERT)
In order for the CERT Team to be responsive it requires key personnel from the Team to sustain on-going engagement and participation in the Belfast Emergency Preparedness Group. Membership of this Group includes the PSNI, Ambulance Service, Fire and Rescue Service, Belfast City Council (BCC) and key voluntary and charitable organisations.

Responsibility for assisting with critical incidents now rests with the Community Development Team during daytime hours. Responsibility for assisting out of hours critical incidents lies with on-call managers in Adult Services. The Service Manager in Physical and Sensory Disability is Co-ordinator for the Trust Community Emergency Response Team (CERT) which is activated during a declared major incident.

The Service Area participates in the Trust's Emergency Preparedness, Planning and Implementation Group and Belfast Emergency Preparedness Group to ensure effective preparedness and response to incidents with relevant partners internally and externally.

PSNI
The Service Area continues to engage via the Joint Protocol arrangements with the Public Protection Unit to safeguard Vulnerable Adults and as referenced above as partners in the Belfast Emergency Preparedness Group.

MARAC and PPANI
The Service Area has participated as appropriate in local MARAC and PPANI Panels.

	Local Adult Safeguarding Panel (LASP) The Service Area is represented at the local LASP group to promote Adult Safeguarding. **Belfast Area Supporting People Partnership (BASPP)** The Service Area participates in BASPP meetings with key Trust colleagues, HSCB and NIHE staff to increase the supported living provision for people with disabilities and complex needs. **Office of Care and Protection** The Service Area continues to engage with the Office of Care and Protection in relation to the management of service users' financial affairs in those circumstances in which they are not in a position to do so. **Judicial Reviews and Significant Court Judgements** The Service Area has not had any Judicial Reviews or significant court judgements in this reporting period but take cognisance of any significant judgements that have implications for practice.

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
1.	**Adult Safeguarding** The capacity within the current workforce to meet the demand of adult safeguarding referrals continues to be a challenge within the Service Area. There is also concern regarding how the new Adult Safeguarding Policy will impact on ensuring safe and effective assessment and protection planning for service users.	Please refer to the Adult Safeguarding Report which outlines a summary of the challenges and measures put in place to address same.	Issues pertaining to Adult Safeguarding are on the Trust risk register and categorised as Medium.
2.	**Lack of capacity within the Private/Independent Provider Sector** The Service Area reported previously that there was a lack of capacity within this sector. It is regretful that this situation remains unchanged. The Service Area is finding it difficult to secure timely care packages due to shortage of capacity within the sector. This is continuing to cause significant concern to the Service Area as it is having direct negative impacts	The Service Area continues to complete a risk assessment for all cases where the providers are unable to implement packages. Further to this family engagement is sought for assistance with personal care tasks or the service user is offered Direct Payments, nursing or residential placement as appropriate.	Issues pertaining to the Lack of providers are on the Service Area Risk Register and categorised as High.

	on service delivery and capacity to meet performance targets in relation to hospital discharges.	The Trust is progressing procurement of domiciliary care providers to assure fairness and equal opportunities for providers to access volumes of work allocated by the Trust.	
3.	**Appropriate Accommodation for service users with complex needs** As previously reported, the Service Area continues to struggle to source appropriate accommodation and placements for service users with complex needs, particularly those with Huntington's disease, bariatric care, brain injury and Alcohol Related Brain Injury (ARBD). The Service Area continues to receive the majority of referrals for service users who have a diagnosis of ARBD and notes that there is significant spend required to meet the need of this service user group. During the reporting period the Service Area was pleased to receive additional funding to develop a more appropriate care pathway for this service user group. There continue to be limited placement options for service users with complex needs such as brain injury or Huntington's	Progress for the provision of eighteen units of supported accommodation for people with Complex Neuro-Disability has regrettably been delayed due to funding constraints within NIHE.	Issues pertaining to the lack of appropriate accommodation for service users are on the Service Area Risk Register and are categorised as High.

	Disease. These service users tend to be placed in generic residential and nursing facilities and staff can often lack the specialist skills and knowledge required to care for these service users. This can result in additional spend to procure one-to-one supervision to reduce risks to service users.		
4.	**Recruiting and Retaining a Sustainable Workforce** Following the Interim Report, the Service Area has experienced further staff vacancies due to staff retirements, maternity and sick leave. Experience to date has demonstrated that recruitment and sustaining a suitable workforce is a significant challenge. The Trust's scrutiny arrangements together with the internal processes contribute to significant delay in replacing posts. These delays result in increased pressures on staff who are continuing to manage existing caseloads, trying to prioritise waiting lists for assessment of need and respond to targets. This adversely impacts on providing timely services to service users and their families as well as impacting on	At Directorate level-confirmation that there is an on-going need for the post and the discharge of statutory functions is prioritised within the scrutiny process. Teams affected by staff vacancies are aware of the need to manage waiting lists as a measure of managing service demand. Referrals are screened on a regular basis to ensure that service user needs are prioritised appropriately and casework continues to be reviewed with staff within formal and informal supervision. For the first time in the Service Area, agency staff have been recruited to ensure the safe discharge of statutory functions.	Issues pertaining to recruitment are on the Service Area Risk Register-categorised as Medium.

	staff morale and sustaining staff long term.		
5.	**Self-Directed Support** A departmental indicator has been identified that '*By March 2019, all service users and carers will be assessed or reassessed at review under the Self Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified'.* The Trust exceeded the target for 2014/15. The Trust has delivered Direct Payments to 599 clients during 2015/16, however at the 31 March 2016 only 528 clients were currently in receipt of Direct Payments. The Trust requests that consideration is given to measuring the number of Direct payments in place over the course of the year rather than the number in receipt at year end. The Trust has recently completed a revised implementation plan outlining a phased plan for the implementation of Self Directed Support (SDS) with service areas	The Trust has both an SDS Steering Group and an Implementation Group with service user and carer representation to ensure the effective implementation of Self Directed Support. The Trust continues to work internally and with colleagues across the region to develop SDS. One of the key measures of SDS is the number of clients and carers in receipt of Direct Payments. Significant numbers of staff have attended training across Service Areas to support implementation of SDS. In addition, engagement with provider organisations is ongoing to ensure that the full range of SDS options is available, in particular Trust Managed Budgets.	There is a separate Risk Register for Self-Directed Support, as requested by the HSCB.

	identifying when they will process all new referrals under SDS. In addition, CIS does not currently support SDS implementation. Another challenge is ensuring that the identification of Personal Budgets is transparent, equitable, sufficient and affordable in the meeting of identified need within the eligibility criteria. Supporting development of the marketplace to ensure personalisation meets the requirements of choice, flexibility and control is not fully developed.		
6.	**CIS Implementation** The Service Area is pleased to report that the CIS implementation has been completed. Ongoing concerns regarding the accuracy of statistical information continue and the Service Area will monitor this during the next reporting period.	The Service Area continues to be actively engaged with the implementation officers to ensure the system supports and enhances service performance for service users, carers and staff.	CIS remains on the Service Area Rsk Register and is categorised as Medium.

7.	**Implementation of Business Services Transformation Programme (BSTP)** BSTP continues to place significant demands on managers who are required to directly manage their core business functions which would previously have been supported by corporate and administration staff. This increase in workload is labour intensive for managers who are struggling to meet increasing demands.	The Service Area is now live for all staff on the BSTP system. Currently not all HR functions are available, such as managing annual leave. It is anticipated that this will be included in the next reporting period. Managers continue to be supported to attend necessary training.	Implementation of BSTP is not on the Risk Register.

3.8	**Key Social Work Workforce issues, including recruitment, retention, flexible working arrangements, workforce continuity etc. Information provided should include level and type of vacancies and any vacancy control systems in place.**
	Workforce issues including recruitment and retention As previously noted in section 3.5 and 3.6 there are robust vacancy control systems within the Trust. All vacancies are scrutinised to ensure the post is still required and fit for purpose. Any vacancy must be approved by an internal Directorate Scrutiny Process before recruitment of new staff can be progressed. Following this the HR process for recruitment is currently experiencing significant delays in securing positions in an appropriate timeframe. The Service Area has continued to experience significant challenges during this reporting period to secure and sustain an appropriate skills mix across the workforce. Due to increasing demands on services, staff vacancies and recruitment delays, the Service Area has recently appointed two agency social workers. **Flexible Working Arrangements** The Service Area facilitates flexible working and promotes family/carer friendly arrangements to accommodate staff needs where possible via part time, flexi-hours, compressed hours and term time options. The Service Area continues to ensure that these arrangements are regularly reviewed so that service delivery is not adversely affected.
3.9	**Trusts should provide a copy of their charging policies and provide explanation of what aspects of service provision you apply this to?**
	Home Help Service – The Trust operates in accordance with the Model Scheme for the Provision of a Home Help Service. **Residential and Nursing Homes Charging** – The Trust has been operating in accordance with the DHSSPS March 2016 Charging for the Residential Accommodation Guide (CRAG) to determine charges.
3.10	**Social Workers who work within designated hospitals.** **Give an account of how these duties are fulfilled by Social Workers working in these designated hospitals**
	The Service Area has no direct responsibility for social work within designated hospitals. However, it does recognise their significant role

	in assessing and arranging services in a timely manner at the point of discharge. The Service Area supports hospital social work staff to comply with the hospital discharge targets. The Sensory Support Service provides direct social work and rehabilitation intervention at the Royal Victoria Hospital audiology and low vision clinics. The Team recognises the benefits for service users of having access to timely interventions to prevent deterioration in service users' mental health post-diagnosis.
3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	The Service Area remains committed to incorporating human rights considerations into all aspects of its work. Staff work with service users and stakeholders to support, promote and uphold the UN Convention of the Rights of People with Disability. It is recognised by staff within the Service Area that people with disability should be treated as individuals whilst being empowered to live their lives as independently as possible and treated with respect and dignity. All of these themes promote a human rights culture in the Service Area. The Service Area undertakes a human rights approach in its work with service users, their families and carers. Human Rights are inseparable from social work and social care values, ethics and practice. All Trust policies are screened to ensure compliance with Equality and Human Rights considerations. Staff are facilitated to attend human rights and related training courses. Staff adhere to specific policies and procedures which ensure human rights considerations are recorded within the following documentation: ➢ Vulnerable Adults Safeguarding ➢ Capacity, Consent and Best Interest meetings ➢ Risk Assessment and Risk Management ➢ Care Planning Documentation If particular concerns are raised regarding the infringement of individual human rights, staff will record this and provide written explanations as to why such proportionate actions are necessary. This is shared with service users to ensure and promote service users' rights and demonstrate respect via open and transparent engagement. The Service Area is committed to engaging with service users and carers through consultation groups. These groups support and assist staff to develop and implement a human rights-based approach and to ensure it is embedded in service delivery.

HUMAN RIGHTS

3.12	Identify any challenges encountered in the balancing of Rights.	3.13 What action have you taken to Manage this challenge?	3.14 What additional actions (if any) do you propose to manage any On-going challenges?
	Adult Safeguarding With regard to Adult Safeguarding, there continues to be an on-going challenge in balancing the service user's right to a private life and promoting her/his individual choice to make their own decisions which may continue to place them at risk. In addition, conflict can also arise if service users are reluctant to engage as they may not want PSNI involvement and/or information shared with or about family members. This is particularly pertinent when working with service users who are suspected to be victims of human trafficking, in many instances adversely impacting on the relationship between social workers and service users.	The Service Area welcomes the implementation of the Revised Joint Protocol which will provide enhanced clarity for Designated Officers with regard to mandatory reportable matters to the PSNI. Staff will continue to have access to mandatory training on Human Rights and Adult Safeguarding, including Joint Protocol arrangements. Human Rights considerations are addressed in supervision, reflective learning events and the spectrum of Service Area Mandatory and professional training. Staff are prompted to consider and reflect on human rights dimensions to service delivery in core assessment and review documentation.	All on-going.

	Deprivation of Liberty This is an on-going and significant challenge for staff within the Service Area when they are required to balance the right to protection versus the right to client self-determination. It is recognised that there is a need to support individuals in placements, including supported living and ensure that they are not deprived of their liberty. This is particularly relevant for service users with cognitive difficulties who may require that restrictive practices are put in place such as locked doors, cupboards etc. Staff find this area challenging when completing care plans that demonstrate that they have balanced the individual's human rights with the need to protect them from potential harm.	Staff attend mandatory training on Human Rights and have one to one supervision and access to peer support to reflect on their practice. Staff complete risk assessments and hold best interest meetings with service users, their families and advocates as appropriate and promote a transparent and open engagement to ensure that human rights are considered and promoted.	All on-going.
	Service Users with capacity who are non-compliant with Care Plans Service users who are deemed to have capacity to make their own informed choice and decisions about their care needs but who choose not to comply with their care plans continue to pose	Staff complete risk assessments with service users, their families and advocates as appropriate and promote transparent and open engagement to ensure that human rights are considered and	All on-going.

	significant challenges for staff. In these circumstances staff are required to balance the risk of harm associated with the individual's non-compliance with an individual's right to self-determination in the delivery of services.	promoted. Staff also attend mandatory training on Human Rights and have access to one to one supervision and peer support fora.	

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	Notwithstanding the challenges that the challenges that the Service Area has had to address during this reporting period, there is recognition of the significant achievements secured as a result of staff dedication and commitment to empowering people with physical and sensory disabilities through the delivery of qualitative, person centred services. The Service Area has procured a new Carer Service. This new Service commenced in January 2016 and provides information, advice and signposting to carers. Regular training sessions to support carers' health and well-being and practical skills to help them care safely will also be facilitated. This Service will also be working with GP practices to develop a carer support pathway within practices. In addition, the Service Area has had several carer events throughout the reporting period and carer feedback has been positive. The Hear 2 Help pilot scheme has proved successful in supporting people who wear hearing aids to optimise their functionality and to have timely access to repair services when needed. The Service Area contributed to the regional evaluation and it has been agreed that a regionally procured service will be implemented in the next reporting period. Following the launch of the Deaf Blind Needs Analysis, the Service Area is please to report that funding has been secured to appoint a Rehabilitation Assistant who can take forward the recommendations. In addition, recurrent funding has been secured for the two Community Access Workers. As previously reported, their role is integral to the modernisation of traditional Day Care service provision. The Service Area continues to develop communication opportunities with service users and carers through a range of audio and visual formats including service newsletters: ➢ Newsletter for carers. ➢ Newsletter for the Mourne Project. ➢ Newsletter for People with Sensory Loss. These newsletters include information on services, new developments and articles from service users and providers associated with the service. The Service Area is committed to reviewing and improving its engagement with our service user representative groups in relation to all aspects of service delivery, modernisation, improvement and

	development. The Service Area continues to collate monthly returns of compliments which are acknowledged at Governance meetings to highlight the good practice of staff. As previously mentioned audits of service user and carer satisfaction have been positive reflecting that, overall, service users feel valued and listened to.
3.16	**SUMMARY**
	The Service Area continues to experience significant challenges in this reporting period in implementing the strategic direction outlined in Transforming Your Care, Self-Directed Support and the Physical and Sensory Disability Strategy, whilst ensuring on-going safe, operational practice within increasing budgetary restraints. The Service Area continues to experience high demand for services which are characterised by increasing complexity of needs. The additional funding for ARBD service users is welcome and provides opportunities to improve services in this area. The Service Area continues to modernise day opportunities in consultation with service users, carers and relevant staff. There are significant service improvements initiatives currently underway within the Community Brain Injury Team. In addition, the public consultation on the Communication Review for Deaf Users is expected to take place during the next reporting period and it is anticipated that this will result more equitable access to interpreting services. The Service Area is co-ordinating work on the new Carers Strategy, continuing to develop services to carers and to optimise engagement with them. The Service Area continues to lead on the promotion of Self Directed Support and Emergency Planning and Response within the Trust. Delays in recruitment continue to adversely impact on staff caseloads and staff morale, however it is anticipated that the current vacancies will be filled in the next reporting period and the Service Area should see an improvement in this area.

DATA RETURN 1
PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

1 GENERAL PROVISIONS			
		<65	65+
1.1	**How many adults were referred for assessment of social work or social care need during the period?**	**1677**	**1029**
1.2	**Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?**	**1003**	**369**
1.3	**How many adults are in receipt of social work or social care services at 31st March?**	**1613**	**364**
1.3a	**How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?**	**590**	**364**
1.4	**How many care packages are in place on 31st March in the following categories:**		
	vii. Residential Home Care	**17**	**0**
	viii. Nursing Home Care	**98**	**0**
	ix. Domiciliary Care Managed	**608**	**0**
	x. Domiciliary Non Care Managed	**243**	**0**
	xi. Supported Living	**57**	**0**
	xii. Permanent Adult Family Placement	**0**	**0**
1.4a	**For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular.** ***Narrative*** The Service Area complies with the DHSSPS Care Management Circular and works closely with the Trust's Finance Department to ensure accurate charging as appropriate.		
1.4b	**Please describe how the Care Management process is being managed in this programme with particular reference to decision making levels, review and care planning, highlighting any particular difficulties being experienced and how they are being addressed.** ***Narrative*** All service users who require care packages to support their personal care needs in the community or to sustain them within a placement are referred to the Care Management Team. NISAT and additional assessments if appropriate will determine the level of care required. A private provider or direct payment will be commissioned to meet their assessed need. Values and principles of the Circular are implemented throughout all engagement with service users and carers.		

	The Service Area continues to experience on-going difficulties securing packages of care as highlighted in section 3.5 of the report. In addition some providers decline packages due to their staff sustaining verbal abuse from service users or if they are non-complaint with their care plans.		
1.4c	**Please articulate how the views of service users, their carers and families are included in the decision making process, review and care planning.** ***Narrative*** The Service Area ensures that NISAT is completed with each service user and carer if appropriate which promotes shared decision making and person centred working. Care plans are shared with service users who retain a copy in their own homes. Service users, their carers and families are invited to attend reviews and contribute to the care planning and decision making process.		
1.5	**Number of adults provided with respite during the period**	*PMSI return*	*PMSI return*
1.6	**Number of adults known to the Programme of Care in receipt of Centre based Day Care**		
	- **Statutory sector**	**222**	**0**
	- **Independent sector (MS Centre and SENSE)**	**130**	**0**
1.6a	**Number of adults known to the Programme of Care in receipt of Day Opportunities**	**419**	**80**
1.7	**Of those at 1.6 how many are EMI / dementia**		
	- **Statutory sector**	**0**	**0**
	- **Independent sector**	**0**	**0**
1.8	**Unmet need (this is currently under review)**	**X**	**X**
1.8a	**Please report on Social Care waiting list pressures** ***Narrative*** Due to the financial demands on the budget-spend, service users who are not deemed at risk will be on a waiting list for services. The most significant current service delivery pressures are: waiting times for completion of initial assessments; waiting times for provision of care packages; and care management capacity.		

1.8b	**Please identify possible new service innovations that are currently supported by non-recurrent funding** ***Narrative*** Non recurrent funding has been made available for the following projects: ➢ Hear 2 Help Project which supports people with hearing aids issues. This money has been extended until June 2016 to facilitate development of a regional procurement proposal for this service. ➢ Self-Directed Support implementation posts.		
1.9	**How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?**	**1**	**0**
1.10	**Complaints –Please describe any service change or improvement implemented or intended as a result of complaint investigations.** ***Narrative*** The Service Area has made a number of amendments/changes as result of complaint investigations; Although these have been minor in nature, the Service Area fully considers the learning from complaints and takes necessary actions to improve service delivery resulting from them.		

Data for 1.5, 1.8 and 1.10 will be sourced by Board officers from existing returns.

DATA RETURN 1
PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	**How many adults or children were referred to Hospital Social Workers for assessment during the period?**	Not applicable to PHSD	Not applicable to PHSD	Not applicable to PHSD
1.2	**Of those reported at 1.1 how many assessments of need were undertaken during the period?**	Not applicable to PHSD	Not applicable to PHSD	Not applicable to PHSD
1.3	**How many adults or children are on Hospital Social Workers caseloads at 31st March?**	Not applicable to PHSD	Not applicable to PHSD	Not applicable to PHSD

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

Physical & Sensory Disability Service Area has no managerial or operational responsibility for Hospital Social Work staff.

DATA RETURN 2
PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	**Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65**	**N/A**	**N/A**
2.2	**Number of adults known to the Programme of Care who are:**		
	Blind	**293**	**933**
	Partially sighted	**142**	**413**
2.3	**Number of adults known to the Programme of Care who are:**		
	Deaf with speech	**134**	**76**
	Deaf without speech	**87**	**48**
	Hard of hearing	**584**	**3486**
2.4	**Number of adults known to the Programme of Care who are:**		
	Deaf/Blind	**15**	**127**

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

Adults who are visually impaired: **Under 65: 172**
Over 65: 985

DATA RETURN 3
PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	**Number of referrals to Physical/Learning/Sensory Disability during the reporting period.**	**2706**
	Number of Disabled people known as at 31st March.	**1977**
3.2	**Number of assessments of need carried out during period end 31st March.**	**2257**
3.3	~~Types of need that could not be met~~: (this is now collected at 1.8)	
	Narrative ➢ Care managed services ➢ Home care provision ➢ Access to specialist service These themes are addressed in the body of the Service Area report	
3.4	**Number of assessments undertaken of disabled children ceasing full time education.**	**0**

DATA RETURN 4
PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

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

4.1	**Number of Article 15 (HPSS Order) Payments 13**	**41**
	Total expenditure for the above payments	**£5560.00**
4.2	**Number of TRUST FUNDED people in residential care**	**16**
4.3	**Number of TRUST FUNDED people in nursing care**	**95**
4.4	**How many of those at 4.3 received only the £100 nursing care allowance?**	**3**
4.5	**How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?**	**5**

DATA RETURN 5

PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+
5.1	**Number of adult carers offered individual carers assessments during the period.**	**3**	**340**	**66**
5.2	**Number of adult individual carers assessments undertaken during the period.**	**2**	**169**	**55**
5.3	**Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?**	**0**	**0**	**0**
5.4	**Number of adult carers receiving a service @ 31st March**	**2**	**173**	**24**
5.5	**Number of young carers offered individual carers assessments during the period.**		**31**	
5.6	**Number of young carers assessments undertaken during the period.**		**25**	
5.7	**Number of young carers receiving a service @ 31st March**		**9**	
5.8	**(a) Number of requests for direct payments during the period of 1st April – 31st March 2016** **(b) Number of new approvals for direct payments during the period of 1st April – 31st March 2016** **(c) Number of adults receiving direct payments @ 31st March**		**39** **39** **128**	
5.9	**Number of children receiving direct payments @ 31st March**		**0**	
5.9.a	**Of those at 5.8 how many of these payments are in respect of another person?**		**0**	
5.10	**Number of carers receiving direct payments @ 31st March**		**4**	
5.11	**Number of one off Carers Grants made in-year.**		**328**	
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.				

Commentary

Please refer to narrative in main report for comments on carers.

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DATA RETURN 6

PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

8 SAFEGUARDING ADULTS

DATA RETURN 7
PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

7 SOCIAL WORK STAFF

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 8

PHYSICAL AND SENSORY DISABILITIES SERVICE AREA

8 Assessed Year in Employment

Assessed Year in Employment (AYE) 2015-2016

Return for Employers year ending 31st March 2016

TRUST RETURN SUBMITTED BY SOCIAL SERVICES LEARNING AND DEVELOPMENT SERVICE AND APPENDED TO THIS REPORT

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9

9 The Mental Health (NI) Order 1986			
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6)Article 115			
Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	**Total Number of Assessments made by ASWs under the MHO**	**0**	**0**
9.1.a	**Of these how many resulted in an application being made by an ASW under (Article 5.1b)**	**0**	**0**
9.1.b	**How many assessments required the input of a second ASW (Article 5.4a)**	**0**	**0**
	Comment on any trends or issues in respect of requests for ASW assessment or ASW applications		
9.1.c	**Number of applications made by the nearest relative (Article 5.1.a)**	**0**	
	Comment on any trends or issues in respect of Nearest Relative applications for admissions		
9.1.d	**Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge.**	Not applicable	
Use of Doctors Holding Powers (Article 7)			
9.2	~~**Total Number of Form 5s/5as completed)**~~ **NB Form 5a is no longer used** **How many times did a hospital doctor use holding powers?**	**0**	
9.2a	**Of these, how many resulted in an application being made?**	**0**	
	Comment on any trends or issues on the use of holding powers		
ASW Applicant reports			
9.3	**Number of ASW applicant reports completed**	**0**	
9.3.a	**How many of these were completed within 5 working days**	**0**	
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken.		
Social Circumstances Reports (Article 5.6)			
9.4	**Total number of Social Circumstances reports completed**. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	**0**	
9.4.a	**Number of completed reports which were completed within 14 days**	**0**	
	Please provide an explanation for any Social Circumstances Reports that were not completed within the requisite timescale, and / or any discrepancy between the number of Nearest Relative applications accepted and the number of Social Circumstances Reports completed, and what remedial action was taken.		

Mental Health Review Tribunal

9.5 **Number of ~~referrals~~ applications to MHRT in relation to detained patients**

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**0**	**0**	**0**	**0**	**0**
Patient	**0**	**0**	**0**	**0**	**0**
Nearest Relative	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**
Total	**0**	**0**	**0**	**0**	**0**

Comment on any trends or issues in respect of Mental health Review tribunals

9.5.a	~~Number of MHRT hearings~~	
9.5.b	~~Number of patients regraded by timescales:~~	
	~~a. < 6 weeks before MHRT hearing~~	
	~~b. > 6 weeks before MHRT hearing~~	

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

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-	Number of patients re-	Number unexpectedly discharged by MRHT

				graded > 6weeks before hearing	graded < 6 weeks before hearing	
	Trust	**0**	**0**	**0**	**0**	**0**
	Patient	**0**	**0**	**0**	**0**	**0**
	Nearest Relative	**0**	**0**	**0**	**0**	**0**
	Other	**0**	**0**	**0**	**0**	**0**
	Total	**0**	**0**	**0**	**0**	**0**

9.6.h	**Total number of Discharges from Guardianship during the reporting period (Article 24)**	
	Discharges as a result of an agreed multi-disciplinary care plan: **0** Lapsed: **0** Discharged by MHRT: **0** Discharged by Nearest Relative: **0** Total: **0**	
	Comment on any trends or issues in respect of Guardianship	

Approved Social Worker (ASW) Register		
9.7	**Number of newly appointed Approved Social Workers during period**	**0**
9.7.a	**Number of Approved Social Workers removed during period**	**1**
9.7.b	**Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)**	**1**

CORPORATE COMMENTARY

There has been a steady decrease in the number of ASWs available to participate in the Trust's Day Time Rota over the past number of years. There are concerns that the Trust, under the present arrangements, will not have capacity to meet the statutory requirement set out in Article 115 of the Mental Health (NI) Order 1986 (the Order) in respect of the availability of ASWs to discharge the range of statutory functions as specified in the Order.

While four social workers from the Trust are currently participating in the Regional ASW Training Programme and hopefully will be assessed as competent, they will not be available for appointment by the Trust until October 2016 and will then be required to undertake a period of "shadowed practice" before they can operate as autonomous practitioners. Therefore this could result in them not being on the Daytime Rota until January 2017.

	The potential addition of these four social workers will not fully offset the number of ASWs lost through retirement/those who have moved to other posts/other Trusts/ RESWS. Of the cohort of twenty-eight, one has already indicated that due to demands of work as a Team Leader they will be withdrawing and another has indicated they will be retiring in June 2016. The Trust has twenty-eight ASW trained staff currently on the Daytime Rota. Training of additional ASW staff has been identified as a priority within the Service Area. Nominations for the 2016/17 Regional ASW Training Programme are presently being collated. Additional ASW duties include Guardianship-related functions and inputs into MHRT cases in light of their knowledge, skills and experience in this area. ASWs also provide a consultation role to those teams/services which do not have ASWs or social workers. Service Area ASWs participate in refresher training throughout the year and re-approval training every three years. Due to the pressures of the ASW rota the 'floater' has been replaced as a third member on the ASW rota. This is because it is a regular occurrence that all three ASWs on the Rota on a daily basis are called out to assess patients. On a regular basis there can be multiple ASW assessments requested on the same day. It is now a regular occurrence that ASWs on the Daytime Rota have to wait substantial lengths of time for the ambulance and PSNI to support the conveyance of service users to hospital in those circumstances in which significant risks to the service user or others are extant. These situations are exacerbated by difficulties in accessing beds in the Trust's area. This results in ASWs having to accompany those requiring admissions to hospital to units across the region. Such episodes can significantly impact on the ASWs' ability to fulfil the requirements of their core posts. An inter-agency group involving representatives from the PSNI, the NI Ambulance Service and Trust's Unscheduled Care, GP Out of Hours and ASW Services has been established to address interface matters relating to their respective responsibilities and pathway processes pertaining to assessments for admission under the Order. The Trust has completed a review of ASW activity. The Review highlighted a number of key organisational, logistical and professional issues impacting on the delivery of the ASW Daytime Rota including: the diminution over a number of years of the complement of designated social work posts in the Mental Health Service Area; the increase in demands on available social work resources of the exponential increase in adult safeguarding activity and, in particular, the projected and current impact to date of the Revised Adult Safeguarding Policy determination that social work will be the lead profession in safeguarding service delivery; the increasing complexity of ASW-related activities; the impact of the difficulties of out- of -Trust admissions; the difficulties associated with interfaces across the PSNI, Ambulance Service, Unscheduled Care and ASWs in respect of assessments for admission; the

	need to develop a robust workforce planning approach to social work requirements in Mental Health (including ASWs) incorporating the implications of the Mental Capacity legislation; and the resourcing of and supports for staff engaged in the Regional ASW Training Programme. The Review's proposal for the establishment of a hybrid ASW Core Team to address the immediate pressures on service delivery and to ensure the Trust's capacity to discharge its statutory functions has been agreed and is currently being actioned. The Principal Social Worker (PSW) in Mental Health with operational responsibility for the co-ordination of the Rota works closely with the Regional ASW Group in relation to the review of documentation to ensure a consistent approach across the region. In addition, the PSW has also revised local ASW documentation relating to alternative care planning for patients who have been assessed as not requiring detention for assessment under the Order. Breakaway training has also been scheduled for June 2016 for all ASWs on the Daytime Rota. In-house bespoke training has also been completed on the Regional Interagency Protocol in February 2016. ASWs have been appraised of the PSNII risk assessment process for thresholding and prioritising referrals and have been advised of the importance of providing clear and factual information in respect of assessed risks when requesting PSNI assistance. The PSW has reviewed as a priority the provision of reflective practice supervision sessions for ASW staff. These are now "up and running" and take place on a 6-8 weekly basis. The PSW has also re-launched the ASW Forum which meets twice a year. Attendance at the ASW Forum alternates with the reflective practice groups and attendance is mandatory (i.e. 75% attendance). The Trust will continue to review and develop supports to its ASW workforce. The Regional Audit of Assessments for Admission under the Mental Health (NI) Order 1986 was launched in March 2016. The Report will contribute to an ongoing Trust focus on improving ASW organisational and service delivery arrangements and the management of internal and external interfaces. Trust senior management are reviewing a number of interface issues across the RESWS and the Daytime Rota. The Trust has robust administration structures in place to monitor ASW numbers, accreditation and re-accreditation arrangements.
9.8	**Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If so please provide detailed explanation for each and every instance including their age and relevant powers used.** Not applicable

9.9*	**How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?**	**2**
	Issues or trends relating to notifications to the office of care and protection and on-going management of such arrangements The Service Area will be reviewing on an ongoing basis how an individual's finances can be managed in a way that responds to the individual's circumstances and needs while meeting the requisite regulatory accounting standards.	

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

3. GENERAL NARRATIVE

MENTAL HEALTH SERVICE AREA

3.1	Named Officer responsible for professional Social Work
	The person's role and responsibilities and their direct line of accountability to the Director of Social Work should be explained. **Trusts must provide assurance that the prescribed audit of the application of this scheme has been carried out by the lead Social Worker.** The Associate Director of Social Work is Ms Mary O'Brien, Service Manager for Recovery Services. The Associate Director of Social Work has responsibility for professional issues pertaining to the social care workforce within the Service Area. She is accountable to the Executive Director of Social Work for the assurance of all organisational arrangements underpinning the discharge of statutory functions, pertinent to the delivery of social care services, within the mental health Service Area. The Associate Director is responsible for: ➢ The provision of professional leadership for the social care workforce. ➢ The establishment of structures to monitor and report on the discharge of statutory functions within both adult and children's mental health services. ➢ The provision of specialist advice on professional issues pertaining to the social care workforce and social care service delivery, including discharge of statutory functions. ➢ The collation and assurance of the Service Area Interim and Annual Statutory Functions reports. ➢ Ensuring that arrangements are in place to facilitate the social care workforce's learning and development opportunities. ➢ Ensuring that arrangements are in place to monitor compliance with NISCC registration requirements. An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through line management and professional structures to the Executive Director of Social Work and onto the Trust Board. The Report has been collated by the Service Area Principal Social Worker, Ms Jackie Scott.
3.2	**Supervision arrangements for social workers**
	Trusts must make reference to: Assessed Year in Employment (AYE) and compliance and Caseload weighting arrangements.

	Within the Mental Health Service Area all qualified social workers have access to professional supervision as per Trust supervision policy. Professional supervision arrangements are integrated with and contribute to organisational line management supervision processes. The Service Area continues to achieve satisfactory compliance with the requirements of the Trust's Adult Services Professional Social Work Supervision Policy including the specific requirements pertaining to those staff who are completing their Assessed Year in Employment (AYE). Compliance levels are addressed through an annual corporate auditing of supervision delivery across adult services. The most recent audit in November 2015 evidenced high-very high levels of compliance across fifteen of the seventeen standards audited. The Trust's Staff Development Review (SDR) Framework provides the organisational structure for the annual appraisal and finalising of the individual staff member's Personal Development and Learning Plan. The SDR process draws together key themes which underpin the ongoing delivery of professional and organisational supervision. Supervision affords a mechanism for addressing organisational engagement, performance and accountability and a vehicle for feedback and reflection which are fundamental dimensions to learning and development. Under the auspices of the Regional Social Work Strategy a revised regional adult social work supervision policy and standards is being developed with a strong evidence based-focus, linking investment in supervision delivery with enhanced workforce knowledge and skills and improved service delivery outcomes. The revised policy will incorporate a range of supervision delivery options incorporating group and peer supervision models within a strong emphasis on reflective approaches. Arrangements for the provision of supervision to social workers in the Mental Health Service Area are as follows: The Service Area is compliant with the DHSSPS Circular 02/2015 which details the responsibilities of employing organisations in relation to AYE social work staff. There are currently five Band 5 AYE agency staff in post. One-to-one supervision is provided on a two-weekly basis by PSW/ Senior Social Worker /Band 7 Senior Practitioner staff. As part of AYE social work supervision, the supervisor has the opportunity to directly observe the AYE staff in practice e.g. completing core assessments within New Patient Clinics; carrying out joint home visits; completing core mental health assessments; risk management and care planning reviews. In addition AYE staff receive line management / clinical supervision on a two-weekly basis which alternates with professional social work supervision. Band 6 Social Worker –professional supervision is provided every 6 weeks (or more often if required)

	Band 7 Social Work Practitioner – organisational supervision is provided every 6 weeks. Professional supervision is provided every 12 weeks (or more frequent if required). Band 7 and 8a Social Work manager – organisational supervision is provided 6-8 weekly or more often depending on need, with professional supervision every 12 weeks. All Qualified Social Workers (in dedicated social work posts) receive professional supervision on a quarterly basis. CAPA (Choice and Partnership Approach) is a patient centred clinical management system which facilitates the effective matching of demand with clinical capacity within mental health services. Supervision contributes to the weighting of cases to inform the application of the model. **Mental Health Social Work Forum:** The Forum meets twice per year and provides the opportunity to profile the social work role and central contribution to service delivery across the Service Area. It affords an important vehicle for sharing/developing learning and best practice through reflective events. The PSW has sought to re-energise the Forum as part of a wider initiative to promote social workers' confidence and re-affirmation of the significance of their professional skills, knowledge base and underpinning values in mental health service delivery. **Approved Social Work Forum:** The Principal Social Worker has reviewed the Forum with a view to optimising its potential to contribute to the strengthening of the cohesion of the Trust-wide ASW workforce; to addressing organisational, operational and logistical matters impacting on ASW service delivery; to facilitate engagement with senior management; and as a vehicle to share best practice/disseminate learning and promote improvements in service delivery processes and outcomes for Service Users. The frequency of the Forum is twice per year. ASW trained staff also attend bi-monthly reflective practice groups facilitated by experienced and senior ASW trained staff. Mental Health social workers attend Trust Investigating Officers / ABE / Joint Protocol and DAPO support fora as appropriate.
3.3	**Report on processes, audits, reviews, research and evaluations undertaken during the year, that measure performance against delegated statutory functions, identifying emerging trends and issues (may include cross references to other sections to this report).**
	Professional Supervision In this reporting period, the Service Area participated in a Trust-wide audit of supervision in adult social work services. Please see 3.2 above. The outcome of the audit demonstrated that the Service Area had achieved satisfactory compliance with the Trust's adult social work

supervision policy. Any difficulties in providing supervision are highlighted to the Service Area Associate Director and PSW and requisite actions to address same identified.

File Audits
Within the Service Area Team leaders are required to complete regular file audits. The Service Area Operations Managers are required to complete regular reviews of supervision files. Service Area procedures mandate that any issues emerging from either case file or supervision file audits are appropriately reported to the responsible manager and necessary actions identified to ensure their resolution.

Approved Social Work (ASW)
An audit of compliance with ASW standards for the period 1 January 2015 -31 December 2015 was completed in March 2016. The Draft Report has been disseminated. The audit findings and recommendations will contribute to ongoing focus on strengthening the Trust's ASW workforce and service delivery processes.

A review of Approved Social Work, focusing on the corporate ASW role and function within the Adult, Social and Primary Care Directorate (ASPC) of BHSCT was initiated in 2015 and completed in April 2016.

The purpose of the review was to analyse ASW activity so that consideration could be given to work force planning issues and models of future delivery. The Review's recommendations in relation to current ASW Daytime Rota delivery arrangements, future workforce planning requirements and related service delivery structures are currently being considered by Senior Managers across the Trust.

The Trust participated fully in the GAIN Regional Audit of Assessments for Admission under the Mental Health (Northern Ireland) Order 1986. The audit report was published in March 2016.

The Draft Mental Capacity Legislation will potentially re-define the ASW role in the future. Whilst it is not possible to plan for the details of these changes, it is necessary to ensure that appropriate workforce planning processes are in place at both Trust and regional levels.

Social Work in the Community
Social work staff in Community Teams are experiencing significant pressures as a result of the volume, complexity, unpredictability and diversity of their work.

This complexity is reflected in those particular areas in which social work has lead responsibility – Adult Safeguarding, Joint Protocol / ABE and ASW work. These responsibilities generate substantial administrative and reporting tasks.

	In terms of building the capacity of the social work workforce to deliver the Service Area has a number of challenges to address. Consolidating and developing the capacity of the social work and social care workforce continues to be the principal focus. In addition other challenges include the time consuming recruitment processes, related delays in the backfilling of posts and workload demands all of which have exacerbated pressures on the workforce. The Service Area fully endorse the Regional Social Work Strategy's focus on improvement and quality and hopes that the Social Work Strategy will contribute to the re-engagement of staff in research, reinvigorate enthusiasm for evidence based practice to the delivery of person-centred mental health services. The Service Area is seeking to build the capacity of the social care workforce to progress further the strategic challenges for mental health services as identified in the Bamford Review and referenced in Transforming Your Care in order to modernise and reform service delivery processes. In this regard it fully endorses the objectives of the Regional Social Work Strategy, in particular its focus on: workforce development, the enhancement of the social care workforce's engagement in research, evidence informed practice and outcomes – centred service delivery; partnerships; and co-production. The North Belfast Recovery Team has recently completed an application for Accreditation for Community Mental Health Services (ACOMHS) peer review managed through the Royal College of Psychiatrists. This looked at regional standards for CMHT across the UK. This team, which consists of a number of social work staff, were heavily involved in this review. As a result of undertaking the ACOMHS peer review there has been a significant review of documentation and processes in order to improve the quality of service delivery. The verbal feedback from the peer review team was extremely positive and the North Belfast Recovery Team await the formal outcome of the process in May 2016. One of the Trust's Recovery Teams has been requested to pilot draft documentation related to the Revised Regional Mental Health Care Pathway. The Service Area's Acute Social Work Team, Community Forensic Mental Health Team (CFMHT) and Early Interventions Team are participating in a pilot under the auspices of the Think Child Think Family project. A review of documentation has been undertaken so that assessments are much more child / family focussed. A GAIN audit The Service Users Experience has recently been completed within the Trust. The audit data is currently being collated and analysed with the audit report scheduled for publication in May/June 2016.

ADULT MENTAL HEALTH SERVICES (AMHS) AND CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) ACCREDITATION

AMHS and CAMHS continue to engage in a longitudinal peer review processes. CAMHS community and inpatient services have achieved accreditation under the auspices of a peer led process managed under the Royal College of Psychiatry incorporating an extension of the QNIC programme.

Adult Mental Health in-patient wards have also commenced the AIMS peer review process.

Forensic Services in Shannon have been accredited as part of their own Quality Network. In addition two wards have been fully accredited.

The Trust's Mental Health Service Area has also joined the national NHS Benchmarking Service: please see
http://www.nhsbenchmarking.nhs.uk/index.php
The Trust's Mental Health Service Area is the first from Northern Ireland to do so. This will allow the Trust to benchmark its services across a wide range of indicators against Mental Health Trusts in England and Wales and a significant number in Scotland. The indicators include clinical outcomes, staffing complement, caseload weighting, HR, finance and a range of other information closely aligned to You in Mind.

The Service Area has been mentored by the East London Foundation NHS Trust, a Foundation Mental Health Trust, in respect of its proposed commencement of a service Improvement programme. Please see:
https://www.elft.nhs.uk/About-Us/Our-Focus-on-Quality

The Mental Health Service Area was fully involved in the Trust's recent completion of its tri-annual Investors in People (IIP) re-accreditation process. The Trust was successful in achieving a higher level Bronze accreditation. In confirming the outcome of the process, the Lead Assessor commented "This is a significant achievement for an organisation of such size and complexity. It acknowledges the commitment to continually reflect, learn and improve in order to adapt to changes in the external environment, and drive transformation through culture, processes, systems, strategy and people. This award is testimony to the hard work and effort that staff in all areas of the Trust dedicate to providing quality, safe and person-centred care."

ASW GAIN Audit: Regional Audit of Assessment for Admission under the Mental Health (Northern Ireland) Order 1986
The Trust fully participated in this audit the aim of which was to identify and examine possible sources of delay in the processes of assessment for compulsory admission under the Mental Health (Northern Ireland) Order 1986 (the Order). The following key findings were identified:

- Assessments carried out under the Mental Health (Northern Ireland) Order 1986 were characterised by high levels of need,

	risk and complexity ➢ Assessments carried out required the coordination of different professionals and agencies ➢ That delays arose due to difficulties in coordinating professions / agencies and difficulties in securing an acute admission bed The recommendations were as follows: ➢ A regional interface group should build on existing protocols and guidance to develop and coordinate inter-agency training resources. ➢ Specific issues in relation to the identification of beds outside of the Service User's own Trust area should be addressed as a matter of urgency as part of the Regional Bed Management Protocol. ➢ Trust specific multi-agency interface groups could also support the development of working relationships and provide a forum in which any issues raised could be considered. ➢ Some changes and additions to the ASW's applicant report which were considered useful for ongoing practice should be developed as part of the data collection process. It was recognised that it was important to ensure any revised format was consistently used across Trusts regardless of the individual Trust's IT system/s. ➢ Guidance should assert that the nearest relative should only be considered to act as applicant as a last resort. ➢ The complexities of these processes should be addressed in the new Code/s of Practice for the Mental Capacity Bill. The PSW was closely involved in this audit and has pro- actively taken forward key areas from the audit recommendations. The Trust has established a Multi-Agency Working Group involving PSNI, NIAS, Primary Care, Acute Hospital Services and Mental Health Services (including Home Treatment Team, Unscheduled Care Team, Acute inpatient services and Approved Social Work Lead). The initial Multi-Agency Forum facilitated by the Trust's Social Services Learning and Development Service has been arranged for early May 2106. It is planned that the core group will meet quarterly to continue to take forward the GAIN audit recommendations and to further develop working arrangements between the main agencies .The Service Area Co-Director has agreed to facilitate the interface Working Group the remit of which will include: ➢ Planning for joint training events. ➢ Improving and enhancing the understanding of each interface area and how this impacts on the duties and responsibilities of the ASW. ➢ Reviewing incidents and complaints to inform service improvements. ➢ Reviewing the development on local guidance regarding the Regional Interagency Protocol on the operation of Place of Safety and Conveyance to Hospital under the Order 1986 – October.

	RQIA The Service Area continues to work with RQIA in the discharge of its regulatory and inspectorial functions. During the reporting period RQIA completed a number of inspections within the Service Area including hospital wards, regulated services and safeguarding arrangements in acute facilities. All services inspected have demonstrated compliance with the requirements in relation to the safeguarding and quality improvement plan. **Audits planned / in process / completed in the Service Area:** ➢ CAMHS, Children's Disability, FACE risk screening tool accuracy of information from admission to discharge. ➢ CAMHS, Children's Disability, Rapid Tranquillisation in Under 14s. ➢ CAMHS Children's Disability, Referrals to Step 4 CAMHS (Crisis Assessment and Intervention Team) – An Evaluation. ➢ Mental Health, POMH Topic 13b Prescribing for ADHD in Children, Adolescents & Adults. ➢ Mental Health, Assessing the recovery commitment of Shannon Clinic, medium secure unit. ➢ Mental Health, GAIN Regional Audit of Assessment for admission under the Mental Health (Northern Ireland) Order 1986. ➢ Mental Health, Audit of Standards for Community Forensic Mental Health Services (Re-audit). ➢ Mental Health, Valproate in Women of Childbearing Potential is being adhered to within Resettlement Team. ➢ Mental Health, Prescribing Valproate for Bipolar Disorder (POMH Topic 15a). ➢ Mental Health, Intensive support team in eating disorders. ➢ Mental Health, Adherence to the trust Policy on Guidance for Prescribing & Monitoring of High Dose Antipsychotics in Mental Health Services. ➢ Mental Health, Survey of Patients transferred under Article 53 of Mental Health Order 1986 from NI Prisons to Psychiatric Unit. ➢ Mental Health, Monitoring the Physical Health Needs in patients with a diagnosis of Schizophrenia. ➢ Mental Health, an audit of documentation contained within the medical notes from a ward round
3.4	**Report on the Programme of Care's interfaces with other statutory agencies including for example: NISCC; RQIA; PHA (in relation to social care)** **Trusts should include references to Judicial Reviews or other significant Court Judgements that directly impact on the discharge of statutory functions.**
	The Service Area interfaces with a number of other statutory agencies in relation to the discharge of its statutory functions responsibilities. These include:

	NISCC The Service Area is compliant with NISCC's registration requirements pertaining to the social care workforce. The Service Area supports its social care workforce to access learning and development opportunities to meet NISCC's Post Registration Training and Learning (PRTL) requirements. **RQIA** The Service Area complies fully with reporting of all notifiable incidents in accordance with regulations. The Service Area complies with recommendations emerging from RQIA inspection of Service Area regulated services provision. **PHA** The Service Area seeks to maintain strong reciprocal relationships with the PHA in the discharge of its statutory responsibility to promote the health and wellbeing of the population across health promotion, early intervention, prevention and the delivery of community and acute services to those individuals whose assessed needs warrant specialist health and social care provision. **OTHER STATUTORY AGECIES:** The Service Area is committed to partnership working with all statutory agencies which have responsibilities interfacing with those of the Service Area. These include: the PSNI; the NIHE; the Probation Service; the Northern Ireland Ambulance Service; Lisburn and Castlereagh and Belfast Councils; the Patients and Client Council; Safeguarding Board for Northern Ireland. This list is not exclusive. **JUDICIAL REVIEWS** The Service Area has not been engaged in a Judicial Review during the reporting period.

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	Adult Safeguarding The reporting period has seen a continued significant increase of 71% in the volume of adult safeguarding referrals, a 37% increase in investigations and a 49% increase in protection plans. There is no doubt that this has been as a result of in-house bespoke training for managers and staff within the Primary Mental Health Service. In addition, the PSW meets on a weekly basis with non-social work line managed teams i.e. Primary Care Team Leaders, Unscheduled Team, Home Treatment Team and Community Addiction Team to discuss all adult safeguarding referrals. This has significantly improved awareness of adult safeguarding, improved standards of recording and protection planning. It is envisaged that there will continue to be an increase in referrals within the Service Area.	The Service Area ASW Review has endorsed a bespoke response to alleviate pressures on the Daytime ASW Rota. It is clear that additional social work capacity will be required to respond to the demands of adult safeguarding activity in the context of the revised Regional Adult safeguarding Policy. Figures released by the Dept. (2006 Quality Standards) indicate that Mental Health Services should have in place 1.5 social workers for every 10,000 population. This would highlight the shortfall of approximately 11 social workers in the current workforce (including social workers in hospital posts). Workforce planning within the Service Area must address this issue, securing funding to meet this requirement.	On Service Area Risk Register Moderate Risk

	There are forty teams/services within acute care, primary and recovery mental health which can initiate an adult safeguarding referral. The majority of staff trained as Investigating Officers are from a social work background with a small number of nursing staff trained. These staff are based within the core acute and community mental health teams. Recently across the Service Area nursing staff have refused to take on the Investigating Officer role. Senior Management is currently in discussions with staff side to address this matter. As social work only represents 10% of the workforce across mental health services in comparison to 43% for nursing, the increase in referrals has had a significant impact on the already limited social work workforce in the community and acute teams. These staff are already carrying large, complex case loads and undertaking other statutory functions such as ABE/Joint Protocol and ASW. With the introduction of the new Adult Safeguarding policy July 2015, significant pressure has been placed on the existing trained adult safeguarding staff in particular	Following a review of Adult Safeguarding significant work has been completed across all services in Mental Health to embed adult safeguarding processes and practices.	

	those undertaking the DAPO function. The new Policy outlines that a DAPO is required to be either a band 7 senior practitioner or a Band 7 Team Leader who is social work qualified. The number of such available staff is further limited as within Mental Health Services there are a range of Social Work Staff who are a band 7 but this is due to the specialist nature of their team rather than their role being one of a Senior Practitioner or Team Leader. These staff are not required to undertake the role of DAPO within their current job descriptions. In addition Team Leader posts can be recruited from any professional background. The small numbers of Team Leaders who are social work trained take on this function in addition to other managerial functions. There has been no additional resource made available from the Commissioner to obviate the demands on social work band 7 staff of increased demands related to adult safeguarding requirements. This will give rise to substantial challenges for the Service Area implementing the new Regional Adult Safeguarding Policy. The PSW continues to undertake the role of DAPO supported by two Band 7 social		

	work staff who also assist in discharging the D.A.P.O and ABE functions. The Service Area is presently developing a data base for the processing and tracking of adult safeguarding referrals from screening to closure. The Service Area requires to have a high number of meetings minuted, recorded and circulated in a timely manner to ensure protection planning decision making is appropriately formalised and disseminated. **Approved Social Work** The Regional Interagency Protocol October 2015 has been implemented. Acquiring assistance from the PSNI and Ambulance Services in particular has been one of the main difficulties impacting on ASWs' ability to safely undertake their statutory functions. ASWs often face prolonged periods waiting with a detained person before PSNI /ambulance services will assist reflecting their own demand and capacity pressures	The 2005 DHSSPS Social Services Inspectorate Quality Standards Report for Approved Social Work addressed the issues of comprehensive workforce recruitment. A standard of 1.5 wte social worker per 10,000 of population would equate to 41.25 social	On Service Area Risk Register Moderate Risk

	ASW staff are frequently lone workers and are responsible for the co-ordination of complex risk admissions to hospital between 9am-5pm. However, it is now a regular occurrence that ASWs on the Daytime Rota are still involved in carrying out their functions long after 5pm. This is mostly due to the need to convey Belfast patients to out-of-catchment acute psychiatric beds as a result of the lack of vacant beds in the BHSCT. This results in further difficulties in securing PSNI /Ambulance service to assist when an admission location cannot be agreed. ASW assessments are now taking considerably longer as the ASW is required to wait until the SHO on duty sees and assesses the patient and completes the Form 7. ASWs in BHSCT also have the task of assessing individuals who are located in either of two regional facilities (Beechcroft or Shannon). Difficulties regularly arise in establishing communication with mental health services in the Trust of origin particularly in those situations in which alternatives need to be identified.	workers in Adult Mental Health. Workforce planning profiling would indicate that current social work workforce complement in the Trust's Mental Health Services is lower than this standard. The Quality standards are to be reviewed in 2016. The Service Area is seeking clarification regarding the implications of the new Mental Health Capacity Bill. Until such clarification is achieved, the financial implications cannot be projected with any certainty. In the absence of greater clarity, the Trust is concerned about the potential scale of the impact of the legislation across all services, the substantial organisational challenges to train the workforce in the new legislation relative to their job roles, the need to progress as soon as possible workforce planning arrangements to meet the service delivery demands of the legislation at a Trust-wide level and, in particular for mental Health Services. The Service Area has completed a Workforce Review specifically in relation to ASW duties. The findings of the ASW Review recommend the need for a core ASW team which will work in parallel with a	

	ASW Rota Participation on the ASW rota has become increasingly more stressful. This is because ASWs also face growing demands on their time from within their own substantive posts. There remains a difficulty in retaining ASW trained staff on the Rota which is evidenced by a significant decrease in the number on the Rota over the past four years. Currently most ASWs will be scheduled for three Daytime Rota sessions per month – this will increase over the summer months to 4 or 5 sessions to take account of annual leave periods, term time and consideration for sickness cover. There are a number of retirements due in the coming year from the Rota. **ASW Planning** Uncertainty regarding potential changes to the ASW role linked to the Mental Capacity Legislation and related possible training/workforce/operational changes leaves the Service Area in a difficult position with regard to workforce planning. Major changes may be required in a relatively short timeframe.	secondary ASW rota. In addition, the Report indicates that there is requirement for a significant increase in the social work workforce within the community mental health teams. In light of the proposed Mental Capacity legislation, consideration will need to be given to workforce planning arrangements. The Trust has established a Multi-Agency Working Group involving PSNI, NIAS, Primary Care, Acute Hospital Services and Mental Health Services (including Home Treatment Team, Unscheduled Care Team, Acute inpatient services and Approved Social Work Lead). The initial Multi-Agency Forum facilitated by the Trust's Social Services Learning and Development Service has been arranged for early May 2106. It is planned that the core group will meet quarterly to continue to take forward the GAIN audit recommendations and to further develop working arrangements between the main agencies .The Service Area Co-Director has agreed to facilitate the interface Working Group the remit of which will include: ➢ Planning for joint training events. ➢ Improving and enhancing the	

	Modernisation With the continuing emphasis on community care and resettlement from hospital there is increased pressure on community teams. Teams are seeing a reduction in the ability of its Social Work Workforce to undertake Social Work non statutory function duties due to increase in Adult safeguarding / ABE / joint protocol and ASW duties of the Social Work Workforce.	understanding of each interface area and how this impacts on the duties and responsibilities of the ASW. ➢ Reviewing incidents and complaints to inform service improvements. ➢ Reviewing the development on local guidance regarding the Regional Interagency Protocol on the operation of Place of Safety and Conveyance to Hospital under the Order 1986 – October.	

3.8	**Key Social Work Workforce issues, including recruitment, retention, flexible working arrangements, workforce continuity etc. Information provided should include level and type of vacancies and any vacancy control systems in place.**
	Issues associated with the new regional HRPTS system have resulted in substantial delays in the recruitment process. It has continued to prove difficult to backfill vacant posts by internally recruiting as other programmes of care have been unable to release their staff. However, we have been able to backfill social work posts from agencies and we currently have 5x Band 5 AYE social work agency staff in place and 4x Band 6 Agency social work staff. The Service Area's social work workforce has been relatively stable with social work staff leaving due to retirement and/or to pursue career and professional development opportunities (1x left to join RESWS, 2x took up a specialist post, 2x moved to a different Trust, 2x promotion, 2x retired). The Service Area currently has 9x permanent social work vacancies and 1 temporary vacancy. The Service Area has received an excellent response to the latest recruitment programme and interviews are scheduled for mid-May. Across the community and hospital teams, there is only a limited number of social work staff. They perform a social work function and carry a full social work caseload. A number of social work staff have been recruited into non-designated social work posts as therapists/mental health practitioners. As a result the Service Area's available operational social work capacity has been diluted. This cohort of staff do not discharge statutory functions across safeguarding, carers assessments, ASW duties or case management. **Senior Social Workers / Team Leaders** There is an ongoing difficulty attracting social work staff to Team Leader /Senior Social Work (SSW) posts, a situation mirrored across other Service Areas. The availability of generic Band 7 posts and opportunities to practise as an ASW at Band 7 are disincentives to pursuing a Team leader role with its substantial remit and demands. The integrated organisational nature of the Service Area and the relative size of the social work workforce (10%) have further reduced opportunities for social work staff to secure Team Leader posts exacerbating the disincentives to pursue a managerial career pathway and further diluting the social work profile across the Service Area. The ASW Review has reinforced the need for a robust workforce planning approach to address the Service Area's future social work requirements. The Social Work Team Leader usually carries a small caseload and performs other functions e.g. participation on the ASW rota and discharging the DAPO role.

Approved Social Workers

Please see 3.5-3.7 above.

There continues to be a noted reduction of ASW staff within this reporting year. This is the result of retirements; sickness and maternity leave; staff securing other substantive posts at band 7 and as a result of their commitments in their new roles, no longer being available for ASW duties on the Daytime Rota. As at the end of June 2016 a total of eight staff will no longer be available for the Daytime Rota. Two staff who have completed their ASW training and secured accreditation have taken up post. A further four staff are completing their ASW training and will be in a position to fully discharge ASW functions in 2017. The Trust is currently recruiting applicants to Regional ASW Programme 2016-2017.

To address pressures on the Daytime Rota the operationalising of the recommendation in the ASW Review Report to create additional, dedicated ASW Daytime Rota capacity from the current social work workforce in the Mental Health Service Area and to backfill the released posts to maintain social work capacity across the Service Area. The impact of the hybrid option will be reviewed after six months as part of an ongoing focus on securing the ASW Daytime Rota and ensuring the Trust's capacity to discharge its statutory functions pertaining to the ASW role.

The fulfilment of delegated statutory functions carried out by the ASW continues to be a stressful task. Interfacing with other agencies and acute bed providers is an area of increasing difficulty. Pressures in relation to accessing Police and Ambulance Service assistance, securing inpatient beds when required, the rise in out of Trust admissions and related logistical challenges associated with same have exacerbated the challenges faced by ASW staff. In this context there has been a focus on consolidating and enhancing professional and organisational supports for ASWs to obviate the impact of the current pressures.

Whilst there is an ongoing interest amongst Band 6 social workers in undertaking the ASW training course, there is limited capacity for easement from their day-today workload. This may impact on candidates being willing to put themselves forward for the course. In addition, line managers may have difficulty releasing staff to undertake a year-long course. The Service Area is also required to provide Practice Assessors to work alongside candidates across the duration of the Programme. These are generally Band 7 staff who themselves have substantial operational remits and require some easement to enable them to facilitate their Practice Assessor role.

The ASW Review recommended that the Trust seek to commit staff contractually who complete ASW training to a minimum period of five years practising as an ASW post-accreditation to optimise Trust investment in their participation in the ASW Programme and to stabilise the ASW workforce. This recommendation is being pursued with the support of HR.

	The Trust has previously identified with the Commissioner the need to review the resourcing of the ASW Programme and, in particular, the area of easement to facilitate staffs' participation
3.9	**Trusts should provide a copy of their charging policies and provide explanation of what aspects of service provision you apply this to?**
	Home Help Service – The Trust operates in accordance with the Model Scheme for the Provision of a Home Help Service **Residential & Nursing Homes Charging** – The Trust operates in accordance with the DHSSPS April 2012 Charge for Residential Accommodation Guide (**CRAG**) to determine charges. Recent updated guidance has been circulated to relevant staff.
3.10	**Social Workers that work within designated hospitals** **Give an account of how these duties are fulfilled by social workers working in these designated hospitals**
	Approximately 60% of Service Users admitted to psychiatric inpatient units are already known to a Community Mental Health Team (CMHT). The CMHT key worker (whether social worker or CPN) provides in-reach into the acute psychiatric ward and is involved in assessment, care and discharge planning. Since September 2014, the Trust has had in place a Band 7 Discharge Co-ordinator (social work qualified). The postholder manages a team of three social work staff, 1x Band 7 ASW and 2x Band 6 social work staff. All of the staff are trained as Adult Safeguarding Investigating Officers. The Team has a pivotal co-ordinating remit across inpatient and community services to optimise service delivery continuity along the discharge pathway. The Discharge Co-ordinator and the Acute Social Work Team (the Acute Team) are responsible for providing a social work assessment to all service users admitted to the wards who are not key-worked by the community teams and to those service users known to specialist teams. The Acute Team plays a central role in completion of social histories and social work assessments to inform preparations for safe discharge planning and is also involved in reviewing those patients who have had prolonged admissions and those patients re-admitted within a six-month period. The Acute Team is currently involved in the Think Family Think Child pilot. The service user is assessed holistically with a particular focus on the implications for service delivery of any parenting or carer responsibilities they may have for dependent children. The Discharge Co-ordinator works closely with the Bed Flow Co-ordinator to manage a database which plot trends and patterns across admissions and discharges. The postholder undertakes the roles of ASW, DAPO, chairing of adult safeguarding meetings, chairing of PQC meetings and also holds a small caseload.

	In addition to the Acute Team, the Trust also employs 1x social worker who covers the Low Secure and Head Injury Unit and 2x social workers who cover the Medium Secure Unit based at Knockbracken Healthcare Park. They are managed by a Band 7 senior social worker. This team is supported by the Resettlement Team whose focus is to support long-stay patients who are transitioning from hospital to community living settings. Hospital social workers are regularly involved in submitting written and making verbal presentations to the Mental Health Review Tribunal (MHRT). The staff require a thorough understanding of human rights and the Mental Health (NI) Order 1986 alongside an accomplished knowledge and practice base.
3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with Service Users and carers.**
	Human Rights considerations permeate all aspects of the Trust's discharge of its statutory functions. The Trust's values incorporate a commitment to respecting the integrity of individual service users and to the delivery of person centred, qualitative care which seeks to enhance their wellbeing. The Service Area promotes a rights-based, citizenship model of service delivery within a strong recovery ethos. Partnership with service users and their families/carers in the delivery and review of services, communication, listening, transparency and respect are core dimensions to engagement and provide a template for ongoing interventions. The Service Area is committed to maximising service user participation in the review and development of services. The role of the Service Area's service user consultant encapsulates the embedding of a rights based approach within organisational structures. Human Rights considerations are integral to professional decision-making and are explicitly referenced in case file recordings and reports linked to the discharge of statutory functions involving restrictions of personal liberty. In such circumstances, the use of proportionate and least restrictive interventions informs social work practice. The proportionate use of statutory powers under the Mental Health Order is mandated only in those circumstances in which in the view of the responsible professional no alternative option will secure the safety and welfare of the individual service user or obviate the likelihood of harm to self or others. The Service Area mandates Human Rights awareness training for all staff. Specific training is provided in relation to Human Rights implications of the use of the Mental Health (NI) Order 1986 i.e. compulsory admission to hospital for assessment and treatment, applications for and renewals of Guardianship and referrals to the Office of Care and Protection.

	Service Area monitoring arrangements in relation to ASW and adult safeguarding documentation afford an opportunity to assure the quality of practice and incorporate a particular focus on evidencing the human rights of the service user. The Cheshire West Supreme Court Judgement 2014 details the test informing the concept of deprivation of liberty: ➢ The person had capacity to make decisions about their care and residence and is not free to leave without permission ➢ The person be subject to continuous supervision and control. ➢ The deprivation is the responsibility of the state and under Article 5 of the European Convention on Human Rights people cannot be deprived of their liberty unless it is lawful and with appropriate procedures and safeguards in place. Declaratory judgements are increasingly being considered in cases of complexity and uncertainty to ensure that a human rights-based approach informs practice, care and treatment of vulnerable service users. In light of recent advice form the Trust's Legal Representative which has been shared with the Commissioner, the Service Area is reviewing all those situations in which there is a deprivation of liberty to prioritise those which are of a nature and significance which would warrant consideration of the initiation of Declaratory Order proceedings. This is an area of significant concern to the Trust and it would be seeking early clarification from the HSCB as to the currency of available Guidance pertaining to this area, their expectations of the Trust in light of the legal advice available and the necessary resources to progress requisite actions. Within the Service Area, there is one current Guardianship case which has been referred to the Court for a Declaratory Judgement.

HUMAN RIGHTS

3.12	Identify any challenges encountered in the balancing of Rights.	3.13 What action have you taken to manage this challenge?	3.14 What additional actions (if any) do you propose to manage any on-going challenges?
	The use of compulsory powers under the Mental Health (NI) Order 1986 requires the careful balancing of human rights.	Staff training in human rights. Staff updates on legislative developments. ASW refresher and re-approval training. The provision of guidance and support on incorporating human rights considerations into all aspects of practice via training opportunities. The use of tools to prompt human rights considerations. The provision of accessible information to Service Users about their rights and the right to apply to the Mental Health Review Tribunal. The provision of independent advocacy services.	All on-going.
	The Mental Health Review Tribunal system is such that those who seek an independent review of an admission for assessment under the Mental Health (NI) Order 1986 are generally unable to obtain this within the timeframe of the assessment period. This again creates potential human rights concerns in relation to Article 6, Right to a Fair Trial.	This issue has been raised by the Service Area during consultation processes on new legislation which is currently being drafted.	On-going.

	Adult safeguarding work raises many issues in relation to balancing Human rights. Again these generally involve someone's right to protection versus a right to self-determination. It can also involve complex risk management decisions which seek to balance an individual's rights with those of others. The sharing of confidential information without the consent of a service user to safeguard the welfare of a child or vulnerable adult is an area of particular complexity.	Staff training on Human rights. Staff training on data protection. Staff training on adult safeguarding issues. Service area input into the Joint Protocol pilot. The provision of support groups for investigating officers and designated officers to promote good practice. The use of adult safeguarding tools which prompt consideration of human rights issues.	All on-going.

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	➢ The Trust has been awarded for the first time the full QNIC standards accreditation for Beechcroft CAMHS and Iveagh CAMHS. ➢ The Service Area's Psychological Talking Therapy Hubs were awarded second place at the Annual Chairman's Awards ceremony. ➢ A further Chairman's award was made to the HOPE Project, a recovery centred inpatient programme. ➢ The Trust was also a finalist in the DEL Employment Scheme for its supported deployment programme which seeks employment for a range of service users in AMH. ➢ The Service Area contributed the Trust's IIP Bronze Award accreditation. ➢ Forensic services in Shannon Clinic have been accredited as part of a quality network. ➢ Successful resettlement of Service Users and re-deployment of staff following a further ward closure and the development of a 24/7 community rehabilitation service. ➢ The opening of the new Fountainville Supported Housing Scheme with 24/7 supported accommodation for eighteen tenants. ➢ Service users and staff were involved in the development of five film clips to be used in the Recovery College's "How to make the most from appointments" course. ➢ The establishment of a Recovery College which has successfully been delivering courses/events throughout the year. ➢ The establishment of a 2 –7 community rehabilitation service as a result of significant investment following the closure of inpatient rehabilitation beds.
3.16	**SUMMARY**
	This has been a challenging year in the context of the overarching financial situation, the volume and complexity of service delivery demands in particular those associated with adult safeguarding service delivery, operational pressures associated with the management of the ASW Daytime Rota and ongoing difficulties in progressing recruitment of staff. From a social care perspective, workforce planning to address current and future social work staffing requirements is a key priority. The ASW Review has provided a succinct and comprehensive analysis of the service delivery, organisational, resource and capacity issues underpinning present operational pressures impacting on the Daytime ASW Rota. The early operationalising of the proposed hybrid model will

	facilitate the Trust's ongoing discharge of its ASW statutory functions and afford an opportunity to establish a robust template upon which to plan for the implementation of the Mental Capacity legislation which is likely to impact significantly on the ASW role. The Revised Adult Safeguarding Policy will present major challenges for the Service Area. A resolution of the Service Area's safeguarding service delivery structures will be a central theme in ongoing discussions with the Commissioner. Supervision arrangements within the Service Area have been strengthened. In this context, arrangements for the Trust's ASW Forum and the Service Area Social Work Forum have been reviewed to reflect an enhanced focus on structures to promote reflective learning and dissemination of best practice.

DATA RETURN 1
MENTAL HEALTH SERVICE AREA

1 GENERAL PROVISIONS			
		<65	65+
1.1	**How many adults were referred for assessment of social work or social care need during the period?**	**2458**	**15**
1.2	**Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?**	**2065**	**11**
1.3	**How many adults are in receipt of social work or social care services at 31st March?**	**1724**	**60**
1.3a	**How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?**	**1537**	**44**
1.4	**How many care packages are in place on 31st March in the following categories:**		
	i. Residential Home Care	**51**	**21**
	ii. Nursing Home Care	**67**	**38**
	iii. Domiciliary Care Managed	**113**	**48**
	iv. Domiciliary Non Care Managed	**53**	**8**
	v. Supported Living	**254**	**9**
	vi. Permanent Adult Family Placement	**0**	**0**
1.4a	**For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular.** ***Narrative*** The Service Area can provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care management HSC ECCU/1/2010 Circular.		
1.4b	**Please describe how the Care Management process is being managed in this programme with particular reference to decision making levels, review and care planning, highlighting any particular difficulties being experienced and how they are being addressed.** ***Narrative*** **Management Structure** The Service Area Care Management Service is organisationally managed and responsible to the Mental health Community Services Manager. The Operational Manager in turn provides the operational management to the service, including service planning, supervision and governance.		

	Decisions with regard to the day-to-day role and function of the Service are taken by the care managers who are responsible for managing the assessment of need, delivery and review of the care provided. Care Managers are qualified staff and registered with a professional body. **Challenges to the Service** With the continued and desired positive shift from hospital to community care, the Care Management Service faces particular challenges when the assessed need is for Supported Living Accommodation. It is noted that there has been an increase is complexity of referrals, specifically in relation to Service Users with a dual diagnosis- alcohol dependence' eating disorders, forensic history, Korsakoffs, acquired brain injuries, autism and personality disorder. There is reluctance on the part of the non-statutory Supported Living sector to consider referrals for these service user groups unless they have had previous admissions to Statutory Supported Living Schemes. The Service Area is finding that providers are unable to manage the numbers being referred with complex needs. Due to the overarching financial situation which is without of Trust control, Supported Living schemes which were expected to have opened this year and those that were planned for opening over the next one to two years have been placed "on hold"/or "approval withdrawn". These schemes are vital to Mental Health services and there absence will continue to place significant pressure on inpatient acute beds not only in BHSCT but on the region as we have seen in the increase in out of area acute admissions. This is also linked to the pressure on ASWs when admitting to out of area acute beds. The schemes that have been affected are University Street, Millburn II and the Altigarron redevelopment. University Street was planned to provide a service that would offer support to a smaller number of service users, in particular service users with a forensic history or dual diagnoses. As a result a number of service users will either be required to remain in hospital or be placed in less appropriate accommodation. Domiciliary Packages have also seen an increase in numbers with increasing complexity. The implementation of Self-Directed Support (SDS) over the coming year will be a driver for change in how services are both delivered and offered to service users. The Mental Health Care Management Service is exploring how to meet the challenge of implementing Self-Directed Support. The opening of new services such as Fountainville Supported		

	Housing and new specialist nursing and residential care facilities alongside requirements from RQIA in relation to the Trust's responsibility for patients finances, is leading to the role of care managers expanding further into a role of quality monitoring in the independent sector. Quality Monitoring includes the recording of incidents through Datix and the Care Management role in reviewing incidents, monitoring for patterns and Adult Safeguarding roles are added pressures on a limited resource. The development and opening of specialist nursing, residential and Supported Housing has been pivotal over the last few years to ensure the achievements and transformation that has already been made. BHSCT have asked that this should remain a priority in order to continue meeting the needs and challenges of the next few years.		
1.4c	**Please articulate how the views of Service Users, their carers and families are included in the decision making process, review and care planning.** ***Narrative*** Service users and carers are involved in all aspects of assessment, decision making, review and care planning. They are included in the decision-making process through a variety of mechanisms. Individual person-centred care plans are used in the care management approach. These care plans also seek to record the views of carers and family members. Every service user is informed of advocacy services and supported to avail of advocacy. Where it is apparent that a Service User or carer would benefit from additional support in this process, the care manager will link in with advocacy services. Service users and carers are central to the decision making and review process. They are encouraged to be fully engaged in their reviews and care planning arrangements. Information regarding the Carers Advocacy Service is disseminated and service users and carers' comments and perspectives on the process are used to inform service delivery developments and improvements. The review process facilitates care and support planning. The Service Area will continue its focus on embedding and strengthening self-directed support principles, culture and practice knowledge and skills base. Monthly monitoring is carried out by care managers in the statutory supported housing schemes The views of service users, carers and other professionals are integral to this process.		

1.5	**Number of adults provided with respite during the period**	*PMSI return*	*PMSI return*
1.6	**Number of adults known to the Programme of Care in receipt of Centre based Day Care**		
	- **Statutory sector**	**283**	**0**
	- **Independent sector**	**560**	**0**
1.6a	**Number of adults known to the Programme of Care in receipt of Day Opportunities**	**48**	**0**
1.7	**Of those at 1.6 how many are EMI / dementia**		
	- **Statutory sector**	**0**	**0**
	- **Independent sector**	**0**	**0**
1.8	**Unmet need (this is currently under review)**	X	X
1.8a	**Please report on Social Care waiting list pressures** ***Narrative*** Data for 1.5, 1.8 and 1.10 will be sourced by Board officers from existing Returns. ➢ 57 service users waiting for placements/package. ➢ 7 service users waiting for domiciliary care supports-waiting lists of up to 1-2 weeks for commencement of packages. ➢ 32 patients were waiting for supported housing at the end of March 2016. There is a continued demand for supported housing, especially in areas where it was historically under-developed. As noted above, the overarching financial situation has impacted on the supported housing development with potentially significant implications for community mental health services. ➢ The closure of the Calder Fountain residential facility has impacted on access to residential provision. ➢ 13 waiting on Nursing Care (4 from acute hospital, 1 community and 8 from NRU). The Priory are working in partnership with BHSCT to meet the specialist ABI nursing needs of the NRU patients. This service is planned for opening in October 2016 and will require extended and phased discharges. Care Management meet with the NRU team on a weekly basis to prepare for the discharges. ➢ Continuing Specialist inpatient provision for patients with an acquired brain injury has not been agreed with		

the Commissioner to date. This has contributed to increased pressures on mental health inpatient bed capacity.

The retraction of 24 in-patient beds has seen the care management and supported housing scheme waiting lists increase. This has been further compounded by the return of patients who have been on Extra Contractual Referrals (ECRs).

Care Management and the Supported Housing Schemes have seen an increase in referrals from Forensic Services, including a demand from other Trusts due to the regional nature of Shannon Clinic.

The opening of the Holywood Road Supported Housing Scheme this month will bring a reduction in these placement pressures. However, the new schemes that were planned to continue the community development are now in jeopardy as previously stated due to uncertainty of the sustainability of Supporting People funding.

The referral list for the statutory housing schemes has reached twenty patients waiting, including four from Shannon Clinic. This is the highest number recorded, more than double any previous number as taken over the last five years, which is evidence that the schemes are unable to meet the current demand. Without sustained development of supported living schemes supported by Supporting People funding this number is likely to increase further.

	Domiciliary Care	Direct Payments	Supported Housing	Residential Care	Nursing Care	Hospital
Acute Hospital	1	0	11	3	4	0
Community	6	0	17	1	1	0
Shannon	0	0	4	0	0	0
NRU	0	0	0	0	8	1
Total	7	0	32	4	13	1

1.8b

Please identify possible new service innovations that are currently supported by non-recurrent funding

Narrative

As identified earlier in the report, the number of private, community and voluntary accommodation based services for mental health Service Users have been increasing, in parallel with the complexity of need that these services are managing.

Drawing upon the learning from historical abuse enquiries and investigations such as Winterbourne, the Service Area as part of an overarching Trust focus, is seeking to develop robust quality monitoring mechanisms and governance

	arrangements that would extend beyond the individual, Service User focused Care Management review process. The Service Area has already established monitoring arrangements in a number of the schemes into which resettlement patients have moved and is seeking to extend such processes across the community sector. This process has facilitated providers accounting for standards of service provision, to identify workforce learning and development needs and other areas for service improvement.		
1.9	**How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?**	**9**	**0**
1.10	**Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations.** The Service Area Governance lead continues to prioritise the monitoring and management of complaints and the dissemination of learning/recommendations/ action planning arising from same. Service users and families/carers can access advocacy services to support and assist with the process of making a complaint.	~~*Board return*~~	~~*Board return*~~

Data for 1.5, 1.8 and 1.10 will be sourced by Board officers from existing returns.

DATA RETURN 1
MENTAL HEALTH SERVICE AREA
HOSPITAL

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	**How many adults or children were referred to Hospital Social Workers for assessment during the period?**	**0**	**273**	**2**
1.2	**Of those reported at 1.1 how many assessments of need were undertaken during the period?**	**0**	***232***	***2***
1.3	**How many adults or children are on Hospital Social Workers caseloads at 31st March?**	**0**	***84***	***2***

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

DATA RETURN 2
MENTAL HEALTH SERVICE AREA

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	**Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65**	**3**	X
2.2	**Number of adults known to the Programme of Care who are:**		
	Blind	**1**	**0**
	Partially sighted	**4**	**0**
2.3	**Number of adults known to the Programme of Care who are:**		
	Deaf with speech	**15**	**0**
	Deaf without speech	**9**	**0**
	Hard of hearing	**7**	**0**
2.4	**Number of adults known to the Programme of Care who are:**		
	Deaf Blind	**0**	**0**

2.2 The Service Area does not feel it can, with confidence, report on those who are blind or partially sighted. The Service Area needs to work with physical health and disability service to identify a process that will accurately account for Service Users within mental health who are on the Register.

2.3 The Service Area does not feel it can, with confidence, report on those as listed in this section. Figures are mainly reflective of the Regional Mental Health and Deafness Service. The Service Area needs to work with physical health and disability service to identify a process that will accurately account for Service Users within mental health who are in receipt of specialist services.

DATA RETURN 3
MENTAL HEALTH SERVICE AREA

3 DISABLED PERSONS (NI) ACT 1989 *Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability*		
3.1	**Number of referrals to Physical/Learning/Sensory Disability during the reporting period.**	**15**
	Number of Disabled people known as at 31st March.	**27**
3.2	**Number of assessments of need carried out during period end 31st March.**	**8**
3.3	This is intentionally blank	
	Narrative This information is not routinely collated in the Service Area. Therefore, there is a strong likelihood that the numbers of people who have a physical disability and are accessing mental health services are vastly under reported above.	
3.4	**Number of assessments undertaken of disabled children ceasing full time education.**	**0**

DATA RETURN 4

MENTAL HEALTH SERVICE AREA

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

4.1	**Number of Article 15 (HPSS Order) Payments**	**67**
	Total expenditure for the above payments	**£3,882**
4.2	**Number of TRUST FUNDED people in residential care**	**73**
4.3	**Number of TRUST FUNDED people in nursing care**	**105**
4.4	**How many of those at 4.3 received only the £100 nursing care allowance?**	**6**
4.5	**How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?**	**5**

DATA RETURN 5
MENTAL HEALTH SERVICE AREA

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65 +
5.1	**Number of adult carers offered individual carers assessments during the period.**	**0**	**362**	**45**
5.2	**Number of adult individual carers assessments undertaken during the period.**	**0**	**208**	**24**
5.3	**Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?**	**0**	**0**	**0**
5.4	**Number of adult carers receiving a service @ 31st March**	**N/A**		
5.5	**Number of young carers offered individual carers assessments during the period.**	**2**		
5.6	**Number of young carers assessments undertaken during the period.**	**2**		
5.7	**Number of young carers receiving a service @ 31st March**	**0**		
5.8	**(a) Number of requests for direct payments during the period 1st April – 31st March**	**9**		
	(b) Number of new approvals for direct payments during the period 1st April – 31st March 2016	**9**		
	(c) Number of adults receiving direct payments @ 31st March	**31**		
5.9	**Number of children receiving direct payments @ 31st March**	**0**		
5.9.a	**Of those at 5.8 how many of these payments are in respect of another person?**	**1**		
5.10	**Number of carers receiving direct payments @ 31st March**	**1**		
5.11	**Number of one off Carers Grants made in-year.**	**387**		

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

Commentary

During 2015/16 an additional £50k was secured for carers bringing the total budget to £177,601. This additional £50k was targeted at Adult ASD and CAMHS with each area receiving £25k. Adult ASD used their allocation on individual carer grants, courses of complementary therapies and enhanced payments to meet carer need. The service also hosted a planning workshop to help inform how they use the monies in 2016/17.

CAMHS also used some of their allocation on individual carer grants and courses of complementary therapies. Additional funding was given to the CAUSE Carer Advocate in CAMHS to organise short break activities. In consultation with carers a library resource

was also developed through the funding.

Within the Service Area, figures remain low in respect of 5.5, 5.6 and 5.7. The Service Area is hopeful that the current joint working with Action for Children will allow a pilot to commence in June/July 2016. This pilot will allow the provision of an Action for Children worker to work alongside Mental Health and Children Services. It is envisaged that part of the pilot will focus on improving an awareness and education of all disciplines on the needs of young carers in partnership with the Think Family Champions across both Service Areas.

DATA RETURN 6
MENTAL HEALTH SERVICE AREA

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

9 SAFEGUARDING ADULTS

DATA RETURN 7
MENTAL HEALTH SERVICE AREA

7 SOCIAL WORK STAFF

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 8

8 Assessed Year in Employment

Assessed Year in Employment (AYE) 2015-2016

Return for Employers year ending 31st March 2016

TRUST RETURN SUBMITTED BY SOCIAL SERVICES LEARNING AND DEVELOPMENT SERVICE AND APPENDED TO THIS REPORT

DATA RETURN 9
MENTAL HEALTH SERVICE AREA

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

Admission for Assessment Process Article 4 and 5		TRUST ASW	RESWS ASW
9.1	**Total Number of Assessments made by ASWs under the MHO**	**231**	
9.1.a	**Of these how many resulted in an application being made by an ASW under (Article 5.1b)**	**168**	
9.1.b	**How many assessments required the input of a second ASW (Article 5.4a)**	**3**	
	Comment on any trends or issues in respect of requests for ASW assessment or ASW applications There is no major change in the requirements or usage of a second approved social worker		
9.1.c	**Number of applications made by the nearest relative (Article 5.1.a)**	**1**	
	Comment on any trends or issues in respect of Nearest Relative applications for admissions There continues to be an improved awareness amongst GPs and medical staff to inform families of the role of the Approved Social Worker in the applications for assessment process.		
9.1.d	**Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge?** The Service Area is compliant with discharge requirements.		
Use of Doctors Holding Powers (Article 7)			
9.2	**How many times did a hospital doctor use holding powers?**		**95**
9.2a	**Of these, how many resulted in an application being made?**		**89**
	Comment on any trends or issues on the use of holding powers		
ASW Applicant reports			
9.3	**Number of ASW applicant reports completed**		**231**
9.3.a	**How many of these were completed within 5 working days**		**231**
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken. Nil identified.		

Social Circumstances Reports (Article 5.6)		
9.4	**Total number of Social Circumstances reports completed.** *This should equate to number given at 9.1c. If it does not please provide an explanation.*	**1**
9.4.a	**Number of completed reports which were completed within 14 days**	**1**
	Please provide an explanation for any Social Circumstances Reports that were not completed within the requisite timescale, and / or any discrepancy between the number of Nearest Relative applications accepted and the number of Social Circumstances Reports completed, and what remedial action was taken. Nil identified.	

Mental Health Review Tribunal

9.5 **Number of applications to MHRT in relation to detained patients**

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**3**	**3**	**0**	**0**	**0**
Patient	**79**	**52**	**0**	**21**	**2**
Nearest Relative	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**
Total	**82**	**55**	**0**	**21**	**2**

Comment on any trends or issues in respect of Mental health Review tribunals

The Service Area recognises the need to have contingency and support plans in place for the service user at the point of the MHRT hearing including inputs from Trust community services, care management and other agencies/providers as appropriate. A pre-Tribunal hearing MDT is convened to review care plans and to identify contingency plans and communication arrangements in the event of a Tribunal decision to discharge out with the Trust's recommendation.

The PSW is currently reviewing the training needs of social work staff in relation to report writing for MHRTs.

9.5.a	This is intentionally blank	

Guardianships (Article 18)

9.6	**Number of Guardianships in place in Trust at period end**	**4**
9.6.a	**New applications for Guardianship during period (Article 19(1))**	**0**
9.6.b	**How many of these were transfers from detention (Article 28 (5) (b))**	**0**
9.6.c	**How many were Guardianship Orders made by Court (Article 44)**	**0**
9.6.d	**Number of new Guardianships accepted during the period (Article 22 (1))**	**0**
9.6.e	**Number of Guardianships renewed during the reporting period (Article 23)**	**4**
9.6.f	**Number of Guardianships accepted by a nominated other person**	**0**

9.6.g **Number of MHR hearings in respect of people in Guardianship**

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**1**	**0**	**0**	**0**	**0**
Patient	**0**	**0**	**0**	**0**	
Nearest Relative	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**
Total	**1**	**0**	**0**	**0**	**0**

9.6.h **Total number of Discharges from Guardianship during the reporting period (Article 24)**

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

Comment on any trends or issues in respect of Guardianship

Guardianship is used on an infrequent basis in the Service Area.

	When appropriate, it provides a proportionate statutory vehicle to promote security and uptake of supports to service users.	
Approved Social Worker (ASW) Register		
9.7	**Number of newly appointed Approved Social Workers during period**	**3**
9.7.a	**Number of Approved Social Workers removed during period**	**5**
9.7.b	**Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)**	**28**

CORPORATE COMMENTARY

There has been a steady decrease in the number of ASWs available to participate in the Trust's Day Time Rota over the past number of years. There are concerns that the Trust, under the present arrangements, will not have capacity to meet the statutory requirement set out in Article 115 of the Mental Health (NI) Order 1986 (the Order) in respect of the availability of ASWs to discharge the range of statutory functions as specified in the Order.

While four social workers from the Trust are currently participating in the Regional ASW Training Programme and hopefully will be assessed as competent, they will not be available for appointment by the Trust until October 2016 and will then be required to undertake a period of "shadowed practice" before they can operate as autonomous practitioners. Therefore this could result in them not being on the Daytime Rota until January 2017.

The potential addition of these four social workers will not fully offset the number of ASWs lost through retirement/those who have moved to other posts/other Trusts/ RESWS. Of the cohort of twenty-eight, one has already indicated that due to demands of work as a Team Leader they will be withdrawing and another has indicated they will be retiring in June 2016.

The Trust has twenty-eight ASW trained staff currently on the Daytime Rota. Training of additional ASW staff has been identified as a priority within the Service Area. Nominations for the 2016/17 Regional ASW Training Programme are presently being collated.

Additional ASW duties include Guardianship-related functions and inputs into MHRT cases in light of their knowledge, skills and experience in this area. ASWs also provide a consultation role to those teams/services which do not have ASWs or social workers. Service Area ASWs participate in refresher training throughout the year and re-approval training every three years.

Due to the pressures of the ASW rota the 'floater' has been replaced as a third member on the ASW rota. This is because it is a regular occurrence that all three ASWs on the Rota on a daily basis are called out to assess patients. On a regular basis there can be multiple ASW assessments requested on the same day.

It is now a regular occurrence that ASWs on the Daytime Rota have to wait substantial lengths of time for the ambulance and PSNI to support the

	conveyance of service users to hospital in those circumstances in which significant risks to the service user or others are extant. These situations are exacerbated by difficulties in accessing beds in the Trust's area. This results in ASWs having to accompany those requiring admissions to hospital to units across the region. Such episodes can significantly impact on the ASWs' ability to fulfil the requirements of their core posts. An inter-agency group involving representatives from the PSNI, the NI Ambulance Service and Trust's Unscheduled Care, GP Out of Hours and ASW Services has been established to address interface matters relating to their respective responsibilities and pathway processes pertaining to assessments for admission under the Order. The Trust has completed a review of ASW activity. The Review highlighted a number of key organisational, logistical and professional issues impacting on the delivery of the ASW Daytime Rota including: the diminution over a number of years of the complement of designated social work posts in the Mental Health Service Area; the increase in demands on available social work resources of the exponential increase in adult safeguarding activity and, in particular, the projected and current impact to date of the Revised Adult Safeguarding Policy determination that social work will be the lead profession in safeguarding service delivery; the increasing complexity of ASW-related activities; the impact of the difficulties of out- of -Trust admissions; the difficulties associated with interfaces across the PSNI, Ambulance Service, Unscheduled Care and ASWs in respect of assessments for admission; the need to develop a robust workforce planning approach to social work requirements in Mental Health (including ASWs) incorporating the implications of the Mental Capacity legislation; and the resourcing of and supports for staff engaged in the Regional ASW Training Programme. The Review's proposal for the establishment of a hybrid ASW Core Team to address the immediate pressures on service delivery and to ensure the Trust's capacity to discharge its statutory functions has been agreed and is currently being actioned. The Principal Social Worker (PSW) in Mental Health with operational responsibility for the co-ordination of the Rota works closely with the Regional ASW Group in relation to the review of documentation to ensure a consistent approach across the region. In addition, the PSW has also revised local ASW documentation relating to alternative care planning for patients who have been assessed as not requiring detention for assessment under the Order. Breakaway training has also been scheduled for June 2016 for all ASWs on the Daytime Rota. In-house bespoke training has also been completed on the Regional Interagency Protocol in February 2016. ASWs have been appraised of the PSNII risk assessment process for thresholding and prioritising referrals and have been advised of the importance of providing clear and factual information in respect of assessed risks when requesting PSNI assistance. The PSW has reviewed as a priority the provision of reflective practice

supervision sessions for ASW staff. These are now “up and running” and take place on a 6-8 weekly basis. The PSW has also re-launched the ASW Forum which meets twice a year. Attendance at the ASW Forum alternates with the reflective practice groups and attendance is mandatory (i.e. 75% attendance). The Trust will continue to review and develop supports to its ASW workforce.

The Regional Audit of Assessments for Admission under the Mental Health (NI) Order 1986 was launched in March 2016. The Report will contribute to an ongoing Trust focus on improving ASW organisational and service delivery arrangements and the management of internal and external interfaces.

Trust senior management are reviewing a number of interface issues across the RESWS and the Daytime Rota.

The Trust has robust administration structures in place to monitor ASW numbers, accreditation and re-accreditation arrangements.

9.8 **Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If so please provide detailed explanation for each and every instance including their age and relevant powers used.**

Age	Mental Health presentation	Location of assessment and Powers used
14	Self-harm, suicidal	Assessed in RVH A&E Form 2, 3, 5 completed
14	Physical aggression, suicidal	Community Assessment Forms 2,3 completed
14	Physical aggression	Community Assessment Forms 2, 3 completed, admitted to Iveagh
15	Suicidal ideation	Assessed at Beechcroft Forms 2,3 completed
15	AWOL, suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
15	Suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
15	Physical aggression	Assessed at Mater A&E Forms 2, 3 completed, admitted to Iveagh
15	Physical aggression / Low mood	Assessed at Beechcroft Forms 2, 3 completed
16	Depression / Eating Disorder	Assessed at RVH Forms 2, 3 completed
16	Suicidal / Physical aggression	Assessed at Beechcroft Forms 2, 3 completed
16	Low mood / suicidal	Assessed at Beechcroft Forms 2, 3 completed
16	Depression / suicidal	Assessed at Beechcroft Forms 2, 3 completed
16	Physical aggression	Community Assessment Forms 2, 3 completed, admitted to Iveagh
17	Suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
17	Suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
17	Depression / Eating Disorder	Assessed at Beechcroft Forms 2, 3 completed
17	Suicidal	Assessed at Beechcroft

			Forms 2, 3 completed
	17	Self Harm	Assessed at Beechcroft Forms 2, 3 completed
	17	Low Mood / Self Harm	Assessed at Beechcroft Forms 2, 3 completed
	Out of Trust Assessments		
	15	NHSCT Depression / Self Harm	Assessed at Beechcroft Forms 2, 3 completed
	17	WHSCT Self Harm	Assessed at Beechcroft Forms 2, 3 completed
	17	WHSCT Self Harm	Assessed at Beechcroft Forms 2, 3 completed

9.9*	**How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?**	**4**
	Referrals to The Office of Care and Protection have been largely made when a person is deemed to be incapable of managing their financial affairs and has no other means of support in managing their finances. Management of an individual's finances is a challenging task for the Service Area given the degree of auditing measures and the sheer size of the organisation. The Service Area will be reviewing how an individual's finances can be managed in a way that responds to the individual's circumstances and needs while meeting the requisite regulatory accounting standards.	
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A (6). **Schedule 2A Supervision and Treatment Orders.**		
9.10	**Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March**	**1**
9.11	**Of the Total shown at 9.10 how many have their treatment required as:**	
	Treatment as an in-patient	**0**
	Treatment as an out patient	**1**
	Treatment by a specified medical practitioner.	**0**
9.12	**Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)**	**0**
9.13	**Of the total shown at 9.10 how many of these supervision and treatment orders were made during the reporting period.**	**1**
	There has been a limited usage of Article (50) A6 Schedule 2A Supervision and Treatment Order. There have been no difficulties with regard to the current Order in place. It has proved to be a productive and effective process for the service user and service.	

LEARNING DISABILITY SERVICE AREA

GENERAL NARRATIVE

3.1	**Named Officer responsible for professional Social Work**
	Ms Aine Morrison remains the Associate Director of Social Work in Learning Disability (LD), a post she has held since 1.7.13. Mr John Veitch, Co-Director for Learning Disability has assured the Service Area Report which meets the requirements of the prescribed audit process in respect of the discharge of statutory functions. The Associate Director of Social Work has responsibility for professional issues pertaining to the social work and social care workforce within the Service Area. She is accountable to the Executive Director of Social Work for the assurance of organisational arrangements underpinning the discharge of statutory functions related to the delivery of social care services within the Service Area. The Associate Director of Social Work is responsible for: ➢ Professional leadership of the social work and social care workforce within the Service Area. ➢ The establishment of structures within the Service Area to monitor and report on the discharge of statutory functions. ➢ The provision of specialist advice to the Service Area on professional issues pertaining to the social care workforce and social care service delivery, including the discharge of statutory functions. ➢ The collation and assurance of the Service Area interim and annual statutory functions' reports. ➢ The promotion and profiling of the discrete knowledge and skills base of the social care workforce within the Service Area. ➢ Ensuring that arrangements are in place within the Service Area to facilitate the social care workforce's learning and development opportunities. ➢ Ensuring that arrangements are in place within the Service Area to monitor compliance with NISCC registration requirements. An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through the Service Area line management and professional structures to the Executive Director of Social Work.
3.2	**Supervision arrangements for social workers**
	The Service Area continues to work to the Belfast Trust Adult Social Work Supervision Policy which covers both line management and professional supervision arrangements. The Policy provides for line management supervision for social workers at least every six weeks and where the line manager is not a social worker, additional professional supervision on a quarterly basis. All supervisory staff have received training on this policy. Supervision affords a mechanism for addressing organisational

	engagement, performance and accountability and a vehicle for feedback and reflection which are fundamental dimensions to learning and development. Under the auspices of the Regional Social Work Strategy a revised regional adult social work supervision policy and standards is being developed with a strong evidence based-focus, linking investment in supervision delivery with enhanced workforce knowledge and skills and improved service delivery outcomes. The revised policy will incorporate a range of supervision delivery options incorporating group and peer supervision models within a strong emphasis on reflective approaches. A team leader vacancy has created some difficulties in meeting these standards in one of the multi – disciplinary teams. This difficulty was managed by continuing with individual supervision but with reduced frequency and by ensuring arrangements were in place to cover immediate case management issues and access to professional supports on request. This team leader post has recently been filled. The Service Area held a workshop with its social work staff in May 2015 to update and develop the learning disability social work pathway. This was a very good opportunity for a significant number of new social workers who had joined the Service Area recently to create a shared vision for social work with the existing staff. Learning Disability social workers also continue to attend Approved Social Work Fora, Designated Officer Support Fora and Achieving Best Evidence Support Fora as appropriate. These are highly valued sessions which ensure staff have access to support in these complex areas of practice and are kept appraised of developments in these fields. In relation to supervision of AYE staff, the Service Area is compliant with the Revised Guidance for Registrants and Their Employers, NISCC July 2010. AYE social workers are facilitated to attend the Trust's AYE Forum. The Service Area has employed one AYE staff member during this reporting year who completed in July 2015.
3.3	**Report on processes, audits, reviews, research and evaluations undertaken during the year, that measure performance against delegated statutory functions, identifying emerging trends and issues (may include cross references to other sections to this report).**
	.The Service Area is now into Phase 3 of its short breaks review. Phases 1 and 2 have involved data collection and analysis of a wider range of factors including; 1. The amount of LD short break provision provided by BHSCT 2. Who is accessing the service and what is the frequency of access. 3. The equity of provision and access. 4. The cost structure. 5. An assessment of need for each service user. 6. The current allocation process. 7. Matching usage to the service user assessment of need. 8. Matching costs and any differential to assessment of need.

9. Reviewing the cost effectiveness and value for money of current provision.

The data collation and analysis have highlighted a number of difficulties relating to;

1. Under usage of some services compared to unmet demand for others
2. Geographical inequities in provision
3. Cost variations with associated value for money queries
4. Allocation matching assessment of need.

Phase 3 to date has involved a series of workshops with service users, carers, statutory sector staff and independent sector providers where the outcome of the data gathering and the data analysis was shared and views on this information sought.

Key themes from service users were;

1. Their enjoyment of short breaks as long as there were plenty of activities available.
2. A wish for more short breaks
3. Some difficulties about sharing with other service users.

Key themes from carers were;

1. The importance of short breaks
2. A wish for more short breaks.
3. A wish for availability of different types of short breaks.
4. A wish for more information about short breaks
5. A wish for earlier notification about their allocation.
6. A frustration with transport difficulties associated with short breaks.

A further series of workshops is planned for June 2016 to develop proposals for the future shape of short break provision.

Service Area internal procedures require team leaders to carry out random file audits during each supervision session with team members. Operations managers are required to carry out quarterly audits of the standard of these file audits. Operations Managers are also required to carry out a monthly audit of the quality of supervision provided by team leaders. As detailed in 3.2, staff absence and vacancies at management level have caused difficulties in meeting some of these internal Service Area standards. A current vacancy at operations manager level will continue to affect performance in this area until the post is filled.

The Service Area complies with Trust procedures on supervision exception reporting which ensures that any difficulties in providing supervision are highlighted to senior management and action plans agreed at that level.

A wide variety of statistics are gathered on a monthly basis from the four community teams. These include statistics on case numbers, adult safeguarding activity, Mental Health Order activity, carers' assessments, direct payments and unmet need. These are monitored at Operations Manager level for compliance with requirements and for emerging issues and trends.

	The Service Area performed well in a regional audit of user and carer involvement in adult safeguarding processes which took place in November 2015. An internal Service Area audit of the quality of safeguarding recording took place in March 2015. The audit found good standards generally but felt that a template/guide to the areas to be covered at meetings would promote consistency across teams. The Service Area's safeguarding service will be taking this recommendation forward. The Service Area performed very well in an internal audit of compliance with supervision standards which took place in November 2015. The Service Area's annual audit of compliance with adult placement regulations took place in May 2015 and found good compliance in all areas. The BSO audited the Service Area in relation to the "Management and Reporting of Discharge of Statutory Functions by Social Workers 2014/15". This audit showed problems with evidence for and assurance of data returns. The Service Area is trying to address these problems but resources and systems for information management remain a challenge. PARIS has recently been introduced for the Service Area but data reports are not yet available for Learning Disability services so this year's report has not been able to make use of these. The Service Area is due to provide information for 2015 – 2016 in June 2016 for the LDSF return. The Service Area will endeavour to report as accurately as possible but remains concerned about the relevance of some of the standards and the difficulties which all Trusts have reported with reliability and validity of some of the data. The HSC Board recently reviewed 120 Service Area files, 60 from community teams and 60 from residential and supported living services for the purposes of LDSF data. The Service Area generally performed well but there was a significant decrease in evidence for annual reviews being available. The Service Area is currently reviewing what may have caused this. B.S.O. audited the Service Area's care management contracting processes but the Service Area has not had an outcome as yet. The Service Area also participated in the regional Gain audit of ASW admissions. The most recent Trust wide audit of compliance with forms and process requirements under the Mental Health (N.I.) Order 1986 showed 100% performance in Learning Disability services.

3.4	**Report on the Programme of Care's interfaces with other statutory agencies including for example: NISCC; RQIA; PHA (in relation to social care) Trusts should include references to Judicial Reviews or other significant Court Judgements that directly impact on the discharge of statutory functions.**
	All social work and social care staff in the Service Area who are required to do so are registered with the NISCC. This is monitored via supervision arrangements in line with the Trust's Registration and Verification Policy. The Trust also maintains a central register and monitors the registration status of all relevant staff through this. Social workers are supported to meet the NISCC's on-going professional development requirements. The Trust's Personal Contribution Framework process allows for each social worker to have a Personal Contribution and Personal Development Plan. The Service Area also provides induction for all new staff which meets the NISCC's induction standards. This includes a two day learning disability-specific induction course developed and run by the Service Area with the direct input of service users and carers. The Service Area carries out a number of functions under The Mental Health (NI) Order 1986 and meets the requirements of the RQIA and the Mental Health Review Tribunal in relation to these. These include the provision of the necessary paperwork, reports and notifications for admissions for assessment, Guardianship and tribunals. The Service Area has reported previously on discussions with the Mental Health Review Tribunal to discuss the implications of its decision to notify patients of discharge on the day of the hearing. The Service Area had met with the MHRT on 3.7.14 and made a number of suggestions about timing of Tribunals and the communication process for Tribunal decisions. The MHRT was to consult further with their staff about these proposals and respond to the Trust. The Trust then had some difficulties in getting any further response. However, a useful meeting was held with MHRT staff on 4.2.16. The MHRT has had a lot of staff changes so previous discussions were not familiar to them. Trust staff noted that the practice of holding Tribunals on Friday afternoons had stopped but that there was still some concern about how informing the patient of the Tribunal decision was managed. Trust staff indicated a clear preference for this to be done when the patient was back on the ward where it would be much easier to make appropriate discharge arrangements. Tribunal staff agreed to consider this. It was also agreed that Trust and Tribunal staff should meet annually to discuss any issues. The Service Area's day care facilities, residential and supported living services are all registered with the RQIA and subject to on-going inspection and monitoring. The Service Area notifies the RQIA of any untoward incidents as per their

reporting requirements.

The Service Area liaises with RQIA on adult safeguarding issues as they arise in relation to any registered facility.

The Service Area has contributed as appropriate to MARAC and PPANI processes.

The Service Area liaises with the PSNI as per the Joint Protocol arrangements where appropriate.

The Service Area remains as reported in previous years concerned about the changes in the Office of Care and Protection (OCP) practice about their willingness to manage service users' affairs. The Service Area has also had some contact from the OCP in relation to a service user whose behaviours are such that they contact the OCP regularly and another Service Area in the Trust has had a similar experience. The OCP charge service users for all these contacts and have suggested that they may no longer be able to provide them with a service. The Trust has significant concerns about such an approach as it is the service users' disabilities that cause them to act in the way that they do. The Trust has recently written to the OCP seeking a meeting to discuss such matters.

The Service Area and the Trust continue to work in partnership with the Housing Executive in relation to the Supporting People programme. However, planning and budgetary uncertainty in the Housing Executive has caused significant difficulties recently where discussion about future schemes has halted altogether and plans for existing schemes have been postponed. As discussed elsewhere in this Report, the Service Area has an ongoing need for supported housing to meet need particularly for those service users with complex needs and this situation is having a significant impact on service delivery.

High Court Applications

The Service Area is in the process of making high court applications for declaratory judgements in two cases where the Service Area believes it is depriving the service users concerned of their liberty.

In the first case, the service user is accused of a serious violent crime and although the criminal justice process has not imposed any restrictions on his liberty to date, the Service Area felt it was necessary to do so in order to keep others safe.

In the second case, the service user has profound disabilities which require a locked door in his adult family placement home to keep him safe. The service user is also subject to Guardianship because his natural family object to the placement with the adult family scheme. The Mental Health Review Tribunal (MHRT) adjourned a hearing with the suggestion that the Trust seek a Declaratory Order in relation to the elements of his care plan that involved a deprivation of liberty (DOL). The Tribunal stated that it could

	only rule on the grounds for Guardianship and that the Trust needed separate authority for other aspects of this service user's care. The Service Area sought legal advice from the Directorate of Legal Services (DLS) on the MHRT's position in this matter, particularly in relation to its application to other similar cases. In a departure from previous advice, DLS suggested that the Trust needed to actively seek legal authorisation for any DOL as defined by the Cheshire West case. The advice read as follows; *'As I understand matters the impetus for a declaratory order application, in the instant case, emanates from the MHRT.* *The MHRT is a creature of statute, its powers are strictly confined to those given to it under the MHO and it is not in a position to approve a DOL* *In cases involving both Guardianship and DOL the MHRT is refusing to deal with the case and making a recommendation that Trusts obtain a Declaratory Order from the High Court giving approval to the DOL. These Guardianship cases are simply being adjourned pending the relevant Trust obtaining a Declaratory Order. A number of such cases are pending.* *Having had a quick review of the papers relating to PT, the "concrete" situation is such that the current living arrangements for PT will be held to amount to a DOL as per the guidance issued by the Supreme Court in Cheshire West.* *Taking into account the fact that practically every single person, either placed by or with assistance from the Trust, for example in an EMI unit will be likely deemed to have been deprived of their liberty, it is possible that Belfast Trust could well be involved with well in excess of 1000 persons who will be deemed deprived of their liberty.* *As it currently stands the Trust will be required to bring forward a declaratory order application for each and every one of these cases. In Northern Ireland such cases can only be adjudicated upon by the High Court. Accordingly, the Trust will be required to pay Court fees in each case and will be liable for the fees of Counsel. In the most straightforward of cases which are dealt with without issue there is likely to be costs to the Trust of approximately £2000. In cases with added complexity the costs could be many times more.* *Further, in each case, the Trust will require to provide specific capacity reports from a psychiatrist and a comprehensive and detailed social circumstances report, most likely compiled by the involved social worker. Both authors will be required to attend Court on every occasion the matter is before the High Court. It must also be remembered that the Court will not grant a "forever" order and additional reports will likely be required to be lodged with the Court, perhaps on a yearly basis. Thus in addition to financial expenditure there will be considerable staff time and effort involved in each case.*

As I understand matters, in England central government allocated an additional 160 million to local authorities for legal expenditure consequent upon the Cheshire West judgment (this despite the fact that other procedures are in place in England which mean that far fewer cases pro rata would require to be brought before the Court). I do not understand there to be any expectation of additional resource from Stormont .

You are aware of the SE Trust case. This case concluded in November 2014 and to date the Court has failed to issue guidance as to the practical way forward in DOL cases. (it was hoped that in straightforward cases that perhaps a paper based procedure could be developed to deal with appropriate cases) I have no expectation that a judgment will be issued in the near future. In the interim a number of cases have been brought before the High Court on a case by cases basis and declaratory orders have been granted.

In light of the above, (and in light of the delay in the judgment in the SE case) my advice is that applications should be brought in ALL cases where there is a deprivation of liberty but mindful of the expenditures both financially and in terms of staff time it may be appropriate to prioritise cases which should be brought before the Court at first instance.

To my mind at least these cases -"red flag cases "- should include inter alia:

- *Cases where family object to placement or conditions of placement*
- *Cases where the service user objects (albeit that in accordance with the dicta of Cheshire West compliance/ non-objection or indeed the positive approval of an incapacitous service user are not relevant)*
- *Cases where the MDT has different or varying perspectives as to the best interests of the patient*
- *Cases where there are severe restrictions placed on the service user*
- *Cases where Guardianship is in situ and the arrangements in place amount to a DOL*

The above list is not exhaustive'

The Service Area is currently working to identify such "red flag" cases.
The advice has very significant implications for Learning Disability services and beyond. This advice potentially applies to a significant proportion of those in residential, nursing home or supported living settings and potentially day care settings. It may also apply to informal patients in psychiatric hospitals and incapacitated patients in acute hospitals.

	The implications fall into four main categories; 1. Workforce capacity. 2. Financial cost 3. Staff training 4. Service user and carer impact Learning Disability services carried out a scoping exercise in 2014 of service users it was believed could be described as deprived of their liberty. It was estimated that 500 service users out of a total community population could be described as deprived of their liberty and 54 out of a total hospital population. These figures demonstrate the scale of the task if legal authority was to be sought for these cases. The minimum cost based on DLS's estimates would be approximately £1 million. As a comparison in terms of workforce capacity, LD services currently have just three service users subject to guardianship and the Trust as a whole has seven. Muckamore Abbey Hospital had 18 Mental Health Review Tribunals in relation to detained patients in the period from 1.4.14 – 31.3.15. Guardianship and detention processes and Tribunals probably offer a reasonable approximation to the amount of time and work involved although this is difficult to gauge as we do not know how the High Court would respond to these issues coming before it. Numbers of those who might fall into the categories suggested by DLS as part of a graduated approach would probably be relatively small but scoping in relation to this has not been completed as yet.

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
1.	Appropriate provision for the accommodation and support of care leavers who have a learning disability continues to be a major difficulty. These young people have highly complex needs and service provision that meets their needs is severely lacking. The Service Area provided accommodation and support packages for two care leavers during last year's reporting period. The combined cost of these packages is £320,430 per annum. The Service Area is working to provide placements for a further six care leavers in 2016-2017. Again, these young people have highly complex needs and placements are expected to have a total cost in the region of £ 628,560 per annum. In addition the Service Area continues to have two young people placed in treatment services in England. We are currently actively seeking a placement in N. Ireland for one of them but are experiencing significant difficulties finding appropriate provision. Initial cost	The Service Area has received significant cost pressure funding from the HSC Board this year to help meet the ongoing financial demands which has been very welcome. The Service Area has very recently introduced a new planning process which ensures that those young people who may need funding beyond the funding available in core day services are identified earlier. The Service Area has an identified Operations Manager with responsibility for transitions planning who continues to scope the needs of this population. The Service Area continues to run an accommodation planning group which plans ahead for their needs. The Service Area works with a number of independent sector providers where opportunities present which may meet the needs of these young people.	This issue is on the Service Area Risk Register and is categorised as a moderate risk.

	indicators from one provider are suggesting a cost of approx. £500,000 per annum for this service user. Difficulties with service provision for children transitioning into adult services are not confined to care leavers. Adult services often struggle to provide the same level of provision as had been the case. This is a particular issue in relation to short breaks provision. In addition, the Service Area is increasingly struggling to find appropriate day services for young people transitioning from school particularly where they have very challenging behaviour and need lots of physical space and individual support.	The Service Area continues to make these cost pressures known to the HSC Board. The Service Area's day services strategy aims to target day centre provision for those with the most complex needs which will involve a process of supporting individuals with less complex needs towards more integrated provision. However, this is a process that will take time and that has to accommodate the anxieties of those involved.	
2.	The HSCB will be aware of the ongoing difficulties the Service Area has encountered in achieving the PTL resettlement target for this year. The target for the year 2015/16 was sixteen. One of these patients died and one patient completed a first overnight but then chose not to continue with the process. Three others have completed or commenced their trial resettlements. This leaves twelve patients to be resettled during 2016-2017. Eight of these patients have plans for a move into their new homes pre March	The Service Area will continue to work with the HSCB in achieving the retraction plan for the hospital. The Service Area believes that the community infrastructure funding which the HSCB has made available has strengthened the services available to support these placements.	This issue is on the Service Area risk register and is categorised as a high risk.

	2017; and four have plans for a new supported living scheme in the Belfast Trust scheduled for completion in June 2017.		
3.	This year's target for funded delayed discharge patients was six. Of these, three have been either resettled or have commenced trial resettlement. The remaining three are awaiting the development of the new specialist supported living scheme in the Belfast Trust scheduled for completion in June 2017. In addition, the Service Area has resettled a further four delayed discharge patients who had complex delayed discharge funding made available to them. There remain sixteen unfunded Belfast Trust delayed discharge patients in MAH.	The Service Area strives to achieve discharge as soon as possible for patients. Discharge planning commences from the point of admission to try and prevent further delayed discharges. The Service Area's accommodation planning group continues to plan for all delayed discharge patients and this group of service users are given high priority for any vacancies that arise.	This issue is on the Service Area Risk Register and is categorised as a high risk.
4.	The Service Area is experiencing pressure on the availability of acute admission beds due to the numbers of delayed discharge patients in admission wards. On eleven occasions, there have been no admission beds available for urgent admissions and patients have had to sleep out in other wards for a number of nights or on occasions for longer. This situation has	The Service Area continues to actively plan for all delayed discharge patients to move out of the hospital as soon as possible. Community services have developed their capacity to provide assessment and treatment in the community and are working to both prevent admission and provide earlier	This issue is not on the Service Area's risk register but is monitored very closely for ongoing trends.

	also meant that planned admissions have had to be delayed. On two occasions this year, patients from the Western Trust have been admitted to Muckamore due to a lack of availability of beds in Lakeview.	discharge support.	
6.	The Service Area remains significantly concerned about deprivation of liberty safeguards for those who lack capacity. The Service Area continues to feel that the Departmental guidance of 14/12/10 on the issue does not give definitive advice about how to act in the legislative vacuum that currently exists. This concern has been heightened by the Cheshire West Supreme Court decision, the recent DLS advice received and the current advice about Guardianship and deprivation of liberty being issued by the Tribunal. The Service Area would welcome further guidance from the HSCB and the DHSSPS as to how it should act while the legal debates continue.	The Trust has made the Department and the HSCB aware of the difficulties it perceives in the guidance and with the current lack of clarity from the courts. The Trust is currently considering the most recent advice issued by DLS.	This issue is on the Trust's Risk Register and is categorised as a high risk.
8.	New organisational arrangements within the PSNI have significantly improved initial response times by the PSNI to adult safeguarding referrals but delays in the later stages of an investigation continue to	Protection plans are always put in place without delay. The Service Area is awaiting the detail of the	This issue is not on the Service Area Risk Register but is kept under review via LASP processes.

	cause some difficulties. Inability to progress an investigation until the PSNI have completed aspects of their own can cause great distress to the alleged victim and alleged perpetrator alike and it can also cause significant operational difficulties for an organisation who have to maintain protection plans which often involve staff suspension while the investigation is ongoing. The increased volume of safeguarding work also causes the Trust significant resource difficulties including difficulties in implementing required timescales, particularly, but not solely, restricted to administrative matters such as written acknowledgement, closure notification and minutes distribution. The lack of funding for dedicated administrative support in relation to adult safeguarding is a major difficulty and compares unfavourably with the recognition of this need in child protection services. The very significant increase in adult protection work in recent years particularly highlights this issue.	procedural guidance to accompany the new regional policy. The Service Area has been fully involved in Trust-wide discussions about the implementation of the new policy. The Service Area is actively involved in LASP and NIASP groups which are reviewing these issues.	
9.	The Trust's financial position continues to have a significant impact on the availability of service provision. A range of direct service provision such as day care	The Service Area operates a service request panel which scrutinises and prioritises requests for service provision as far as possible.	This issue is on the Service Area Risk Register and is categorised as a moderate risk.

	packages, respite, domiciliary care, direct payments and residential/nursing care are all affected and requests continue to be agreed in only the most urgent and critical circumstances. However, the requirement to meet assessed need resulted in approximately nineteen new nursing care packages, twenty-five new domiciliary care packages, seventeen new residential care packages and twenty-four new supported living placements this year. While there was no overspend in the care management budget at the end of the year, this was only achieved because of cost pressures funding given to the Service Area by the HSCB which, while very welcome, was non- recurrent. Of the new nursing home packages purchased this year, 74% were at regional rate and 26% above regional rate. Of new residential placements, 18% were at regional rate and 82% above regional rate. For supported living placements where there are no regional rates, 63% were at or below the regional residential rate and 37 % above. The complexity of need in Learning Disability continues to cause severe cost pressures. Efforts to provide services in a manner that meets the policy direction of	The Service Area continues to use a standardised tool to support decision making about assessing need. The Service Area continues to make representation to the HSC Board about cost pressures. Information on unmet need is collated and analysed. The Service Area seeks to scrutinise costs presented by independent sector organisations as closely as possible and to keep all such funding arrangements under review.	

	individualised, person centred, home based care are often resource intensive and therefore expensive. The Service Area is finding it increasingly difficult to source residential or nursing placements at the standard regional rate. A number of LD providers who previously had done so instigated significant price increases this year so we anticipate seeing the percentage rate of placements above regional rates rise year-on-year from here on as new admissions are made. We are also seeing an increasing trend for higher third party payments which can place significant pressures on families. The lack of regional commissioning agreements regarding high cost cases remains very problematic. In addition, the Service Area has experienced great demand this year for increase in payments for independent sectors to meet the costs of new living wage, night time working and pension requirements.		
	The Service Area has a growing need to provide a range of services to those with forensic histories particularly as more of these service users are being resettled	.The Service Area greatly welcomes the funding recently provided by the Board to develop forensic services and is presently	This area is on the Service Area's risk register and is categorised as a moderate risk.

	from Muckamore Abbey Hospital. These service users have complex needs often presenting with co-morbid drug and alcohol addiction or mental illness. The Service Area struggles to find accommodation and support services willing to accept service users with these difficulties. The Service Area also needs significant extra treatment provision for these service users in community services.	working on implementing the plans outlined in the IPT. The Service Area provides considerable support to providers who do offer placements to this group of service users. The Service Area continues to use the PQC guidance to manage the risk these service users may present to themselves or others.	
	The Service Area continues to experience increasing pressure in making its contribution to the Trust-wide ASW Daytime Rota. The number of ASWs on the rota has reduced which has resulted in increased workload for those remaining. This difficulty is being experienced in all Service Areas. A lack of acute admission beds in the Belfast Trust area has compounded these difficulties. ASWs are experiencing long delays in accessing beds and are often having to travel to Craigavon, Omagh and Derry to access one. This is causing significant distress for	The Trust has completed a comprehensive review of our current model of ASW provision and is in the process of considering its recommendations.	This area is being considered under the ASW review.

	service users and carers and significant operational difficulties for ASWs who are experiencing long working hours and difficulties with negotiating travel and escort arrangements with the PSNI and the ambulance service.		

3.8	**Key Social Work Workforce issues, including recruitment, retention, flexible working arrangements, workforce continuity etc. Information provided should include level and type of vacancies and any vacancy control systems in place.**
	The Service Area continues to have a relatively stable social work workforce and does not experience any retention difficulties. Demand for any temporary or permanent vacancies that have arisen has been high. A very experienced social work lead at Operations Manager level retired at the end of March 2016 and three more experienced social work practitioners will also retire in the coming year. The Service Area has two unfilled social work posts at present, the Operations Manager post created by a retirement and a Band 6 post which has been appointed but not taken up as yet. The new HRPTS and BSO recruitment systems have created significant delays at times in progressing appointments. Flexible working arrangements including part-time hours, flexi-hours and term time working are made available where possible. The Service Area has one social worker currently on the Regional ASW Programme.
3.9	**Trusts should provide a copy of their charging policies and provide explanation of what aspects of service provision you apply this to?**
	Residential and Nursing Homes Charging – The Trust operates in accordance with the DHSSPS Charging for Residential Accommodation Guide **(CRAG)** April 2015 to determine charges. The Trust is now working with providers in a number of schemes to establish a detailed breakdown of costs and charges following the Departmental guidance on service users who choose to pay as tenants for additional support services; " HSC Service Users in Supported Housing Accommodation – Guidance." The Service Area's financial support policy continues to allow for service users to make contributions to staff costs in some limited areas such as holiday travel, holiday accommodation and social activity costs. However, the Service Area remains aware that there is varying practice across Trusts and non-Trust service providers and as noted in previous reports would welcome regional guidance on what is appropriate in this regard. The Service Area continues to receive requests for support with both voids and start-up costs from housing and care providers. This issue is potentially destabilising for these important services and does cause

	significant financial pressures. However, the Trust does not have the financial capacity to cover these costs nor would it feel that this is necessarily the responsibility of Trusts. Again, the Service Area would welcome regional guidance about the role Trusts should play in such circumstances.
3.10	**Social Workers who work within Designated Hospitals Give an account of how these duties are fulfilled by Social Workers working in these designated hospitals**
	Muckamore Abbey Hospital continues to have a small core social work team, comprising of one senior social worker, two social workers and one Band 7 acting as Designated Officer under adult safeguarding arrangements. One of the established social workers in the MAH team continues to provide a service 2.5 days a week in the Iveagh Centre. The previous temporary replacement social worker who had covered the 2.5 days within the hospital left her post and a replacement is in the process of being recruited. The team provides a service to hospital patients from all Trusts. Social work forms a core part of the hospital's services. Social workers are core members of the multi-disciplinary teams on the following wards: Cranfield Men; Cranfield Women; Cranfield ICU; Killead; Donegore; and Sixmile Assessment and Treatment where they actively participate in the assessment and treatment of patients. They also have a key role in discharge and resettlement planning. Liaison with relatives and carers and assessment of home situations is an important part of the hospital social work function. Liaison, co-ordination and communication with community social work colleagues across the region are also key areas. Other wards may request a social work service in individual cases. The Muckamore Social Work Team represents Belfast Trust as the detaining authority at Mental Health Review Tribunals on a regular basis and team members are skilled and experienced practitioners in this regard. While community social workers from both Belfast and other Trusts will sometimes provide the social work evidence to Tribunals, where the patient is best known to the hospital team they will provide this. For the period from April2015 to March2016 social workers from the team have completed seven out of nine tribunals for Belfast Trust patients, two for Northern Trust patients and two for South Eastern Trust patients. In total there were thirteen MHRT hearings in Muckamore Abbey Hospital. There was also one child in the Iveagh Centre whose community social worker undertook the hearing which was not held on the adult hospital site. There were additionally two Belfast Trust patients in Muckamore Abbey Hospital whose tribunal hearings were undertaken by Belfast Trust staff completing the

	Approved Social Work Course as part of a core course requirement. Hospital social work staff provided support and guidance on both occasions. The social work service at Muckamore leads the work on safeguarding, providing advice, support and guidance to other hospital staff. There is one Band 7 lead designated officer. The postholder processes the majority of the hospital's adult safeguarding referrals. The Senior Social Worker is also Designated Officer and covers for periods of sickness or annual leave. The social workers in the team are trained to act as investigating officers. All social work staff are trained to Joint Protocol and pre interview assessment level. Adult safeguarding work forms a very significant part of the team's workload. The social work team has a continued role in the implementation of the Promoting Quality Care guidance. The team has particular skills and experience in risk assessment and management and provides a mentorship service for other staff undertaking this work. In a related function, the social work team link with PPANI, MARAC, the PPU, Gateway services and community adult protection services about hospital patient risk management issues. The Senior Social Worker and the lead Designated Officer report to the hospital's management committee on matters relating to adult safeguarding.
3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	The Service Area remains committed to incorporating human rights considerations into all aspects of its work. All staff are supported to attend mandatory human rights awareness training and more advanced training as appropriate. Training in other relevant topics also considers human rights issues. Specific prompts and guidance on the relevant human rights considerations are provided in the policy, procedures and tools for; i) Adult Safeguarding Procedures ii) Capacity, Consent and Best Interests Issues iii) Guardianship Decisions iv) Admission for Assessment Decisions v) Mental Health Review Tribunal Reports vi) Risk Assessment and Risk Management vii) Restrictive practice and physical intervention processes. viii) Care Plans Human rights considerations are paramount in considering deprivation

	of liberty issues and in any court applications. The Service Area has a value base that encourages respect and dignity for each individual, promotes equal citizenship and equal access to services and supports the empowerment of service users. All of these themes promote a human rights culture in the Service Area. This value base can be seen in Service Area initiatives such as user fora, user consultation, user led training at induction and the provision of accessible information. Human rights considerations are well embedded in everyday practice and all staff are encouraged to bring a human rights focus to all aspects of their work.

HUMAN RIGHTS

3.12	Identify any challenges encountered in the balancing of Rights.	3.13 What action have you taken to manage this challenge?	3.14 What additional actions (if any) do you propose to manage any ongoing challenges?
1.	The use of compulsory powers under the Mental Health (NI) Order 1986 continues to require careful balancing of the human rights issues involved. These generally involve a conflict between an individual or societal right to protection versus an individual's right to self-determination, to liberty and to a private and family life.	Staff training in human rights. Staff updates on legislative developments. ASW refresher and re-approval training. The provision of ASW fora to support good practice. The provision of guidance and support on incorporating human rights considerations into all aspects of practice. The use of tools to prompt human rights considerations. Feedback to consultation processes by the Service Area on new legislation which will have a rights-based approach. The provision of accessible information to service users about their rights. The provision of advocacy services.	All on-going.
2.	As noted in previous reports, the Service Area remains concerned about the lack of consistency in Mental Health Review Tribunal judgements around the definition of severe mental handicap and severe mental impairment. This issue creates potential human rights concerns in relation to Article 6, Right to a Fair Trial.	The Service Area awaits the introduction of the new capacity legislation which should address this issue. Provision of advocacy services.	All on-going.

3.	The Mental Health Review Tribunal system is such that those who seek an independent review of an admission for assessment under the Mental Health (NI) Order 1986 are generally unable to obtain this within the timeframe of the assessment period. This again creates potential human rights concerns in relation to Article 6, Right to a Fair Trial.	The Service Area attempts to be as accommodating as possible in arranging early Tribunal dates but this remains a major difficulty. Even meeting the current six- week timeframe can be challenging.	All on-going.
4.	Adult safeguarding work raises many human rights' balancing issues. Again these generally involve someone's right to protection versus a right to self-determination. It can also involve complex risk management decisions which need to balance an individual victim's protection or societal protection with an individual perpetrator's right to privacy and protection. The duty of Trust staff to consult with the PSNI under Joint Protocol arrangements about any alleged or suspected criminal act, even without the consent of the alleged victim, raises significant human rights' challenges. However, the new Joint Protocol when implemented will improve this situation considerably.	Staff training on human rights. Staff training on data protection. Staff training on adult safeguarding issues. The provision of support groups for investigating officers and designated officers to promote good practice. The use of adult safeguarding tools which prompt consideration of human rights issues. The provision of advocacy services.	All on-going,
5.	The implementation of the Promoting Quality Care guidance on risk assessment	Staff training on human rights. Staff training on data protection.	All on-going.

	and risk management also creates human rights' balancing challenges. These again involve the right to protection versus the right to self-determination and the complexities of information sharing decisions.	Staff training on the Promoting Quality Care guidance. Staff training on capacity and consent issues. Service user training on capacity and consent issues. The use of risk assessment and management tools which prompt consideration of human rights issues. The provision of advocacy services. Staff updates on legislative developments. Legal advice sought on individual cases	
	As previously noted in 3.4 and 3.5 (6), the lack of clarity in relation to the definition of a deprivation of liberty and the necessary actions and safeguards needed in response to any deprivation causes a significant human rights challenge and is a matter of considerable concern for the Service Area.	Issue has been raised with the DHSSPS and the HSCB. The Service Area considers deprivation of liberty issues in care planning and attempts to ensure that decisions about people's care avoid situations which could be construed as deprivations of liberty where possible and, if unavoidable, kept to a minimum and reviewed for on-going necessity regularly.	All on-going

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	The Trust was very pleased to have achieved IIP bronze accreditation this year in recognition of its investment in and commitment to its workforce. The Service Area has completed a major task in creating a carers' database which holds the details of approx. 1200 carers involved with our service users. By improving our information sources, we will be able to better plan for services to carers. The database has already been used in a major outreach exercise to all the carers on it, asking them to let us know their preferences about future involvement with the Trust. The response rate has been very good at 220 written responses. . Sixty-eight carers have responded saying they would be interested in joining a formal carers' reference group which the Service Area is now progressing to set up. The Service Area continues to welcome the significant amount of carers' funding it has received over the last two years including an additional recurrent £50 000 for direct payments for carers and a non-recurrent £62 000. This funding has allowed us to support carers with : 1. individual grants for short breaks 2. Complementary therapies 3. Direct payments for carers 4. Activity programmes for carers as a means of short break provision 5. Carers' group activities and social events The Service Area has developed a sensory care pathway to include guidelines for assessment, diagnosis, training and care for service users who have sensory integration needs. A training programme has been completed and the new service is operational. The Service Area feels that it has made good progress in implementing its community infrastructure development plan. This year has seen the integration of psychology into community teams and the addition of behaviour support practitioners in these teams. It has also seen full staffing of the Intensive Support Service including an extended hours service pilot which has been running since February 2016. The service is available Mon – Fri, 5pm – 8pm currently. To date, the indicators are that the availability of planned interventions outside hours has been very helpful but there has been no demand as yet for unplanned interventions. The Service Area is about to carry out a more detailed analysis to see if there were any crisis situations occurring within those hours where the service was not used.

	The Service Area has made progress with introducing a self-directed support model of care. While there are still some concerns about the nature of some of the processes and the potential funding implications, the Service Area is committed to the principles of more service user choice and control over services they receive. The Service Area has an action plan in place which will see all new referrals for domiciliary care follow the new process from July 2016, then all new referrals for non-residential short breaks by October 2016 and non-statutory day services by December 2016.
3.16	**SUMMARY**
	This year has seen a further period of increasing demand and restricted finances. This report outlines the complexity of work the Service Area undertakes, the level of need that is present and the risks it manages. The level of assessed need in the Service Area and the continued demand for cost savings remains a persistent pressure. Caseload numbers have risen this year again by 50 cases, a trend which the Service Area has seen over the last 5-6 years although it had stabilised last year. However, the Service Area remains of the belief that, within the resources available to it, its service provision is generally effective at delivering a good quality services to people with a learning disability. The Service Area also believes that, despite the acknowledged difficulties with data collation and assurance, its organisational and governance arrangements are largely compliant with statutory responsibilities. The Service Area is looking forward to consolidating the community infrastructure developments that have been put in place. The Service Area is also continuing with modernisation of its day services and residential and supported living services. The Service Area believes that it has a strong value base which is committed to person centred models of care which respect service users and carers.

LEARNING DISABILITY SERVICE AREA
DATA RETURN 1

1 GENERAL PROVISIONS			
		<65	65+
1.1	**How many adults were referred for assessment of social work / social care need during the year?** * (*age breakdown currently unavailable, figures includes 103 Muckamore Abbey Hospital referrals*)	**181***	**0**
1.2	**Of those reported at 1.1 how many adults commenced receipt of social care services during the period?**	**181**	**0**
1.3	**How many adults are in receipt of social care services at 31st March?** (*1.3a – The Service Area has integrated teams which would make it difficult to identify who receives social work support only. Also many of those at 1.4 receive social work support as well as care packages*.**)**	**1700**	**164**
1.3a	**How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?**	**Not available ***	**Not available ***
1.4	**How many care packages are in place on 31st March in the following categories:**		
	xiii. Residential Home Care	**99**	**29**
	xiv. Nursing Home Care	**108**	**68**
	xv. Domiciliary Care Managed	**68**	**10**
	xvi. Domiciliary Non Care Managed	**106**	**25**
	xvii. Supported Living	**224**	**40**
	xviii. Permanent Adult Family Placement	**16**	**0**
1.4a	**For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular.** ***Narrative –*** see response to 1.4b below.		
1.4b	**Please describe how Care Management process is being managed in this programme with particular reference to decision making levels, review and care planning, highlighting any particular difficulties being experienced and how they are being addressed.** ***Narrative.*** The Circular is operational in relation to all commissioned services in 1.4. Trust provided services follow different procedures but within the same framework of assessment, care planning, service provision and review. The Service Area does not use NISAT as this has not been introduced for learning disability. However, it does make use of its own document "About You" which is a person centred, accessible document based on the NISAT.		

	However, the Service Area uses other standardised care management tools which support the implementation of the guidance. The Service Area assesses need against criteria based on the guidance. The Service Area runs a service request panel where all new applications for care managed services are considered. Authorisation for standard costs can be given at Operations Manager level with high cost cases being scrutinised at Service Manager level. Responsibility for assessment, care planning and service provision lies with professionally qualified community team members. Reviews can take place at either assistant care management level or care manager level depending on the complexity of cases. The Service Area is experiencing some difficulties with high volumes of care management work and is about to undertake a review of demand and capacity in relation to this.		
1.4c	**Please articulate how the views of service users, their carers and families are included in the decision making process, review and care planning.** Service users and carers, as appropriate, actively participate in assessment, care planning and reviews. This is achieved through regular communication, provision of information, sharing documents and invitations to meetings.		
1.5	**Number of adults provided with respite during the period**	*PMSI return*	*PMSI return*
1.6	**Number of adults known to the Programme of Care in receipt of Centre based Day Care**		
	- **Statutory sector**	**518**	**48**
	- **Independent sector** -	**60**	**3**
1.6a	**Number of adults known to the Programme of Care in receipt of Day Opportunities** *(figure of 229 relates to service users availing of services commissioned or partially commissioned by the Trust with independent sector organisations*)	**104** **229***	**3**

1.7	**Of those at 1.6 how many are EMI / dementia** Statutory sector *8 under 65, 3 over Independent sector *These figures are based on reports from day care staff about people they believe to have dementia*	**8** **0**	**3** **0**
1.8	**Unmet need (this is currently under review)**		
1.8a	**Please report on Social Care waiting list pressures**; In addition to the delayed discharge population, resettlement and leaving care populations there are fifteen community clients waiting on suitable accommodation options for whom no potential suitable options have been identified. There are fifty-seven people waiting for short breaks, of whom fifty-four are waiting for activity based forms of short breaks provision.		
1.8b	**Please identify possible new service innovations that are currently supported by non-recurrent funding.** The Service Area used non recurrent carers' funding this year to support a number of innovative pilot initiatives for carers which were very well received. This support for carers could be sustained if the funding were recurrent. The Service Area would like to see the funding for existing DES project staff made permanent which would allow us to stabilise the programme. The Service Area believed that it had obtained additional funding this year for more DES staff as Belfast Trust had less funding than other Trusts and had employed someone on a temporary basis. The additional Band 7 has allowed significant extra activity to take place including a range of health promotion activities and health screening for service users who use GP practices who have not signed up to the programme. In March 2016 the Service Area realised that it had not in fact received this additional funding and, while it has made a renewed bid for this at the time of writing, has not received a response.		
1.9	**How many of this Programme of Care clients are in HSC Trust funded care placements outside Northern Ireland?**	**1**	
1.10	**Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations.**	*Board return*	*Board return*

	Learning from complaints has included the need for; ➢ Better preparedness when changing services in order to minimise the impact on the service user. ➢ Communication with all services users well in advance of changes to prepare them for what it will mean for services to them ➢ Inform families of changes in a timely manner. ➢ Communication quickly and directly with patient after a complaint is raised.		

LEARNING DISABILITY SERVICE AREA

DATA RETURN 1- HOSPITAL

1b GENERAL PROVISIONS - HOSPITAL				
		<18	**18-65**	**65+**
1.1 *	**How many adults or children were referred to Hospital Social Workers for assessment during the period?**	**13**	**102**	**1**
1.2	**Of those reported at 1.1 how many assessments of need were undertaken during the period?**	**13**	**102**	**1**
1.3	**How many adults or children are on Hospital Social Workers caseloads at 31st March?**	**6**	**84**	**1**

LEARNING DISABILITY SERVICE AREA
DATA RETURN 2

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978			
		>65	**65+**
2.1	**Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65**	**n/a**	
2.2	**Number of adults known to the Programme of Care who are:**		
	Blind	**23**	*****
	Partially sighted	**40**	*****
2.3	**Number of adults known to the Programme of Care who are:**		
	Deaf with speech	**10**	*****
	Deaf without speech	**15**	*****
	Hard of hearing	**27**	*****
2.4	**Number of adults known to the Programme of Care who are:**		
	Deaf/Blind	**7**	

*Age breakdown not available.

LEARNING DISABILITY SERVICE AREA
DATA RETURN 3

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	**Number of referrals to Physical/Learning/Sensory Disability during the reporting period.**	**181**
	Number of Disabled people known as at 31st March.	**1864**
3.2	**Number of assessments of need carried out during year end 31st March. (***Refers to assessment of need of new referrals only. Assessments of need with existing clients in response to requests for services and changing circumstances are carried out regularly but are not counted as a separate caseload activity)*	**181**
3.3	**Types of need that could not be met: (This is now collected at 1.8)**	
3.4	**Number of assessments undertaken of disabled children ceasing full time education undertaken** *(figure is no of children transitioning to adult services from children's disability services)*	**33**

LEARNING DISABILITY SERVICE AREA
DATA RETURN 4

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

4.1	**Number of Article 15 (HPSS Order) Payments**	**90**
	Total expenditure for the above payments	**£14,629.80**
4.2	**Number of TRUST FUNDED people in residential care**	**127**
4.3	**Number of TRUST FUNDED people in nursing care**	**176**
4.4	**How many of those at 4.3 received only the £100 nursing care allowance?**	**2**
4.5	**How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?**	**5**

4.5 – Figures supplied by PH & D services

LEARNING DISABILITY SERVICE AREA
DATA RETURN 5

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65 +
5.1	**Number of adult carers offered individual carers assessments during the period. ***	Not Avail.	220	Not Avail
5.2	**Number of adult individual carers assessments undertaken during the period. ***	Not Avail.	186	Not Avail
5.3	**Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?**	Not Avail.	0	Not Avail
5.4	**Number of adult carers receiving a service @ 31st March ***	Not Avail.	961	145
5.5	**Number of young carers offered individual carers assessments during the period.**		0	
5.6	**Number of young carers assessments undertaken during the period.**		0	
5.7	**Number of young carers receiving a service @ 31st March**		0	
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March (b) Number of new approvals for direct payments during the period 1st April – 31st March 2016 (c) Number of adults receiving direct payments @ 31st March		38 38 34	
5.9	**Number of children receiving direct payments @ 31st March**		0	
5.9.a	**Of those at 5.8 how many of these payments are in respect of another person?**		32	
5.10	**Number of carers receiving direct payments @ 31st March**		48	
5.11	**Number of one off Carers Grants made in-year.**		229	

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

Commentary

5.1, 5.2 – These figures include assessments and re-assessments. Age breakdown unavailable.

LEARNING DISABILITY SERVICE AREA

DATA RETURN 6

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

DATA RETURN 7

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 8

CORPORATE RETURN SUBMITTED BY SOCIAL SERVICES LEARNING AND DEVELOPMENT SERVICE

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9
LEARNING DISABILITY SERVICE AREA

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

Admission for Assessment Process Article 4 and 5		TRUST ASW	RESWS ASW
9.1	**Total Number of Assessments made by ASWs under the MHO**	**8**	
9.1.a	**Of these how many resulted in an application being made by an ASW under (Article 5.1b)**	**7**	
9.1.b	**How many assessments required the input of a second ASW (Article 5.4a)**	**0**	
	Comment on any trends or issues in respect of requests for ASW assessment or ASW applications		
9.1.c	**Number of applications made by the nearest relative (Article 5.1.a)**	**0**	
	Comment on any trends or issues in respect of Nearest Relative applications for admissions		
9.1.d	**Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge.**	Yes, relatives are routinely involved in all discharge planning processes.	
Use of Doctors Holding Powers (Article 7)			
9.2	~~Total Number of Form 5s/5as completed)~~ NB Form 5a is no longer used **How many times did a hospital doctor use holding powers?**		**2**
9.2a	**Of these, how many resulted in an application being made?**		**2**
	Comment on any trends or issues on the use of holding powers		
ASW Applicant reports			
9.3	**Number of ASW applicant reports completed ***		**16**
9.3.a	**How many of these were completed within 5 working days**		**16**
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken.		
Social Circumstances Reports (Article 5.6)			
9.4	**Total number of Social Circumstances reports completed.** *This should equate to number given at 9.1c. If it does not please provide an explanation.*		**0**

9.4.a	**Number of completed reports which were completed within 14 days**	
	Please provide an explanation for any Social Circumstances Reports that were not completed within the requisite timescale, and / or any discrepancy between the number of Nearest Relative applications accepted and the number of Social Circumstances Reports completed, and what remedial action was taken.	**N/A**

Mental Health Review Tribunal

9.5 **Number of ~~referrals~~ applications to MHRT in relation to detained patients**

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**6 (3)**	**5 (3)**	**1 (0)**	**0 (0)**	**0**
Patient	**4 (0)**	**3 (0)**	**0(0)**	**0 (0)**	**0**
Nearest Relative	**0 (0)**	**0 (0)**	**0 (0)**	**0 (0)**	**0**
Other DOJ	**0 (1)**	**0(0)**	**0 (0)**	**0 (0)**	**0**
Total	**14**	**11**	**1**	**0**	**0**

Comment on any trends or issues in respect of Mental health Review tribunals

Belfast Trust figures first, other Trusts in brackets are 2 Northern Trust and 1 South Eastern Trust.

DOJ referral is South Eastern Trust.

One patient deferred and one adjourned also.

9.5.a	~~Number of MHRT hearings~~	
9.5.b	~~Number of patients regraded by timescales:~~ ~~a. < 6 weeks before MHRT hearing~~ ~~b. > 6 weeks before MHRT hearing~~	

Guardianships (Article 18)

9.6	**Number of Guardianships in place in Trust at period end**	**3**
9.6.a	**New applications for Guardianship during period (Article 19(1))**	**1**
9.6.b	**How many of these were transfers from detention (Article 28 (5) (b))**	**0**
9.6.c	**How many were Guardianship Orders made by Court (Article 44)**	**0**
9.6.d	**Number of new Guardianships accepted during the period (Article 22 (1))**	**1**

9.6.e	**Number of Guardianships renewed during the reporting period (Article 23)**	**3**
9.6.f	**Number of Guardianships accepted by a nominated other person**	**0**
9.6.g	**Number of MHR hearings in respect of people in Guardianship**	

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**0**	**0**	**0**	**0**	**0**
Patient	**0**	**0**	**0**	**0**	**0**
Nearest Relative	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**
Total	**0**	**0**	**0**	**0**	**0**

9.6.h	**Total number of Discharges from Guardianship during the reporting period (Article 24)**	
	Discharges as a result of an agreed multi-disciplinary care plan	**1**
	Lapsed	**1**
	Discharged by MHRT	
	Discharged by Nearest Relative	
	Total	**2**
	Comment on any trends or issues in respect of Guardianship	

Approved Social Worker (ASW) Register		
9.7	**Number of newly appointed Approved Social Workers during period**	**1**
9.7.a	**Number of Approved Social Workers removed during period**	**0**
9.7.b	**Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)**	**6**

	CORPORATE COMMENTARY There has been a steady decrease in the number of ASWs available to participate in the Trust's Day Time Rota over the past number of years. There are concerns that the Trust, under the present arrangements, will not have capacity to meet the statutory requirement set out in Article 115 of the Mental Health (NI) Order 1986 (the Order) in respect of the availability of ASWs to discharge the range of statutory functions as specified in the Order. While four social workers from the Trust are currently participating in the Regional ASW Training Programme and hopefully will be assessed as competent, they will not be available for appointment by the Trust until October 2016 and will then be required to undertake a period of "shadowed practice" before they can operate as autonomous practitioners. Therefore this could result in them not being on the Daytime Rota until January 2017. The potential addition of these four social workers will not fully offset the number of ASWs lost through retirement/those who have moved to other posts/other Trusts/ RESWS. Of the cohort of twenty-eight, one has already indicated that, due to demands of work as a Team Leader, they will be withdrawing and another has indicated they will be retiring in June 2016. The Trust has twenty-eight ASW trained staff currently on the Daytime Rota. Training of additional ASW staff has been identified as a priority within the Service Area. Nominations for the 2016/17 Regional ASW Training Programme are presently being collated. Additional ASW duties include Guardianship-related functions and inputs into MHRT cases in light of their knowledge, skills and experience in this area. ASWs also provide a consultation role to those teams/services which do not have ASWs or social workers. Service Area ASWs participate in refresher training throughout the year and re-approval training every three years. Due to the pressures of the ASW rota the 'floater' has been replaced as a third member on the ASW rota. This is because it is a regular occurrence that all three ASWs on the Rota on a daily basis are called out to assess patients. On a regular basis there can be multiple ASW assessments requested on the same day. It is now a regular occurrence that ASWs on the Daytime Rota have to wait substantial lengths of time for the ambulance and PSNI to support the conveyance of service users to hospital in those circumstances in which significant risks to the service user or others are extant. These situations are exacerbated by difficulties in accessing beds in the Trust's area. This results in ASWs having to accompany those requiring admissions to hospital to units across the region. Such episodes can significantly impact on the ASWs' ability to fulfil the requirements of their core posts. An inter-agency group involving representatives from the PSNI, the NI Ambulance Service and Trust's Unscheduled Care, GP Out of Hours and ASW

	Services has been established to address interface matters relating to their respective responsibilities and pathway processes pertaining to assessments for admission under the Order. The Trust has completed a review of ASW activity. The Review highlighted a number of key organisational, logistical and professional issues impacting on the delivery of the ASW Daytime Rota including: the diminution over a number of years of the complement of designated social work posts in the Mental Health Service Area; the increase in demands on available social work resources of the exponential increase in adult safeguarding activity and, in particular, the projected and current impact to date of the Revised Adult Safeguarding Policy determination that social work will be the lead profession in safeguarding service delivery; the increasing complexity of ASW-related activities; the impact of the difficulties of out- of -Trust admissions; the difficulties associated with interfaces across the PSNI, Ambulance Service, Unscheduled Care and ASWs in respect of assessments for admission; the need to develop a robust workforce planning approach to social work requirements in Mental Health (including ASWs) incorporating the implications of the Mental Capacity legislation; and the resourcing of and supports for staff engaged in the Regional ASW Training Programme. The Review's proposal for the establishment of a hybrid ASW core team to address the immediate pressures on service delivery and to ensure the Trust's capacity to discharge its statutory functions has been agreed and is currently being actioned. The Principal Social Worker (PSW) in Mental Health with operational responsibility for the co-ordination of the Rota works closely with the Regional ASW Group in relation to the review of documentation to ensure a consistent approach across the region. In addition, the PSW has also revised local ASW documentation relating to alternative care planning for patients who have been assessed as not requiring detention for assessment under the Order. Breakaway training has also been scheduled for June 2016 for all ASWs on the Daytime Rota. In-house bespoke training has also been completed on the Regional Interagency Protocol in February 2016. ASWs have been appraised of the PSNII risk assessment process for thresholding and prioritising referrals and have been advised of the importance of providing clear and factual information in respect of assessed risks when requesting PSNI assistance. The PSW has reviewed as a priority the provision of reflective practice supervision sessions for ASW staff. These are now "up and running" and take place on a 6-8 weekly basis. The PSW has also re-launched the ASW Forum which meets twice a year. Attendance at the ASW Forum alternates with the reflective practice groups and attendance is mandatory (i.e. 75% attendance). The Trust will continue to review and develop supports to its ASW workforce. The Regional Audit of Assessments for Admission under the Mental Health (NI) Order 1986 was launched in March 2016. The Report will contribute to an

	ongoing Trust focus on improving ASW organisational and service delivery arrangements and the management of internal and external interfaces. Trust senior management are reviewing a number of interface issues across the RESWS and the Daytime Rota. The Trust has robust administration structures in place to monitor ASW numbers, accreditation and re-accreditation arrangements	
9.8	**Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If so please provide detailed explanation for each and every instance including their age and relevant powers used.** N/A	
9.9*	**How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?** Please see commentary at 3.4.	**7**
	See above.	
The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A (6). **Schedule 2A Supervision and Treatment Orders.**		
9.10	**Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March**	**1**
9.11	**Of the Total shown at 9.10 how many have their treatment required as:**	
	Treatment as an in-patient	
	Treatment as an out patient	**1**
	Treatment by a specified medical practitioner.	
9.12	**Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)**	**1**
9.13	**Of the total shown at 9.10 how many of these supervision and treatment orders were *made* during the reporting period.**	**0**

FAMILY AND CHILD CARE SERVICE AREA

GENERAL NARRATIVE

3.1	Named Officer responsible for professional Social Work
	Ms Lesley Walker, Co-Director of Children's Social Care Services, has overarching responsibility and accountability for the operational delivery of statutory functions by the Family and Child Care Service Area. An unbroken line of accountability for the discharge of statutory functions by the social work and social care workforce runs from the individual practitioner through the Service's line management and professional structures to the Executive Director of Social Work and onto the Trust Board.
3.2	**Supervision arrangements for social workers**
	The Service Area has completed a number of audits pertaining to supervision of the social work workforce. While the returns have indicated satisfactory levels of compliance with supervision processes, the Service Area has identified a number of areas for improvement in relation to qualitative dimensions of supervision-the facilitation of the supervisee's professional development through reflective and critically challenging, supportive engagement with the supervisor; the "depth" of supervision discussion and recording; and the linkages between supervision and performance. The Service Area is considering opportunities for further developing its reflective learning programme and is exploring initiatives in peer supervision, coaching and mentoring across its workforce. The Directorate is fully engaged in a number of initiatives under the auspices of the Regional Social Work Strategy and the Trust's quality improvement and modernisation programme to facilitate the development of a coaching and mentoring infrastructure to provide additional supports to individual and cohorts of social work staff across management and practitioner settings. The promotion of reflective learning events to disseminate and share learning and the assimilation of skills and knowledge through the supported application of taught learning are central to augmenting and adapting supervision models. The linking of supervision delivery to improved service user outcomes remains central to the development of a robust supervision evidence base. The Trust has implemented a professional social work supervision exception reporting system. Monthly returns from the Service Area evidence satisfactory compliance with the requirements in respect of the frequency of supervision and facilitate monitoring of non-compliance. The Regional Children's Services Caseload Management Model has been implemented across the Service Area. The Service Area has achieved satisfactory compliance with the standards specified in the Revised Guidance for Registrants and their Employers NISCC July 2010 in relation to the supervision of AYE staff.

3.3	**Report on processes, audits, reviews, research and evaluations undertaken during the year, that measure performance against delegated statutory functions, identifying emerging trends and issues (may include cross references to other sections to this report).**
	Education, Training and Employment (ETE) for 16 + looked after young people care leavers remains a key component in Care and Pathway planning. During the reporting period the Trust continues to improve performance with regard to the number of young people involved with either, Education, Training or Employment. The Employability Service's partnership with the voluntary sector also means that those young people not ready to enter into ETE can avail of several preparation programmes. There have been very positive developments with regard to progressing opportunities for young people to experience different career opportunities across Trust Directorates. A Trust-wide initiative to optimise employment opportunities for young people transitioning from care to avail of placement opportunities has been successfully launched with strong support from the Trust Board. A number of Directorates have already committed to offering opportunities to young people reflecting a Trust-wide appreciation of its corporate parenting role. During the reporting period the Service Area's Case Conference Chairs Group has continued to meet on a regular basis to reflect on key practice, administrative and organisational issues impacting on the effectiveness of the case conference process incorporating chairing skills, exclusions, review of the minutes formatting and contents and related data protection considerations. Assurance arrangements with regard to residential care services include: monthly Monitoring Officer visits to and completion of reports in relation to individual residential homes; RQIA announced and unannounced inspections of residential homes; and HSCB reporting requirements pertaining to the operationalising of Restriction of Liberty Panels and adverse incidents reporting. The Service Area completed GAIN audits in May 2015 and January 2016. The Audit Action Plan has identified the following qualitative themes for particular focus: ➢ Strengthening analysis within assessment processes through an emphasis on the application of evidence based approaches to the collation, of information, the interrogation and weighting of its significance and the development of robust hypotheses and related actions linked to anticipated outcomes. ➢ Capturing and giving expression to the persona and individuality of the child in all aspects of the social worker's assessment and planning. ➢ Promoting reflective, evidence based, child centred outcomes which underpin case planning and review processes and contribute to an understanding of the effectiveness of interventions. A follow-up audit relating to attendance of professionals at case conferences and the presentation of case conference reports by professional staff was presented to the Trust's Safeguarding Committee in February 2016. The audit evidenced a

	relative improvement in attendance levels at case conferences while the figure for presentation of reports at case conferences was unchanged. A series of case file reviews in relation to young people who were vulnerable to sexual exploitation were conducted to establish baselines for the development of practice, knowledge and skills in this highly significant area. The Trust contributed fully to the fieldwork conducted by both the Marshall and Thematic Reviews prior to their respective publications. The Trust is fully engaged in the development of regional and local action plans to address the respective review recommendations. The Trust submitted its annual Section 12 Audit return to the SBNI in July 2015. The audit of supervision case files by the Service Area's Senior Managers was completed in April 2015. The audit established satisfactory compliance with the standards detailed in the regional supervision policy. Reflective practice sessions for managers relating to Case Management Reviews MR's, SAI's, Complaints, Internal Case Reviews etc. have continued to be a key to driving forward improvements in practice. An overview of the role of SBNI, the CMR process and the learning from a number of CMRs was presented at a Trust safeguarding Committee Reflective Learning Event in October 2015. The Trust participates fully in the Case Management Review arrangements under the auspices of the Safeguarding Board for Northern Ireland (SBNI). It is compliant with the requirements in relation to the reporting and dissemination of learning arising out of Serious Adverse Incidents and Untoward Events.
3.4	**Report on the Programme of Care's interfaces with other statutory agencies including for example: NISCC; RQIA; PHA (in relation to social care)** **Trusts should include references to Judicial Reviews or other significant Court Judgements that directly impact on the discharge of statutory functions.**
	The Service Area is engaged with the Education and Library Board through a number of regional and local partnership fora. The importance of strong links with the education sector at both strategic and operational levels is pivotal to improving the life outcomes for children in need and looked after children in particular. A principal focus during the reporting period has remained the development of personal education planning for looked after children (PEPS) which seek to optimise and co-ordinate a multi-agency focus on enhancing a looked after child's educational and life skills attainments. The Service Area has established partnerships with the third level education sector, Belfast Metropolitan College, University of Ulster and Queens University Belfast in relation to social work and social care learning and development. The Service Area has a substantial engagement with the Public Health Agency in

	the context of the Children's Strategic Partnership, the Outcomes Group and the Belfast Strategic Partnership, its remit in relation to community health provision and, more specifically, the Service Area's participation in the Regional LAC Health Group. The aim of this group is to promote and meet the health and wellbeing needs of Looked After Children and young people. The Service Area has achieved compliance with the requirements in relation to the registration of the social work and social care workforce. The Trust recognises the significance of its relationship with NISCC both in terms of its workforce regulatory role and its lead responsibilities for Degree level and post qualifying social work learning and development. The Trust is fully supportive of the launch of NISCC's Professional in Practice Post Qualifying Accreditation Framework (PiP). The Trust is presently working with NISCC to progress the registration of the social care workforce. The Service Area has provided Quality Improvement Plans in response to requirements and recommendations arising from RQIA inspections of Children's Homes. These are reviewed by senior managers within the Trust on a quarterly basis. The Trust participated in the RQIA review of workforce regulatory arrangements. The Executive Director of Social Work/Director of Children's Community Services represents the Trust on the SBNI and chairs the organisation's Policy Sub-Committee. . The Trust's representatives on the Belfast Safeguarding Panel are: the Co-Director Children's Social Care Services; Designated Doctor for Safeguarding Children; Co-Director Mental Health Services; and Named Nurse for Safeguarding Children. A number of staff from a range of Service Areas have been co-opted by the SBNI onto its various Sub-groups. The Executive Director of Social Work/Director of Children's Community Services also represents the five Trusts on the Strategic Management Board of PPANI (Public Protection Arrangements Northern Ireland). The Service Area's Public Protection Team members undertake the role of representing the Trust at MARAC Panels. The Service Area is engaged in a substantial number of partnerships with service user, community, voluntary and statutory sector organisations in the development of integrated service delivery responses to the spectrum of needs across Belfast's childhood population. The Trust's Co-Director for Children's Social Care chairs the Belfast Outcomes Group which is driving forward the operationalising of a Belfast-wide Early Intervention Transformation Service (EITS). The EITS is seeking to improve outcomes for vulnerable children and their families through the provision of a range of local, accessible, evidence-based services to support families and children who are experiencing difficulties before they become established and to enable children to develop to their full potential. This initiative is predicated on a multi-systemic approach to supporting families at different points and to building relationships with families as the key lever for change. The template for the EITS incorporates a

	commitment to multi-sectoral partnership working within a shared vision delivered through an outcomes-based performance management and assurance framework. In this context the development and operationalising of Family Support Hubs which signpost families with specific needs to appropriate services is of central importance. The Trust is engaged with Belfast City Council and other key stakeholders in the planning for and the development of a Belfast Community Plan-a vision for the city predicated on collaboration, partnership and optimising of resources across the spectrum of city stakeholders.
3.5	**Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions**
	This section should be read with the Data 10 Corporate Parenting Return and related spreadsheets. **ADOPTION AND PERMANENCE SERVICES** The Service Area continues to find it a challenge to recruit sufficient adopters with appropriate skills and abilities and understanding to meet the often complex needs of young Looked After Children in need of permanent adoptive homes. Chronic neglect, foetal alcohol syndrome, attachment difficulties and developmental delay continue to feature. Protracted Court proceedings in many cases continue to impact on achieving timely permanence, especially where adoption is the Care Plan. The conclusion of the Consortium arrangements with the South Eastern Trust has been agreed and arrangements for case transfers and the final resolution of the outstanding apportionment of funding has been resolved. The Trust has satisfactorily addressed a number of workforce matters related to the re-distribution of South and East and Belfast Trusts' respective Adoption Service staff. .In reviewing the complement of funded staff within the Belfast Trust's Adoption Service, taking account of vacancies, the Trust was able to retain its complement of staff. An Action Plan has been put in place to reduce delays in assessing adopters and improving the length of time currently taken to achieve permanency. This includes: ➢ Once the Care Plan is confirmed as Adoption, the PSW for Adoption will be notified by the Fieldwork Team; ➢ A new Adoption database will capture key information to monitor progress towards Adoption; ➢ PSW for Adoption will monitor timescales for presentation to the Adoption Panel for the 'Best Interests' recommendation; ➢ PSW for Adoption will continue to track progress from 'Best Interest' recommendations to achieving Adoption; ➢ Any undue delays or failure to progress Adoption will be reported to the Head of Service for Adoption;

- If the Care Plan for Adoption is changed following a 'Best Inter' recommendation, the case will be re-referred to the Adoption Panel to provide a formal record of the change, reason for same and to identify any learning.

With regard to the recruitment of adopters, all applicants are now dually approved and matched with children who have a Best Interest Recommendation. The Trust is also seeing a steady increase in the number of same sex applicants to adopt. While additional funding has assisted in addressing the backlog of assessments, there continues to be a capacity issue to keep pace with applicants completing the preparation course and commencing their adoption assessments.

The HOT Project (concurrent placements for 0 – 2 year olds) has seen a rise in interest from prospective adopters willing to consider a concurrent placement. All applicants to adopt are advised of the HOT Project and the nature of concurrent placements is included in the preparation course.

The importance of Post Adoption support is recognised in the Trust with new initiatives now in place, such as a monthly support group for adoptive mothers and the delivery of the nurturing attachments programme. Individual placement needs are addressed though the Trust's Therapeutic Support Service.

GEM SCHEME

The GEM scheme continues to provide placement stability for a growing number of young people 18+ who can remain with their former foster carers. The increase in numbers however, does impact on the continued availability of the foster carers, to provide a foster placement for other Looked After Children. While additional funding has assisted in meeting the financial pressures from the GEM Scheme, if the trend continues for more young people to remain in their foster placement post 18+, this will lead to a further increased pressure on the current budget.

KINSHIP STANDARDS

The Trust's Kinship Service has substantially reduced the number of outstanding assessments following on from the receipt of additional funding supports from the HSCB. It projects that the backlog of assessments will be fully resolved by the end of May 2016.

The Service Area has reviewed current structures and related business processes to optimise its available capacity using the recurrent and non-recurrent funding to focus on the completion of assessments within the requisite timescales.

The funding for the Extern Big Lottery Project is scheduled to end. The Trust understands that an evaluation of the Project will inform decision making with regard to its future.

SUPPORTED LODGINGS

The Trust currently has a number of jointly commissioned accommodation options which support young people transitioning into independent living. These options provide a spectrum of peripatetic supports which meet the diverse needs of those

young people leaving care. The Trust has identified a need for supported lodgings and had secured recurrent funding for same during the reporting period. Unfortunately, in light of the non-availability of previously agreed shared funding from Supporting People the Trust has not been able to progress the development of this initiative. While a major disappointment, the South Eastern and Belfast Trusts are jointly exploring the possibility of establishing a joint Supported Lodgings scheme, albeit with a reduced capacity to those originally envisaged.

There is a particular pressure on the Service Area to identify suitable accommodation for those young people with complex needs and challenging behaviours, often presenting with risks to themselves and to others. These young people require bespoke packages of intensive supports and more specialist accommodation with attendant additional costs.

PLACEMENT PRESSURES

There continue to be pressures in matching foster placements to the needs of individual Looked After Children as a result of the volume of children who are currently looked after, the throughput of children through the care system, the complexity and range of their needs and the substantial challenges for the Trust's Fostering Service of maintain and increasing the Trust's foster carer base.

CARE ORDERS AT HOME

The Trust recognises there are a significant number of children placed at home with their parents under the auspices of Care Orders. The Trust is proposing to establish a project to review the practice and planning themes underpinning service delivery to this cohort of children to ensure that robust child centred review and planning processes are in place.

LEGAL DUTY TO ACCOMMODATE YOUNG PEOPLE

The Service Area has more recently been put under extreme pressure to 'accommodate' young people with little or no previous contact with the Trust following Judicial Review cases; it is clear that the Trust has a legal duty to provide accommodation for all young people identified as children in need. This is often to prevent remands to custody for young people with serious criminal behaviours including drug and alcohol problems. This is creating considerable pressure on already limited resources and risks disruption for other Looked After Young People within Trust provision.

FAMILY SUPPORT AND CHILD PROTECTION CASELOADS

The Trust continues to face significant difficulties in allocating cases within its Family Support Teams. Caseloads within these teams continue at a level that is not conducive to ensuring families are appropriately supported to facilitate timely change as identified in the relevant case plans. The Trust is seeking to bring about a reduction in caseloads and greater equity across the Service Area via its Care Pathways Review but this will not ease the pressures until mid-2016 at the earliest and will not fully resolve the issues regarding caseloads in Family Support.

CHILD SEXUAL EXPLOITATION (CSE)

The Trust has appointed a Senior Practitioner (SP) with specific responsibility for CSE. The SP is co-located with the Public Protection Unit in Antrim Road PSNI station. The SP supports staff with the identification of CSE within caseloads and provides advice and consultation on the range needs and service delivery response to this very vulnerable group of young people. The worker has a key role in working with PSNI to identify intelligence relating to potential networking of adults who pose a risk to Young people.

The Trust is leading on the development of Regional Safety Planning to inform practice and service delivery to young people who are at risk of CSE. The Trust continues to provide in-house training to a range of staff whilst facilitating briefing sessions on CSE to voluntary and community Groups.

SEPARATED CHILDREN

The challenges for the Trust with this group of young people include identification of appropriate placements particularly when the individual's age is in dispute, ensuring cultural and religious needs are met, communication barriers due to language and young people having being advised prior to approaching Gateway to share very limited information about their circumstances. The Service Area is compliant with the Working Arrangements for the Welfare and Safeguarding of Child Victims of Human Trafficking Guidance.

Glenmona Resource Centre's regional unit was opened with effect from October 2014 specifically to meet the accommodation needs of separated children has provided an important resource in alleviating pressures associated with the identification and provision of appropriate accommodation for this group of young people who by virtue of their circumstances have complex and diverse needs and in the development of a local practice centre to profile and shared learning and to promote practice skills and knowledge. The Trust has centralised its management of this vulnerable group of children within the Intensive Adolescent Support teams to allow for the development of an expertise and skill base in this complicated area of work.

FAMILIES WITH NO RECOURSE TO PUBLIC FUNDS

The Trust continues to experience a significant volume of referrals of children and their families with no recourse to Public Funds. These families often have extremely complex needs, are socially isolated and English is not their first language. They require extensive family support and financial input. There is a clear need for a consistent approach linked to the National Network and legal advice. The Trust is re-scoping the width of service demands for this group with a view to developing a business case to secure the appropriate level of resource to support service delivery to this vulnerable group.

CASE CONFERENCE MINUTES

As at 31 March 2016, the Service Area had achieved 76% compliance with the timeline for the distribution of Child Protection Case Conferences, an improvement of 10% relative to the figure as at 31 March 2015.

	UNALLOCATED CASES AND CARE PATHWAYS Unallocated cases continue to be an area of significant pressure including rising timescales for assessment in Gateway. The Service Area has robust assurance and reporting processes in place to monitor on unallocated cases. **FINANCIAL CONTEXT** The overarching budgetary context remains particularly challenging. The Service Area is committed to the modernisation and reform of service delivery to maximise the effectiveness of its resource base. However, there are substantial financial and capacity pressures related to service delivery volumes, performance requirements, the complexity of the work and the cumulative information collation and reporting requirements. While the Service Area will continue to prioritise its discharge of statutory functions, the efficiencies and savings required will inevitably impact on its capacity to sustain the range and levels of service delivery.
3.6	**EMERGING ISSUES** **FAMILY SUPPORT SERVICES** The Trust's Family Support Strategy provides the framework within which services are delivered to those vulnerable children and their families including those who are at risk of becoming involved in offending behaviours. Central to the Strategy is the Trust's ongoing commitment to early intervention, partnership and engagement with its local communities, voluntary sector groups and other statutory agencies to provide a continuum of services to meet the needs of vulnerable children and their families within evidence-based, outcomes-centred service delivery approaches. The Trust has contracted with a number of community-based providers to deliver direct services to children who are at risk of engagement in interface conflict and supports to their parents to obviate same. The Trust is a full partner on the Belfast Police and Community Safety Partnership and has representation on the City-wide four local Partnership Groups. The Trust's Co-Director for Children's Social Care chairs the Belfast Outcomes Group which is driving forward the operationalising of a Belfast-wide Early Intervention Transformation Service (EITS). The EITS is seeking to improve outcomes for vulnerable children and their families through the provision of a range of local, accessible, evidence-based services to support families and children who are experiencing difficulties before they become established and to enable children to develop to their full potential. This initiative is predicated on a multi-systemic approach to supporting families at different points and to building relationships with families as the key lever for change. The template for the EITS incorporates a commitment to multi-sectoral partnership working within a shared vision delivered through an outcomes-based performance management and assurance framework. In this context the development and operationalising of Family Support Hubs which signpost families with specific needs to appropriate services is of central importance.

Ten Family Support Hubs have now been established and provide full coverage in the Belfast Area. The ten Hubs have secured seed funding from until March 2017. The Trust on behalf of the Belfast Outcomes Group has commissioned £500k worth of Family Support services to be delivered over the period April 2016 to March 2017. The Outcomes Group's Action Plan seeks to maximise opportunities to optimise the available resource base through the establishment of integrated planning and service delivery processes across the respective sectors and agencies.

Initial evaluation of the impact of the Hubs has been positive, particularly in relation to the benefits of connectivity and partnership working across the various sectors and organisations. From a Trust perspective, the Trust Family Support Stakeholders Group (CAMHS, Health Visiting, Gateway staff) report that the Hubs have strengthened their relationships and engagement with local voluntary and community groups. The aggregation and dissemination of learning linked to the enhancement of a local evidence base are central aspects of the overarching Hubs' development.

The Trust is currently engaged in discussions with the Commissioner to address future funding for the Hubs.

PARENT AND ADOLESCENT COMMUNITY SUPPORT SERVICE - PACS (Formerly Known as the Edge of Care Project)

The Trust's PACS Project was established in December 2015. The Service provides intensive family support packages to families with the aim of supporting parents and young people to manage difficulties and challenges in their relationships and to maintain the young person at home. It seeks to obviate the number of older young people entering the care system through the provision of a range of evidence based, bespoke services incorporating statutory, community and voluntary provision centred on supporting the young person and his family in addressing the immediate and underlying issues which have precipitated the impetus for a care admission within a focus on optimising outcomes for the young person.

PACS provides a rapid response and intensive supports to enable young people and families to manage the immediate crisis and to develop coping skills to prevent further crises occurring.

The PACS workers use interventions such as restorative practice, task-centred methods, solution focussed approaches and resolving family conflicts using negotiation and mediation techniques and also provide advice on parenting and child and adolescent development. Where appropriate, the PACS workers refer and signpost families and young people to relevant community, statutory and voluntary resources. The PACS workers support the young person and families to access these services using sustainable methods, i.e. public transport. Critical to the success of the Service is securing and maintaining the engagement of families and young people,

During the reporting period the Trust closed one of its short term children's homes

based at 57a College Park Avenue. This facility now serves as the PACS Resource Centre housing the PACS Team.

The Service will be evaluated using the National Childrens Bureau (NCB) Outcomes Framework and will report to the PACS Multi-Agency Steering Group which will review and monitor the effectiveness of the new Service.

CARE PATHWAYS PROJECT

The restructuring of the LAC/16+ service has been a major reform and modernisation project during the reporting period. There has been engagement with young people and their families, staff, management, staff side and other departments/professionals within and external to the Trust. Work is still progressing to complete the implementation of the reforms and engagement with staff and young people will continue.

Following operationalising of the Care Pathways model, the LAC service will be extended to all young people up until the age of 18 at which point the young person will transfer to an 18+ Service which will provide a range of bespoke, wrap-around services to support young people in transitioning to independence. The promotion of the young person's social and emotional wellbeing, helping a young person to build a positive social network, to realise their academic potential and to optimise their employability skills will be central dimensions to the delivery of supports and services. For that cohort of young people who will continue to experience significant challenges in transitioning, the co-ordination and integration of specialist services as required and access to ongoing social work supports will be of central importance in promoting their wellbeing.

This new model will offer a more person centred approach to young people 16+ as there will be a continuity of social worker up until the age of 18, rather than the need to change/break established relationships at the age of 16. The Trust recognises that this is a radical change impacting on those staff in the 16+ Service who will be moving teams, as the numbers of teams reduce from 4 to 2 in the new 18+ Service. A Principal Social Worker will manage the two 18+ teams and interface with the LAC service to oversee the transition of young people 16+. The selection and team identification process has been completed and a training programme is underway. Staff from the current 16+ Service will either be in the 18+ Service, LAC Service or the Family Support service which is being enhanced to help address the ever increasing volume of work and unallocated cases. Additionality has also been provided to the LAC Service.

The PA Service will sit in the 18+ Service, with staff divided between the two teams. Referrals for PAs from LAC/Children with Disability Services will come into the 18+ Service and allocated according to matched need. During the reporting period, the PA Service has faced a demand and a capacity issue and additional funding for two more PAs has been provided by the HSCB. Unfortunately there have been delays in recruitment due to difficulties with HRPTS alongside managing staff absence due to sickness/maternity leave. This has led to a need to prioritise referrals for a PA for young people based on need and current circumstances, eg if in a settled foster/kinship placement look to other supports as

opposed to a vulnerable isolated young person who would benefit from PA support.

Once fully implemented, the new model will be reviewed after one year to consider if the staffing ratios in the reconfigured service areas are appropriate to meet service needs. The current funded complement of PAs will also be kept under review.

As part of its review of Care Pathways for Children and Young People, the Service has looked at the journey of young people through its services and its transfer points. Following the consultation with young people, their parents and staff, the Project is proceeding to implementation whilst taking on board the feedback. This will involve the movement of key transfer points and has resulted in a decision to ensure young people retain consistent social work input throughout their Care experience and until adulthood, i.e. until 18 years.

AUTISM SERVICES

Belfast Children's Autism Diagnostic Service:

The Service is currently funded to provide 312 diagnostics. However during the reporting period 2014-15 the Service had received a total of over 795 referrals. In the current period of April 2015- September 2015 a total number of 401 referrals have been received and, as a result, the Service continues to be unable to maintain a non-breach position of 13 weeks.

A business case re capacity/demand shortfall was submitted by the Trust to the HSCB in August 2013. However, even since this submission the number of referrals has continued to grow and this will need updated. Whilst there has been no additional recurrent investment, the HSCB has provided non-recurrent investment to address the position re breaches. However, due to the specialist nature of the assessments it is very difficult to recruit non-recurrently to provide an actual increase in diagnostics slots. Work is currently ongoing with the Board looking at a number of recovery proposals to reduce the current breech situation.

A model of Directed Conversations was piloted in 2014-15. Whilst feedback on this model generally was not positive, and it produced treatment tails which were unhelpful, the Trust has acted on one aspect of positive feedback from this pilot. Parents and carers commented favourably regarding the helpfulness of the information provided at Directed Conversation regarding the diagnostic process. The Trust has thus developed and implemented (with no additional resource) a workshop which is offered to families 6-8 weeks prior to an appointment being offered. This provides information regarding autism and the diagnostic process, allowing parents to better understand what they are potentially engaging in, and to make more informed decisions about whether to proceed with assessment at this time. It is also an opportunity to engage with parents and carers regarding the information needed for a diagnostic assessment, thus increasing the timely availability of this information once the family proceeds to a diagnostic appointment. As it is offered close to the appointment being available it is also better timed with regards to managing expectations. Feedback regarding this

	workshop has been very positive. At the end of September 2015 the breach position is at 84 weeks. Without a resolution of the capacity situation there are likely to be continued extended waits for a diagnostic appointment, this is particularly the case in respect of more complex cases with co-morbidities, as this is the area with the smallest diagnostic resource at the level of specialism required. A current piece of work is being completed within the Trust to re-profile the waiting list, ensuring equity in the waits. The Trust will move to two streams of assessment: primary aged and post primary aged. In partnership with the Board, Belfast Trust has been pursuing the need to move from a diagnostically driven service model towards a more needs based offer of early intervention. The Board has identified an additional £100,000 recurrent funding to begin to develop such a model and an IPT is under current consideration. Part of this funding is also to promote a more inclusive childrens' service model, facilitating multi-disciplinary and inter-service co-working. This is a joint project across a number of directorates, led by the Head of Psychological Services and Clinical lead for Autism within the trust. **Belfast Children's Autism Intervention Service:** This Service is managed within Psychological Services and provides a multi-disciplinary and multi-agency service delivery model of care. This service has generally maintained a non-breach position since it started, however recurrent staffing vacancies since 2014 have resulted in a current breech position of 21 at end of September 2015. It is hoped that the service will be back to being compliant with its 13week target by end of the financial year 2014-15. It should be noted that recovery plans which aim to reduce breeches in the Diagnostic Service have a knock- on effect on the workload and capacity of the Intervention Service. Plans are being drawn up as to how to increase capacity for Intervention when discussing any potential reduction in breeching at Diagnostics. There are on-going significant pressures in relation to access to interventions due to the levels of demand and available capacity within the Service. Demand continues to be managed by a more group-oriented programme of delivery across all specialisms. Level 2 specialist and focused workshops continue to be offered and to have high uptake (e.g. sleep, anxiety and toileting), complementing the Core Workshops already being offered and which have been highly rated by families in feedback evaluation. The need to be mindful of the needs of carers is also important and a carer mindfulness session was piloted very successfully, and it is planned that this will become a fixture on our programme.
3.7	**Indicate if the issue is included on your Trust Risk Register and at what level**
	The following risks in relation to the discharge of statutory functions were

	included on the Directorate Risk Register as at 31/03/16. Potential for young people to come to serious harm as a result of poly substance Medium – Directorate Risk Register. Risk of young person from having unauthorised absences from going missing from care High - Directorate Risk Register.
3.8	**Key Social Work Workforce issues, including recruitment, retention, flexible working arrangements, workforce continuity etc. Information provided should include level and type of vacancies and any vacancy control systems in place.** **Trusts should attach their Training Accountability Report for the year in question.**
	The Trust has developed a Protocol to facilitate the operationalising of the Trust's Improving Working Lives Policy. The Service Area has facilitated flexible working opportunities for staff including part-time working/ job share/ compressed working week arrangements. Within the residential sector the issue of cost pressures related to staff complement funding remain outstanding. The RIT Residential Workstream had highlighted the need for a substantial increase in the staffing complement for differentiated units - up to seventeen residential staff and five waking night staff to provide adequate levels of cover for individual units. The Trust is currently funded for one Team Leader, one Deputy and 9.5 wte residential social workers per unit leading to a continuing reliance on overtime/bank staff. The issue of compliance with the Working Time Directive is also unresolved and the Trust continues to highlight to the Commissioner cost pressures arising from these issues within the residential sector. This issue is the subject of ongoing discussions with staff side following the outcome of an Employment Tribunal in relation to residential staff in another Trust who successfully pursued an action with regard to non-compliance and non-implementation of the Working Time Directive by that Trust in respect of residential staff on "sleep in" duties. The Trust has robust workforce management arrangements. All vacancies are scrutinised to ensure that the filling of the post is required to enable the Directorate to deliver services in a safe and effective manner. An internal Directorate scrutiny process informs the review system and authorises the actioning of recruitment processes where the need for the post is clearly established and where identified funding is available. A key area involves the proactive management of sickness absence with a view to compliance with the corporate target in respect of same. Ongoing difficulties with the implementation of HRPTS recruitment processes have presented particular difficulties across the reporting period resulting in extended delays in progressing recruitment to vacancies.

	The Service Area has been engaged in two major service improvement initiatives as referenced above which have involved substantial engagement with HR and staffside to manage the workforce implications of significant reforms of service delivery structures and processes. It would wish to acknowledge the commitment of staff to maintaining service delivery continuity and quality through a stressful and demanding period of change. The Service Area has continued to support investment in learning and development opportunities and supports for staff to develop their knowledge and skills. A key area for ongoing focus is the development of structures which facilitate meaningful staff engagement-mechanisms which enable staff to contribute to/participate in the Service Area/ Directorate management planning arrangements; to improve Service Area communication processes by providing clear channels for staff's perspectives to be addressed/and responded to; and to build on the success of the Service Area/Directorate's participation in the recent IIP Bronze Award accreditation utilising the Assessor's Report as a vehicle to drive continuous service improvement through maximising the workforce's potential.
3.9	Trusts should provide a copy of their charging policies and provide explanation of what aspects of service provision you apply this to?
	Intercountry Adoption Services – Costs related to assessment and approval process.
3.10	**Social Workers in Designated Hospitals.**
	The Service Area has no operational line management responsibility for staff working in hospital settings.
3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	Human Rights principles are mainstreamed and central to the design, development and practice of all Belfast Trust policies and proposals. One of the Trust's five core values is to treat everyone with respect and dignity – including colleagues, patients and clients. Cognisant of the intrinsic link between human rights, equality and disability, Belfast Trust policy makers and managers, when screening a policy, use a template which incorporates the human rights dimensions alongside the prescribed statutory equality and disability considerations. This ensures that an analysis of the proposal incorporating the human rights principles of dignity, equality, respect, fairness and autonomy is conducted and considered: ➢ In the context of the articles of the Human Rights Act 1998; ➢ Who the rights holders are; and ➢ How the Trust will ensure that those rights are protected, promoted and fulfilled. Belfast HSC Trust in its Section 75 inequalities action-based plan for 2014-2017, has committed to develop a human rights based approach in regard to all its functions.

	The Trust is currently developing a Human Rights Manual which will help staff adopt best practice in their daily work. This will include information on the Articles of the Human Rights Act and the UNCRPD and case studies to depict how promotion of human rights can make such a fundamental difference in how a person is treated and ultimately feels. Training is provided on Human Rights specifically and is also covered in mandatory Equality Training. Human Rights considerations are fundamental to the delivery of all services pertaining to children and families. Respect for the integrity of the individual child, their parents and carers, their engagement with and active participation in decision making affecting them and the proportionate exercise of statutory authority in any intervention while retaining a focus on the paramouncy of a child's welfare provide the core template underpinning the Service Area's discharge of its statutory functions. At a Service Area level, awareness of the importance of human rights within Trust and professional value bases which fully respect the integrity and rights of individual services is of fundamental significance. The exercise by Service Area staff of statutory powers is subject to judicial, public, organisational and professional scrutiny.

HUMAN RIGHTS

3.12	Identify any challenges encountered in the balancing of Rights.	3.13 What action have you taken to manage this challenge?	3.14 What additional actions (if any) do you propose to manage any ongoing challenges?
	The Trust continues to receive a significant number of referrals in relation to families with No Recourse to Public Funds (NRPF). In assessing the needs of the families, the Trust is required to balance the right to family life in any decisions that it takes regarding the provision of funding or the offer of returning the families to their country of origin.	This is a relatively new but expanding area of work for the Trust. The Trust is developing its experience and skills base in working with NRPF Families and is establishing relationships with the key agencies involved e.g. the United Kingdom Border Agency (UKBA).	The HSCB has published guidance on access to social care for people from EEA and non-EEA countries. The operationalising of the guidance will present significant challenges as a result of the complexity of the legislative framework, the residual nature of the Trust's statutory remit.
	The expectations and levels of post adoption contact for children who are subject to Freeing Orders and subsequently placed for adoption is significant issue in balancing the rights of parents and children who are adopted.	Collaborative work is on-going with the Looked after Children Teams.	To maximise the potential of every opportunity to engage in discourse with the Judiciary and Guardian ad Litem (GAL) Service in relation to this area.

	Discharge of statutory responsibilities which impact on the Human Rights of children and parents In discharging its statutory responsibilities to secure the safeguarding of children.	The Trust provides regular training and reflective learning opportunities for its social work staff in relation to the proportionate balancing of human rights considerations and the discharge of statutory duties to protect children. Professional practice is underpinned by the values and principles referenced in the NISCC Code of Practice and the Trust's own values. The initiation of statutory authority is contextualised within such values and principles and informed by statutory guidance and procedures. The involvement of children and parents/carers in all decisions which impact on their Human Rights is fundamental to practice.	To ensure relevant, up to date research is available for all staff and contributes to practice and planning approaches. The Service Area will continue to review its practice in this area. It will seek to enhance opportunities for service users to contribute to the review and development of services and to ensure that service users have access to independent advocacy and legal representation.

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	The GEM scheme continues to grow, providing better outcomes for care leavers in terms of education, employment, vocational/training opportunities as well as offering enhanced stability in emotional and social wellbeing. The number of GEM placements currently stands at 72. The enhanced collaboration between Adoption and Fostering has provided a much better framework to engage in joint recruitment initiatives to identify permanent foster carers, dual approved adopters and concurrent carers. The HOT project has achieved success in promoting the concept of concurrent placements with prospective adopters. The successful partnership with Opportunity Youth and Include Youth, with regard to the Employability Scheme for Looked After young people and care leavers has continued to develop a wide range of potential opportunities for young people in the workplace and in education. There has also been positive engagement with Further Education Colleges to support young people with their education. The Trust, as Corporate Parent, has committed itself to enhancing employment placement opportunities for looked after young people. Under the auspices of an initiative driven forward by the Co-Director for Childrens Social care, corporate and operational Directorates have participated in the development of such placement opportunities. The Trust has continued to consolidate and further develop its engagement with community, voluntary and other statutory partners under the auspices of the Children and Young People's Strategic Partnership, the SBNI and other local and regional partnerships. The PACS and Care Pathways Projects are substantial and innovative improvement initiatives which capture the Service Area's focus on continuous improvement and quality. The Service Area contributed fully to the Trust's IIP Bronze Award accreditation. This success was predicated on a strong practice and professional value base, pragmatism, energy, workforce engagement and resilience. The accreditation encapsulated the Service Area's commitment to optimising the skills and knowledge base of its workforce to deliver, safe, person centred, high quality care.
3.16	**SUMMARY**
	The overarching financial situation will present substantial ongoing challenges. The development and implementation of the PARIS system is of fundamental significance to the Service Area. The potential of an electronic case file and information management system to contribute to service delivery improvement, performance, service development, audit and assurance has a central

	significance for the Service Area. If successful, implementation will have benefits across the following key areas: the sharing of contemporaneous case file information to inform assessment and planning within appropriate information governance parameters; the capacity to collate service delivery activity data to inform performance and to link with costs will contribute to service planning, performance management and value for money monitoring processes. The Service Area is committed to: purposeful engagement with service users and the workforce; to collaborative partnerships with statutory community, voluntary and independent groups across sectors to maximise opportunities for joint planning and resourcing of service delivery. It is engaged in the preparations for the development of the Belfast Community Plan. The Service Area will continue to optimise the strengths of its engagement with and commitment to partnership working at locality, Trust-wide and regional levels. The Service Area is committed to the retention and development of its workforce, to facilitating their access to training and accredited learning linked to career pathway opportunities and to promoting a strong reflective, child centred outcomes and evidence based practice culture.

FAMILY AND CHILD CARE SERVICE
DATA RETURN 1

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	**0**	**0**
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?	**0**	**0**
1.3	How many adults are in receipt of social work or social care services at 31st March?	**0**	**0**
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?	**0**	**0**
1.4	How many care packages are in place on 31st March in the following categories:	**0**	**0**
	xix. Residential Home Care	**0**	**0**
	xx. Nursing Home Care	**0**	**0**
	xxi. Domiciliary Care Managed	**0**	**0**
	xxii. Domiciliary Non Care Managed	**0**	**0**
	xxiii. Supported Living	**0**	**0**
	xxiv. Permanent Adult Family Placement	**0**	**0**
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular.	**N/A**	**N/A**
1.4b	Please describe how the Care Management process is being managed in this programme with particular reference to decision making levels, review and care planning, highlighting any particular difficulties being experienced and how they are being addressed.	**N/A**	**N/A**
1.4c	Please articulate how the views of service users, their carers and families are included in the decision making process, review and care planning.	**N/A**	**N/A**
1.5	Number of adults provided with respite during the period	*PMSI return*	*PMSI return*
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care		
	- Statutory sector	**0**	**0**
	- Independent sector	**0**	**0**
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	**0**	**0**

1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector	**0**	**0**
	- Independent sector	**0**	**0**
1.8	Unmet need (this is currently under review)	**0**	**0**
1.8a	Please report on Social Care waiting list pressures	**N/A**	**N/A**
1.8b	Please identify possible new service innovations that are currently supported by non-recurrent funding	**N/A**	**N/A**
1.9	How many of this Programme of Care clients are in HSC Trust- funded social care placements outside Northern Ireland?	**0**	**0**
1.10	Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations. Dissemination of learning from complaints investigations. Reflective practice learning events focussed on review and learning from complaints. Development of action plans in response to individual complaints progress against which is monitored and reviewed by the CSM Group.	~~*Board return*~~	~~*Board return*~~

Data for 1.5, 1.8 and 1.10 will be sourced by Board officers from existing returns.

FAMILY AND CHILD CARE SERVICE
DATA RETURN 1 – Hospital

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

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

The Service Area has no operational or managerial responsibility for the delivery of hospital social work services.

FAMILY AND CHILD CARE SERVICE
DATA RETURN 2

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

FAMILY AND CHILD CARE SERVICE
DATA RETURN 3

3 DISABLED PERSONS (NI) ACT 1989 *Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability*		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	**0**
	Number of Disabled people known as at 31st March.	**0**
3.2	Number of assessments of need carried out during period end 31st March.	**0**
3.3	(this is now collected at 1.8)	
3.4	Number of assessments undertaken of disabled children ceasing full time education.	**0**

FAMILY AND CHILD CARE SERVICE
DATA RETURN 4

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

4.1	Number of Article 15 (HPSS Order) Payments	**297**
	Total expenditure for the above payments	£44,001
4.2	Number of TRUST FUNDED people in residential care	**0**
4.3	Number of TRUST FUNDED people in nursing care	**0**
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	**0**
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	**5**

FAMILY AND CHILD CARE SERVICE
DATA RETURN 5

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65 +
5.1	Number of adult carers offered individual carers assessments during the period.	**2**	**42**	**0**
5.2	Number of adult individual carers assessments undertaken during the period.	**2**	**32**	**0**
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	**0**	**32**	**0**
5.4	Number of adult carers receiving a service @ 31st March	**0**	**11**	**0**
5.5	Number of young carers offered individual carers assessments during the period.		**2**	
5.6	Number of young carers assessments undertaken during the period.		**2**	
5.7	Number of young carers receiving a service @ 31st March		**48**	
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March (b) Number of new approvals for direct payments during the period 1st April – 31st March 2016 (c) Number of adults receiving direct payments @ 31st March		**0** **0** **0**	
5.9	Number of children receiving direct payments @ 31st March		**0**	
5.9.a	Of those at 5.8 how many of these payments are in respect of another person?		**0**	
5.10	Number of carers receiving direct payments @ 31st March		**0**	
5.11	Number of one off Carers Grants made in-year.		**41**	
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.				

Commentary

Action for Children is providing services to approximately 46 young carers from the Belfast Trust area AS AT 31 March 2016.

MAHI - STM - 300 - 2600

FAMILY AND CHILD CARE SERVICE

DATA RETURN 6

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

DATA RETURN 7

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 8

CORPORATE RETURN SUBMITTED BY SOCIAL SERVICES LEARNING AND DEVELOPMENT SERVICE

FAMILY AND CHILD CARE SERVICE
DATA RETURN 9

9 The Mental Health (NI) Order 1986			
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115			
Admission for Assessment Process Article 4 and 5			
9.1	Total Number of Assessments made by ASWs under the MHO	**16**	Reported by RESW
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	**16**	Reported by RESW
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	**0**	Reported by RESW
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	**0**	
9.1.d	The Service Area is compliant with its duties.		
Use of Doctors Holding Powers (Article 7)			
9.2	How many times did a hospital doctor use holding powers?	**14**	
9.2a	Of these, how many resulted in an application being made?	**14**	
	Applications made following Form 5 make up approximately one-third of all applications in the Service Area. This relatively high proportion could be explained by the fact that out of hours requests for ASW assessments when a person is being held under a form 5 are being generally passed to the day time service. This issue has been raised with RESWS.		
ASW Applicant reports			
9.3	Number of ASW applicant reports completed	**16**	
9.3.a	How many of these were completed within 5 working days	**16**	
Social Circumstances Reports (Article 5.6)			
9.4	Total number of Social Circumstances reports completed.	**0**	
9.4.a	Number of completed reports which were completed within 14 days	**0**	
Mental Health Review Tribunal			
9.5	Number of applications to MHRT in relation to detained patients		

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	**0**	**0**	**0**	**0**	**0**
Patient	**0**	**0**	**0**	**0**	**0**
Nearest Relative	**0**	**0**	**0**	**0**	**0**
Other	**0**	**0**	**0**	**0**	**0**
Total	**0**	**0**	**0**	**0**	**0**

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

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

Approved Social Worker (ASW) Register		
9.7	**Number of newly appointed Approved Social Workers during period**	**0**
9.7.a	**Number of Approved Social Workers removed during period**	**0**
9.7.b	**Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)**	**0**
	CORPORATE COMMENTARY There has been a steady decrease in the number of ASWs available to participate in the Trust's Day Time Rota over the past number of years. There are concerns that the Trust, under the present arrangements, will not have capacity to meet the statutory requirement set out in Article 115 of the Mental Health (NI) Order 1986 (the Order) in respect of the availability of ASWs to discharge the range of statutory functions as specified in the Order. While four social workers from the Trust are currently participating in the Regional ASW Training Programme and hopefully will be assessed as competent, they will not be available for appointment by the Trust until October 2016 and will then be required to undertake a period of "shadowed practice" before they can operate as autonomous practitioners. Therefore	

	this could result in them not being on the Daytime Rota until January 2017. The potential addition of these four social workers will not fully offset the number of ASWs lost through retirement/those who have moved to other posts/other Trusts/ RESWS. Of the cohort of twenty-eight, one has already indicated that, due to demands of work as a Team Leader, they will be withdrawing and another has indicated they will be retiring in June 2016. The Trust has twenty-eight ASW trained staff currently on the Daytime Rota. Training of additional ASW staff has been identified as a priority within the Service Area. Nominations for the 2016/17 Regional ASW Training Programme are presently being collated. Additional ASW duties include Guardianship-related functions and inputs into MHRT cases in light of their knowledge, skills and experience in this area. ASWs also provide a consultation role to those teams/services which do not have ASWs or social workers. Service Area ASWs participate in refresher training throughout the year and re-approval training every three years. Due to the pressures of the ASW rota the 'floater' has been replaced as a third member on the ASW rota. This is because it is a regular occurrence that all three ASWs on the Rota on a daily basis are called out to assess patients. On a regular basis there can be multiple ASW assessments requested on the same day. It is now a regular occurrence that ASWs on the Daytime Rota have to wait substantial lengths of time for the ambulance and PSNI to support the conveyance of service users to hospital in those circumstances in which significant risks to the service user or others are extant. These situations are exacerbated by difficulties in accessing beds in the Trust's area. This results in ASWs having to accompany those requiring admissions to hospital to units across the region. Such episodes can significantly impact on the ASWs' ability to fulfil the requirements of their core posts. An inter-agency group involving representatives from the PSNI, the NI Ambulance Service and Trust's Unscheduled Care, GP Out of Hours and ASW Services has been established to address interface matters relating to their respective responsibilities and pathway processes pertaining to assessments for admission under the Order. The Trust has completed a review of ASW activity. The Review highlighted a number of key organisational, logistical and professional issues impacting on the delivery of the ASW Daytime Rota including: the diminution over a number of years of the complement of designated social work posts in the Mental Health Service Area; the increase in demands on available social work resources of the exponential increase in adult safeguarding activity and, in particular, the projected and current impact to date of the Revised Adult Safeguarding Policy determination that social work will be the lead profession in safeguarding service delivery; the increasing complexity of ASW-related activities; the impact of the difficulties of out- of -Trust admissions; the	

	difficulties associated with interfaces across the PSNI, Ambulance Service, Unscheduled Care and ASWs in respect of assessments for admission; the need to develop a robust workforce planning approach to social work requirements in Mental Health (including ASWs) incorporating the implications of the Mental Capacity legislation; and the resourcing of and supports for staff engaged in the Regional ASW Training Programme. The Review's proposal for the establishment of a hybrid ASW core team to address the immediate pressures on service delivery and to ensure the Trust's capacity to discharge its statutory functions has been agreed and is currently being actioned. The Principal Social Worker (PSW) in Mental Health with operational responsibility for the co-ordination of the Rota works closely with the Regional ASW Group in relation to the review of documentation to ensure a consistent approach across the region. In addition, the PSW has also revised local ASW documentation relating to alternative care planning for patients who have been assessed as not requiring detention for assessment under the Order. Breakaway training has also been scheduled for June 2016 for all ASWs on the Daytime Rota. In-house bespoke training has also been completed on the Regional Interagency Protocol in February 2016. ASWs have been appraised of the PSNII risk assessment process for thresholding and prioritising referrals and have been advised of the importance of providing clear and factual information in respect of assessed risks when requesting PSNI assistance. The PSW has reviewed as a priority the provision of reflective practice supervision sessions for ASW staff. These are now "up and running" and take place on a 6-8 weekly basis. The PSW has also re-launched the ASW Forum which meets twice a year. Attendance at the ASW Forum alternates with the reflective practice groups and attendance is mandatory (i.e. 75% attendance). The Trust will continue to review and develop supports to its ASW workforce. The Regional Audit of Assessments for Admission under the Mental Health (NI) Order 1986 was launched in March 2016. The Report will contribute to an ongoing Trust focus on improving ASW organisational and service delivery arrangements and the management of internal and external interfaces. Trust senior management are reviewing a number of interface issues across the RESWS and the Daytime Rota. The Trust has robust administration structures in place to monitor ASW numbers, accreditation and re-accreditation arrangements	

9.8 **Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If so please provide detailed explanation for each and every instance including their age and relevant powers used.**

Age	Mental Health presentation	Location of assessment and Powers used
14	Self-harm, suicidal	Assessed in RVH A&E Form 2, 3, 5 completed
14	Physical aggression, suicidal	Community Assessment Forms 2,3 completed
15	Suicidal ideation	Assessed at Beechcroft Forms 2,3 completed
15	AWOL, suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
15	Suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
15	Physical aggression / Low mood	Assessed at Beechcroft Forms 2, 3 completed
16	Depression / Eating Disorder	Assessed at RVH Forms 2, 3 completed
16	Suicidal / Physical aggression	Assessed at Beechcroft Forms 2, 3 completed
16	Low mood / suicidal	Assessed at Beechcroft Forms 2, 3 completed
16	Depression / suicidal	Assessed at Beechcroft Forms 2, 3 completed
17	Suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
17	Suicidal ideation	Assessed at Beechcroft Forms 2, 3 completed
17	Depression / Eating Disorder	Assessed at Beechcroft Forms 2, 3 completed
17	Suicidal	Assessed at Beechcroft Forms 2, 3 completed
17	Self- Harm	Assessed at Beechcroft Forms 2, 3 completed
17	Low Mood / Self Harm	Assessed at Beechcroft Forms 2, 3 completed
Out of Trust Assessments		
15	NHSCT Depression / Self Harm	Assessed at Beechcroft Forms 2, 3 completed
17	WHSCT Self Harm	Assessed at Beechcroft Forms 2, 3 completed
17	WHSCT Self Harm	Assessed at Beechcroft Forms 2, 3 completed

9.9*	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?	**0**

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6).

Schedule 2A Supervision and Treatment Orders.

9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	**0**
9.11	Of the Total shown at 9.10 how many have their treatment required as:	

	Treatment as an in-patient	**0**
	Treatment as an out patient	**0**
	Treatment by a specified medical practitioner.	**0**
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	**0**
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period.	**0**
	Commentary *(include any difficulties associated with such orders, obtaining treatment or liaison with specified medical practitioners, access to the supervised person while an in-patient)*	

MAHI - STM - 300 - 2607

CHILDREN WITH DISABILITIES SERVICE AREA

GENERAL NARRATIVE

3.1	**Named Officer responsible for professional Social Work**
	Oversight of professional social work practice and standards within the Children with Disabilities Service Area is the responsibility of Mrs Pauline McDonald, Children's Services Manager, who is accountable to the Co-Director, Mrs Carol Diffin. Both managers are qualified social workers. An unbroken line of accountability for the discharge of statutory functions by the social work workforce runs from the individual practitioner through Service Area line management and professional structures, to the Executive Director of Social Work and therefore onto the Trust Board. In her role as Co-Director for Children with Disabilities, Child Health and the Regional RESWS, Mrs Carol Diffin has responsibility for the delivery of Statutory Functions within the Service Area.
3.2	**Supervision arrangements for social workers**
	Trusts must make reference to: Assessed Year in Employment (AYE) and compliance and caseload weighting arrangements. The Service Manager for Children with Disabilities and Assistant Service Manager posts are designated social work posts. Team Leader posts in social work teams are also designated social work posts and supervision is regarded as an important assurance measure. Forest Lodge as a registered Nursing Home is managed by a qualified nurse and the Children's Interdisciplinary Schools Team and Children's Therapeutic Services are multi-disciplinary in nature and management structures reflect this, with one social work post in the Children' Interdisciplinary Schools Team. All staff within the service are expected to have monthly supervision from their line manager. **AYE Staff** The Service Area has had a number of Agency social workers in field work and hospital social work posts who were also AYE workers during the reporting period. The Service Area was compliant with all statutory and regulatory requirements in respect of Agency/AYE staff. The service has had a positive experience of these staff and they have provided a good service to families. **Supervision across the service** The Service Area has had difficulties in maintaining last years' level of performance with regard to frequency of supervision in fieldwork and residential teams due to a combination of significant recruitment delays caused by the introduction of the new HRPTS system and move to Shared Services. The Service Area has addressed this issue by providing additional informal consultation for staff, group sessions and available managers have provided additional

	sessions to staff who do not normally report to them. It has been very positive to see managers pull together in this way. Senior managers also provided supervision to Band 6 staff on several occasions. PCP compliance levels have improved and the service is now implementing a new and more comprehensive tool which will ensure that PDP numbers come into line with PCP's The service Area oversaw improved performance towards the end of the reporting period in this respect. Limited progress has been made in implementing The Regional Caseload Weighting system and it remains challenging to review caseloads on a monthly basis due to caseload sizes and complexity. Team leads and senior managers are working with Belfast Trust Change Co-Ordinator to improve compliance and will develop an action plan which enables managers to support the implementation of the system more effectively. **The Service Area has assurance processes to monitor compliance with the discharge of its statutory functions:** **Somerton Road Children's Home** is registered as a home for children with Learning Disability and behaviours which challenge. This has been a positive year with a new manager and deputy manager in post who have worked well as a management team and are providing strong and cohesive leadership to the unit. Until these post holders were recruited and settled within the Service, supervision levels were not satisfactory however this issue has now been resolved and supervision is happening regularly and is of good quality. Managers are very aware that this issue is being closely monitored and are delivering improved performance. Monthly monitoring and file audit is ongoing (Monitoring Officer). Despite a resignation and retirement of social work postholders, the service has settled and adapted well to both new residents and staff. The Service has embraced Positive Behaviour Support as an ethos and there has been a notable reduction in the use of physical restraint and restrictive practice within the home. Two members of staff have been trained as PBS coaches and a network of PBS trained staff is planned for this year. The Service is excited about the potential of PBS to provide a cohesive and unifying framework across teams, services and with other departments within the Trust. Two positive inspections have taken place in the past year. The Service is seeking access to the Therapeutic LAC Service in order to improve staff support, wellbeing and governance within the unit. **Forest Lodge Short Break Service** is registered as a nursing home and is also required to meet the Childrens Homes minimum standards, despite being a nurse-led unit for children with Learning Disability and Complex Health Care Needs. The Home is jointly inspected by nursing and social work inspectors as part of the RQIA regulatory arrangements and is monitored monthly by the Monitoring Officer in line with Nursing and Childrens Home Regulations. The Associate Director of Nursing

provides professional nursing governance advice, guidance and monthly supervision to the registered manager. Monthly supervision is also provided to the manager by the Assistant Service Manager.

This has been a positive year for the Service. The Service is regularly evaluated positively by families and professional colleagues. And, whilst Inspections have made recommendations and requirements about functional and important process issues to which the Trust has responded, RQIA have been complementary of the quality of interaction between staff and children. The Service is fully compliant with LAC requirements in respect of Short Breaks and is appropriately linked with corporate nursing

WILLOW LODGE SHORT BREAK SERVICE: Willow Lodge is a registered Children's Home with two beds and up to 22 children who use the Service at various times and at varying levels, depending on assessed need. Care inspections have been positive and the estates inspection raised a number of issues which have been responded to and addressed with the exception of one outstanding issue related to the replacement of worktops which is in the process of being resolved. The Service has also embraced PBS and has had two staff members trained as PBS coaches. The team has engaged positively with managers in respect of the review of Short Break services and has made constructive suggestions about possible new models. Monthly monitoring is prioritised by the Service and both the monitoring officer and Registered Manager audit service user records to ensure quality and consistency. The Service has recruited a new registered manager.

Social work services to the Royal Belfast Hospital for Sick Children (RBHSC) and Royal Jubilee Maternity Hospitals (RJMH) are delivered in a uni-professional model within a medical and nursing operational environment. Social work is seen as a distinct, but vital part of the multi-disciplinary team and staff provide advice and input on safeguarding matters and the social and emotional needs of families of children in treatment and palliative care. A close partnership exists with the Clic Sargent cancer charity in respect of support for families of children receiving cancer treatment and the charity funds one of two Oncology Department social work posts. Supervision levels in this part of the service are consistently high. Files are regularly audited by the team leader and senior manager responsible for the Service.

Community Teams
Recruitment difficulties have hit teams particularly hard due to one long standing vacancy, two resignations and a retirement in the reporting period. In response to these circumstances the Service has employed Agency staff whilst recruitment issues are resolved. The ongoing difficulties caused by problems with HRPTS have contributed to a dip in morale and additional operational pressures. The management team is aware of these issues and providing as much support to first line managers as possible. Teams are engaged with managers to finalise a referral and allocation pathway which will be complimentary to UNOCINI requirements and will streamline the management, referral and allocation

	of cases. Trade Unions are also engaged in discussions on behalf of their members. **Childrens Therapeutic Service (CTS)** Following HSCB investment via IPTs, Childrens the Therapeutic Service Team has been formed under the leadership of a Consultant Clinical Psychologist. The Team complement includes Behaviour Specialists, AHP colleagues and is currently recruiting a team Co-Ordinator and Family Support Workers. The Service works closely with community social work and nursing teams and is currently providing intensive interventions and supports for a small cohort of children. The further investment provided will enable the Service to take forward more early intervention and preventive work with families and schools. The Service has also engaged with BILD and has overseen the roll-out of PBS across all of our services at awareness level and has trained ten PBS coaches who will act as champions within key services. This training has required considerable investment and has been funded via the IPT for Challenging Behaviour. Waiting times and outcomes are measured and recorded and information gained is used to improve the quality of the service provided. **Unallocated cases** are reported on a monthly basis in Priority 5 returns. Team Leaders assess and prioritise work in to ensure maximise the available staff resource, minimise and manage unallocated cases and strive to adhere to UNOCINI assessment and review timeline requirements. **Carer Assessment and Young Carer assessment** performance has improved as has engagement with parents and carers with further developments planned for 2016/17. **Carer support and engagement** has been an area of significant development in 2015/16 and the Service has invested a considerable amount of its Carer Support IPT money in Carer Wellbeing events and Time for Me programmes delivered by several respected Independent sector organisations. A Carer Support Working Group has been established and has planned further carer events (a Family Woodland Day, Barbeque and two planned four-week Mindfulness courses for carers) will take place in the next reporting period. Two carer focus groups were also held as part of the Service review during the year. **Children with Complex Health Care Needs** CWD service continues to work closely with the Community Child Nursing (CCN) Service to ensure co-ordinated discharges from hospital and joint assessment and support to families of these children. IPT investment has been directed to fund three intensive support packages and associated equipment required and an in-reach short break service. A 0.5 social worker has been appointed to take forward recruitment of specialist Foster Carers to provide essential placements for complex children on the edge of care. The Service is working closely with Fostering Service colleagues in order to deliver appropriate placements.

3.3	**Report on processes, audits, reviews, research and evaluations undertaken during the year, that measure performance against delegated statutory functions, identifying emerging trends and issues (may include cross references to other sections to this report).**
	Access to Services The Service Area has written Referral and Allocation criteria for each service which detail the responsibilities and accountabilities of Team Leaders and practitioners. Criteria remain in Draft pending the completion of work (under the auspices of Childrens Services Improvement Board (CSIB) to ensure common criteria for access to Children with Disabilities Services across the region. Belfast and Northern Trusts have collaborated closely on this work. The Service has further developed the processes (pathways) to support the proposed criteria and is consistent with Trust Referral and Allocation Policy expectations, UNOCINI Framework and "Hardiker" Thresholds of Need model. Processes ensure that all urgent or child protection referrals are responded to within 24 hours. The Service Area has also developed a comprehensive referral pathway process aligned to UNOCINI requirements which takes account of all services managed by CWD to which a child with a disability may be referred. In effect this creates one front door and ensures that all new referrals into the service are offered a Carer Assessment and initial assessment within the UNOCINI Assessment Framework. **Professional Registration** The Service Area is compliant with the Trust's procedures in respect of the professional registration of the social care workforce. The Trust's NISCC Data Base has a central role in providing assurance in relation to same. The Service Area has developed a quarterly registration exception reporting return which will provide additional assurance that the individual services are compliant with professional registration requirements. **Service User Audit, Engagement and Feedback.** The Service Area seeks feedback from children and parents who access Short Break and residential services and their carers via the LAC process. We continue to report on this in monthly reports to RQIA and the perspective is used to inform service development plans. During the reporting period the Service Area actively engaged in various forms of stakeholder and user engagement as outlined below and is continuing to implement its PPI strategy, though management capacity challenges continue to limit developments in this area. The Service Area has increased partnership work with the independent sector with particular emphasis on early intervention and this has also involved working more closely with parents and carers. The Service Area is working with the Carer Co-Ordinator for children to develop a more regular and relevant Carer Forum. The Service Area has also run a number of workshops/sessions for siblings which have been positively

evaluated.

Children with Disabilities Service Review
The CWD Service Review is at an advanced stage and the Senior Management Team is currently collating a final report with proposals for consultation on referral criteria, pathways and structures and the development of a more efficient Short Break system. The Review's aim was to undertake a service review across Children's Disability Services, identifying recommendations for delivering agreed improvements and efficiencies and to agree a set of principles and related proposals which would deliver:

- Equitable and transparent access across each of the services.
- A review of services currently provided and action to improve same.
- Assess demand and capacity to inform workflow plans.
- Deliver improved pathways and service outcomes.
- Arrangements to improve efficiencies in delivery and cost.
- An agreed set of performance indicators
- A stronger user and carer voice and influence.

The improvement work was taken forward via six individual work streams. All work streams had clear objectives which were aligned to the overall aims of the Review. Each work stream has now concluded Individual improvement projects are being taken forward to deliver a leaner, more efficient. Service user and outcomes-centred provision.

The views of service users and their families were sought in focus groups, a large-scale survey returns and a series of smaller engagement sessions. "Arts Care" completed an engagement process with children who access residential and Short Break services to capture their perspectives on service delivery and to their own sense of their needs and experiences as service users. These engagement processes will be of central significance in securing service delivery improvements.

Staff side representatives have been consulted and apprised of plans throughout and the Senior Management Team has engaged with staff on an ongoing and regular basis.

Increasing Complexity of need in younger children
The Service Area Review has clearly demonstrated the need for increased behavioural and Short Break services and has confirmed the increasing complexity and range of needs across the children with disabilities population. These children present with several common co-occurring conditions- SLD, Autism, ADHD and often epilepsy. Community Teams and CTS are working closely to maintain these children at home, to obviate the significant pressures and demands on parents and carers. A particular aspect of this work has been to develop links with education services to prevent early exclusions of these children from school and to secure their access to and limited access to educational psychology services.

Accidents and Incidents
Accidents and incidents are monitored and reviewed regularly at the Directorate's Governance meeting and at local level through the social care audit cycle and management processes. The review of accidents and incidents is a standing item on managers' meetings and senior managers review incident reporting on a quarterly basis to establish and respond to trends and pressures. It is pleasing to report a continued reduction in the use of physical interventions in short break and residential services.

Risk register
The Service Area has a process in place which ensures that its Risk Register is regularly reviewed and updated. All risks are reviewed at least quarterly and the Service Manager and Governance Manager liaise regularly.

Looked After Children (LAC) Reviews
The Service Area is compliant with the requirements in respect of the scheduling of LAC reviews (with one exception during the reporting period due to staff sickness).

Direct Payments
The Service Area has now identified areas for improvement in respect of Review arrangements and eligibility for services and is currently working through these. An Action Plan has been developed which has now been assimilated into the Service Area's Self-Directed Support (SDS) Implementation Plan. The Service Manager represents CCS on the Trust SDS Implementation Group.

Regulation Quality and Improvement Authority
Overall the Service Aerea has achieved satisfactory levels of compliance with the relevant regulatory standards. Themes of inspections completed during the reporting period have included:

Somerton Road Residential Unit:

Delivery of safe, effective and compassionate care
Areas examined were :
Safety of care practices-the quality of life for children,
Risk management
Safe working practices.
Safeguarding.
Staffing levels and staff satisfaction.
Children`s satisfaction levels,
Staff knowledge of complaints and whistle blowing procedures.
Staff knowledge of child abuse, signs symptoms of sexual exploitation of children, training in these child protection areas.
Quality of interaction between staff and children interaction and Fire training.

The Service Area achieved good compliance in all identified areas and

has fulfilled all requirements and recommendations.

Forest Lodge Short Break Service
During the reporting period there has been one care inspection (11/8/15), focusing on:
Individualised care and support and
The safeguarding of children and young people.

RQIA also conducted an Estates inspection (4th Feb 2016) of the unit where the focus of the inspection was:
Premises
Safe and healthy working practices
Fire safety.

Willow Lodge Short Break Service

Willow Lodge has had two inspections between 1/10/15 and 31/3/16-

Announced Estates Inspection on 6/10/15 *Standard 11: Providing a suitable physical environment; and*
Standard 22-Health and Safety Working Practices.

The Trust accepted the recommendations and has had the unit re-painted and replaced all furniture in living areas. An outstanding issue remains the repair/ replacement of kitchen cupboards and work surfaces and Estates Services have been advised of the importance of completing this work promptly

Unannounced Care Inspection on 22/12/15 *Standard 4 Children and young people feel safe and are safe in the care of the home. Arrangements are in place to safeguard them and help them understand how to protect themselves from harm.*

The Trust has fully engaged with the RQIA inspection process and has responded comprehensively to any recommendations or requirements from these inspections. A Quality Improvement Planning (QIP) and review process will be introduced to assist residential managers to monitor delivery of regulatory requirements and recommendations.

Gain Audit
During the reporting period the Service Area has taken part in CCS Supervision Audit, the outcome of which was that supervision was occurring regularly and PCP levels were good. Areas for improvement are around immediate rescheduling of cancelled sessions, reflective practice and continuity of issues between sessions. The Service Area has developed an Action Plan and is currently implementing same in order to ensure improvement in the number of PDP's completed and consistent standards across all teams.

The ***Network***

Very positive engagement has been gained from multi-disciplinary

colleagues and a formal ***Network*** (branded as such) has been established to ensure efficient cross-Departmental working and continuous improvement within and between the disparate parts of the Child Health, Community Paediatric and Children with Disabilities system. The ***Network*** meets quarterly and sponsors improvement projects and collaborative practice initiatives. Closer working relationships are evident and plans are in place to take forward Joint CPD events, accessible communication and carer support events.

CIDS Team has again completed several satisfaction surveys and outcome audits. Teachers and parents continue to evaluate the service highly and provide valuable feedback which will assist the Service in pursuing further improvements.

Regional Groups
The Service Manager represents the Belfast Trust on two Children and Young Peoples Strategic Planning Groups (CYPSP) related to children with disabilities (CWD and Transitions) and is a member of the Children with Disabilities Children Services Improvement Board (CSIB) Sub-group which is chaired by the Service Area Co Director. CSIB is working towards completing work on a regional model and criteria for CWD services

Family Group Conferencing
The Service Area continues to offer access to Family Group Conferencing (FGC) in appropriate cases and has a number of social work staff trained in chairing FGCs. The Service Area is using the model as appropriate for discharge and care planning for children with complex health care and in complex cases. The Service Area is considering how the model could be applied more broadly across services.

File Review
During the reporting period the Service Area undertook two social work case file reviews in Community Teams and RJMH. The Community Teams reviews clearly showed that where UNOCINI Family Support pathways had been implemented, records were clearer and intervention more co-ordinated. A programme is in place to ensure full implementation of the Family Support pathway in all family support cases.

The RJMH social work case file review indicated high levels of compliance with revised criteria, fewer inappropriate referrals and has given insight into the role and function of hospital social workers. This information is informing the ongoing improvement project into hospital social work service delivery.

BRAAT 2
The Service Area has submitted scores for all teams and is working to address areas for improvement which have been identified. The Service Area is well on target to complete the work within the required time frame. Action plans are reviewed at managers' meetings and in

	managerial supervision to ensure that the process is meaningful and linked to outcomes for each team. The service's overall score is high and managers are focussed on maintaining this.
3.4	**Report on the Programme of Care's interfaces with other statutory agencies including for example: NISCC; RQIA; PHA (in relation to social care)** **Trusts should include references to Judicial Reviews or other significant Court Judgements that directly impact on the discharge of statutory functions.**
	Compliance with NISCC Regulatory Requirements The Service Area is compliant with NISCC registration requirements pertaining to its social work and social care workforce. Staff are supported to meet the NISCC PRTL requirements through the PCP/DP process and can access a wide variety of training and development opportunities. **PHA/HSCB** The CIDS Service continues to participate in the Review of Interdisciplinary Schools Teams undertaken by the HSCB and PHA to ensure equity of service provision across the region. Regional principles have been developed and an agreed model of care has been proposed in respect of service provision to children in mainstream schools who present with additional needs and disabilities. Conclusions and recommendations have not yet been published. **Adverse and Serious Adverse Incidents**. Service Area processes in relation to RQIA and HSCB reporting requirements have been audited to ensure full compliance with .same This has been achieved in-year. The Service Area has used SEA Review structures to allow it to review two incidents which did not meet SAI criteria, but which were complex. These processes allowed for objective review and follow up action. All other incidents were reviewed quarterly at first line managers' meetings and CCS Governance meeting. **Judicial Review and Court Judgements** The Service Area has not been engaged in either Judicial Review or Court proceedings during the reporting period.

3.5	Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions	3.6 Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications	3.7 Indicate if the issue is included on your Trust Risk Register and at what level
	Maintenance of consistent and satisfactory levels of supervision in the Service Area when there are unavoidable gaps in the managerial team.	The Service Area has undertaken a comprehensive review of all services in order to ensure financial and operational efficiency	N
	Compliance with supervision requirements	The Service Area is working to ensure improved performance in this area.	Not on Risk Register
	Staff retention and support	The Service Area has been unable to recruit vacancies in a timely way as outlined above and throughout this report. This has led to low staff morale and some staff on temporary contracts have left because of the direct pressures which this situation has created, particularly within community teams. This has led to further vacancies, delays and slower response times.	CCS Directorate Register
	To provide adequate governance of services within existing structures and capacity	To review management capacity within the service to ensure a sufficient resource to meet assurance requirements.	Not on Risk Register

	Increasing complexity of behaviour and co-morbid conditions within young children, including pre- school children	The Service Area has welcomed and embraced the additional investment in essential community and therapeutic family support services however this has placed considerable pressure on the already inadequately resourced management team. The service has been able to identify some non recurrent money to temporarily improve governance and performance, but in the current circumstances will be unable to maintain this investment beyond 31/3/17	Not on Register
	Lack of an appropriate range of more intensive family support and home treatment services.	The Service Area is working collaboratively with colleagues in Child Health and Community Paediatrics to improve structures and operational efficiency and reduce duplication. This work is important, but is unlikely to make a significant impact on levels of need currently presenting.	Not on Register
	Ability to move from a reactive model of service delivery due to the building pressures and complexity within caseloads Lack of access to Principal Practitioners for Family support and Safeguarding, Therapeutic LAC and lack of access to Family centres, contact services.	The Service has targeted HSCB investment at families in crisis and those with complex needs and plans to increase the focus on early intervention following the completion of current recruitment.	Not on Register
	Increase in the numbers of children and families from BME backgrounds including those with no recourse to Public funds.	As Above, however the service is focusing on developing early intervention in the	

		second phase of service planning and is working closely with Early Years and the Independent sector to move forward.	Not on Register
	Lack of suitable provision of appropriate residential placements for a small number of young people with very challenging behaviour on discharge from Iveagh.	CWD Service is pressing within BHSCT for access to these services.	Not on Register
	Implementation of PARIS CIS across CCS	The service has responded to need as it presents, but is seeking to be more organised in responses and action. A scoping exercise will be undertaken to profile need and appropriateness of response in the next reporting period.	Not on Register
	Difficulty in recruiting an Professional Nurse Lead for the Service Area.	The Service Area has had to consider placements in Glencraig for some of these young people and is working with SEHSCT in relation to governance arrangements for these placements.	CCS Directorate Risk Register
		An implementation plan a and training is in place to support the roll out	Not on Register
		This role is temporarily being covered by one the team leader of forest Lodge with support from the Assistant Director of Nursing	

3.8	**Key Social Work Workforce issues, including recruitment, retention, flexible working arrangements, workforce continuity etc. Information provided should include level and type of vacancies and any vacancy control systems in place.**
	Staff Retention The Service Area had one retirement within its field social work service, one residential social worker also retired and there were three resignations of staff from temporary posts in community teams. Staff who resigned cited lack of certainty about structures and future recruitment as the main reason for leaving. The Service Area is aware of this issue and linking with senior HR managers to address delays in recruitment. **Flexible Working Arrangements** The Trust has developed a protocol to facilitate the effective management of the Trust's Improving Working Lives Policy which is central to workforce and skills retention .The Service Area has facilitated movement of staff to part-time/ job share/ compressed working week arrangements where the needs of the Service Area have permitted. However, this is increasingly challenging amid the pressure to modernise and use resources as efficiently as possible. Wherever practical and safe the service will facilitate flexible working requests, but this is becoming much more of a challenge than ever before. **Recruitment** The Service Area complies with the corporate workforce management arrangements. This remains challenging as a result of the timeline for the replacement of posts and need for vacancy controls. The Trust has robust workforce management arrangements. All vacancies are scrutinised to ensure that the filling of the post is required to enable the Directorate to deliver services in a safe, effective and efficient manner. Difficulties with HRPTS difficulties have resulted in a number of significant delays in progressing recruitment. **Absence Management** Priority is given to the proactive management of sickness and absence. The Service works closely with HR and Occupational Health Services to improve its performance in this area. Performance has shown a small dip in the past year due to a number of serious illnesses among staff and one serious accident within a small service. **Caseloads** Caseload numbers have reduced during the reporting period due to working in a much more targeted way and the closure of outstanding cases. The complexity and risk profile of new and on-going cases appear to be increasing. The Service Area is currently considering the implications of this for workload management and planning. The complexity and resource implications of cases must be contextualised against the backdrop of a shrinking resource base and stringent financial efficiency requirements. The Trust would wish to highlight that regionally there has never been a capacity and demand exercise in relation to the

	workload activity for Children with Disability Teams. No investment has been received into these front line social work teams since RPA whilst significant investment has gone into Gateway, Family Support and LAC services. **Implementation of the Regional Caseload Management Model** This continues to prove challenging within the Service Area due to recruitment issues outlined in this report. The Service Area continues to look at ways to implement this model. **Residential Care Model** Under the auspices of the Service Area Review, the Service Area has completed a comprehensive review of the model of care and ethos of its specialist children's home. Progress on this work has been outlined elsewhere in the report. **Partnership Working** The Trust is engaged in a number of significant partnerships with independent and voluntary sector providers targeted at the provision of early intervention and supports, short break services and Transitions. This will be a continuing priority moving forward. **Management Capacity** The service has continued to experience challenges in meeting regulatory and statutory requirements within available management capacity. Supervision and monthly monitoring report performance has been variable due to this issue and the Service Area has identified non-recurrent funding to begin to address this gap in governance through the employment of an additional temporary ASM for a 9 month period. Improvement is noted at the end of the reporting period.
3.9	**Trusts should provide a copy of their charging policies and provide explanation of what aspects of service provision you apply this to?**
	N/A
3.10	**Social Workers who work within designated hospital- Give an account of how these duties are fulfilled by Social Workers working in these designated hospitals**
	The social work services in the RJMH and the RBHSC are managed by the Service Area. In RJMH staff work in a task centred way to determine the need for referral to Gateway or FIT Teams and to ensure that lower level safeguarding concerns are shared appropriately and in a timely manner with community professionals. If families are already known to Social Services, the appropriate social worker is made aware of the referral and circumstances. The Hospital social worker will attend/provide a report to case conferences and core group meetings as appropriate

	and ensure that child protection plans are understood by ward staff. Post-delivery referrals are usually in respect of emerging child protection concerns. On those occasions when babies are not being discharged to the mother's care, the Team liaises closely with all relevant professionals within the hospital to ensure the timely implementation of the Regional Child Protection Policy and Procedures and appropriate interim safeguarding arrangements. The Service provides advice to doctors and midwives on thresholds for intervention and onward referral and the management of risk. A new development in conjunction with midwifery and obstetric colleagues is the establishment of a specific ante-natal clinic for pregnant women with socially complex issues such as drug and alcohol abuse. This clinic has been developed to meet the needs of these patients in the context of the NICE guidelines and to ensure the safeguarding of their unborn children. Social workers in RJMH also provide a service to the Neonatal Unit which is situated within in the same building. This can be in respect of child care concerns and/or for supports to families following the birth of a baby with complex medical issues and support needs. Bereavement support to families at the time of a baby's death is also provided by the Team. Social workers in the RBHSC offer assessment and support to children and young people with complex health care needs, disabilities, chronic or life limiting or threatening illness and their families. Social workers provide supports to inpatients and outpatients with complex renal conditions, cancer, blood disorders and cystic fibrosis regionally. All wards within the Hospital can refer to a social worker in line with established referral criteria. A Team Effectiveness programme has recently commenced. The first event was positive and enabled staff to work with managers to establish priorities for the Service. The Service works in partnership with community social work teams and CCN teams across the region to achieve co-ordinated and appropriate discharge of children with complex health care needs who require complex discharge planning arrangements.
3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	The protection and promotion of Human Rights is central to the design, development and practice of all Belfast Trust services and policies. It is regarded as fundamental to treat everyone with respect and dignity – including colleagues, patients and service users. Cognisant of the intrinsic link between human rights, equality and disability, Belfast Trust policy makers and managers, when screening a policy, use a template which incorporates the human rights requirements alongside the prescribed statutory equality and disability considerations.

Training
Human Rights training is provided on an on-going basis by the Learning and Development Service. This is mandatory for all social work and social care staff.

The Service Area ensures the promotion of a human rights approach in all social work and social care practice and service delivery. Managers work closely with practitioners to ensure that consideration of the human rights of service users is integral to practice and not tokenistic. A number of initiatives that support the upholding of human rights are described below.

Mental Health Order
All staff involved in activities and actions under the Mental Health Order (NI) Order 1986 are required to give clear consideration to any potential breaches or engagements of rights referenced in Articles 5 and 8 with regard to assessments which may result in deprivation of liberty or choice of individual service users, carers and families.

Safeguarding
All safeguarding practice includes processes which demonstrate the upholding and consideration of Human Rights of children and parents in decision-making, risk assessment and actions taken in the context of the paramouncy of the needs of the child. Staff are required to ensure that any statutory interventions with an individual or families are proportionate to the risk presented.

Transitions Practice
The Service Area has continued to work with managers from adult services to ensure that their practice is person centred and sensitive to the promotion of individual human rights. The Service Area promotes service users' human rights through the principles of respecting the child and family's values and beliefs, meaningful person centred engagement, empathic presence, partnership and advocacy.
The Service Arera has invested in additional training in Positive Behaviour Support and formed a strong partnership with BILD to ensure that the ethos remains central to all services in a way that enhances the human rights of children and young people cared for and supported by our staff.

HUMAN RIGHTS

3.12	Identify any challenges encountered in the balancing of Rights.	3.13 What action have you taken to manage this challenge?	3.14 What additional actions (if any) do you propose to manage any on-going challenges?
	Consent and capacity to the accessing of and receipt of services.	Wherever possible, children's consent to using services will be sought by social work staff. The views and wishes of children who are Fraser-competent will be sought and respected in relation to service delivery matters. The Service Area endeavours to assist parents to see the importance of hearing their child's opinion and enabling them to make choices where possible while fully respecting their rights to exercise parental responsibility.	Staff address this issue with parents at the point of referral in order to ensure that the views and perspectives of the child are fully represented in all service requests.
	Restrictive Practices in children's homes and Use of Physical interventions in the management of behaviours which challenge	Restrictive practices are used as little as possible however are sometimes necessary to maintain a child's safely within a residential or short break setting. Decision making in relation to restrictive practices is informed by multi-disciplinary assessment and review processes which seek to incorporate parental and child advocacy participation. All such practices are subject to regular review.	On-going monitoring and review of trends pertaining to use of restrictive practices.

		During the reporting period the Service Area partnered with BILD in order to embed PBS practice which is human rights based and safe. As a result there has been a reduction in the use of physical interventions within residential services and a shift from doing things to or for residents to completing tasks and activities with them.	The Service Area is working with multidisciplinary colleagues and has established strong links with BILD to develop best practice and governance structures in delivering services to young people with challenging behaviours.
	Ensuring the child's voice is heard and their wishes fully considered in all decision making processes.	As part of the Review the Trust has commissioned Arts Care to deliver a series of arts based workshops aimed at reflecting children's views on services.	This work will continue and hopefully develop into meaningful consultation and participation for our children. . The Service Area will seek to develop mechanisms and structures to promote the engagement with children and young people in the review, planning and development of services.

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	Modernisation of Social Work Services The Service Area has been assimilated into the Childrens Community Service Directorate. While this was challenging, relationships and practice are more productive. A clear service pathway has been developed and One Front Door will exist for all specialist Children with Disabilities services, enhancing response times and joint working between services. Increased and improved multi-disciplinary working is evident across the Service Area despite the many resource and structural challenges which are extant. **Unallocated cases** The Service Area has continued to improve its performance in this area and has ensured the timely allocation of referrals. **Complaints** The Service Area has continued to engage positively with families and has taken a proactive approach to the management of concerns and communication with carers. The Service Area has dealt with several complex complaints from one parent during the reporting period which have proved challenging to resolve. The Trust is continuing to work to resolve concerns and improve relationships. **Interdisciplinary Working and User Engagement** The Children's Interdisciplinary Schools Team (CIDS) work to an interdisciplinary model, facilitate service user focus groups and have led within the Service Area on shaping and improving practice in relation to service user involvement and service delivery. Both teachers and parents rate the service highly and provide valuable feedback and perspectives on service delivery. CIDS has achieved significant successes across early intervention, accessibility, trans-disciplinary working, achieving positive outcomes and optimising user involvement. The Service also won the PHA Advancing Heath Care Award for its Classroom Assistant development course developed by CIDS and delivered in partnership with OCNNI which provides accreditation for the course. This is a significant achievement and evidence of the Team's ethos of working in partnership across professional and organisational boundaries. One Team Leader within the Service Area has been awarded a Doctoral Fellowship at UU, funded by the PHA and will carry out research into working memory, attention and language, topics of particular relevance to this Service Area and public health within Northern Ireland. **Autism** The Service continues to develop a positive, collaborative working relationship with colleagues in the Belfast Autism Assessment and Intervention Service (BAAIS).

	The Service Area's specialist social worker for autism has actively engaged with groups of parents throughout the year to provide additional support as part of our plan to expand carer support services. The Service Area continues to focus on meeting the needs of parents and carers of children with Autism to develop resilience at an earlier stage and to promote good mental health and wellbeing. Establishment and development of the ***Network***: The Service Area has promoted the establishment and maintenance of this formal and regular forum for good practice and service improvement. It has also developed a Charter which service leads and champions have adopted and a set of outcome measures which will ensure that this is a productive and outcome focused entity and is a conduit for improvement projects and inter departmental working. As part of this work four voluntary organisations are working with the Trust to ensure that Big Lottery investment is appropriately targeted and two posts will actually be located within Belfast Trust premises. **User and Carer Involvement** This area of our work has seen significant development and improvement during the reporting period along with more intentional Partnership Working with the community and voluntary sector. These developments along with the ***Network*** are aimed at creating an organic system where partnership is valued and facilitated in a meaningful way. **Improvement in practice for children with Acquired Brain Injuries** The Service Area is committed to working with other departments and services within the Trust to deliver improvement as per RQIA recommendations and Trust Action Plan**.** Both the Co-Director and Service Manager have attended relevant meetings and a recent improvement workshop and are developing stronger links with relevant voluntary organisations. **Contract Revision** The Service Area is working closely with the voluntary sector to bring historic contracts into line with current strategic priorities and needs**.**
3.16	**SUMMARY**
	In a continuing challenging service delivery context, the Children with Disabilities Service Area has maintained a positive focus and has undertaken substantial work in reviewing all of its services to ensure that structures, financial and staff resources are utilised as efficiently and effectively as possible and are focussed on improved and demonstrable outcomes. Proposals will be presented for consultation during the next reporting period. The investment in services received from the HSCB has resulted in the development of a new therapeutic service which will work closely with community and residential teams and schools .This investment has also enabled the Service Area to roll out PBS awareness raising training across and resulted in training ten PBS Coaches who will ensure that the ethos is promoted in all of our services and will meet as a collective to support each other in this work.

	The Service Area is collaborating where possible within the wider Directorate and with colleagues across children's and adult services to ensure better experiences for children and their parents, in particular in respect of Looked After Children, children with Autism and children in transition from childrens to adult services. The Service Area has completed work on a Transitions Protocol for Young People moving to Adult Learning Disability services and is engaged in developing similar arrangements for young people moving to Physical and Sensory Disability services and those with Complex Health Care needs who may need the support of District Nursing or other adult nursing services. These protocols will be cross referenced to Autism services. New organisational structures and service delivery processes for community Teams are at an advanced stage and will be delivered within the next reporting period. The Service Area is pleased to have been able to continue the development of therapeutic and psychological services for children with challenging behaviours and their parents and families. Services to children with Complex Health Care needs have expanded to deliver flexible short breaks, provide essential equipment and the successful discharge from hospital of three vulnerable children. The Service Area is fully engaged in the Trust Carer Strategy delivery and is progressing plans to increase access to personalised budgets and self-directed care.

CHILDREN WITH DISABILITIES
SERVICE AREA

1 GENERAL PROVISIONS			
		<65	65+
1.1	**How many adults were referred for assessment of social work or social care need during the period?**	N/A	N/A
1.2	**Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?**	N/A	N/A
1.3	**How many adults are in receipt of social work or social care services at 31st March?**	N/A	N/A
1.3a	**How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?**	N/A	N/A
1.4	**How many care packages are in place on 31st March in the following categories:**	N/A	N/A
	xxv. Residential Home Care	N/A	N/A
	xxvi. Nursing Home Care	N/A	N/A
	xxvii. Domiciliary Care Managed	N/A	N/A
	xviii. Domiciliary Non Care Managed	N/A	N/A
	xxix. Supported Living	N/A	N/A
	xxx. Permanent Adult Family Placement	N/A	N/A
1.4a	**For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular.** ***Narrative***	N/A	N/A
1.4b	**Please describe how the Care Management process is being managed in this programme with particular reference to decision making levels, review and care planning, highlighting any particular difficulties being experienced and how they are being addressed.** ***Narrative***	N/A	N/A
1.4c	**Please articulate how the views of service users, their carers and families are included in the decision making process, review and care planning.** ***Narrative***	N/A	N/A
1.5	**Number of adults provided with respite during the period**	PMSI return	*PMSI return*
1.6	**Number of adults known to the Programme of Care in receipt of Centre based Day Care**	N/A	N/A

	- **Statutory sector**		
	- **Independent sector**		
1.6a	**Number of adults known to the Programme of Care in receipt of Day Opportunities**	N/A	N/A
1.7	**Of those at 1.6 how many are EMI / dementia**	N/A	N/A
	- **Statutory sector**		
	- **Independent sector**		
1.8	**Unmet need (this is currently under review)**	X	X
1.8a	**Please report on Social Care waiting list pressures** ***Narrative***	-	-
1.8b	**Please identify possible new service innovations that are currently supported by non-recurrent funding** ***Narrative***	-	-
1.9	**How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?**	0	0
1.10	**Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations.** ***Narrative***	~~*Board return*~~	~~*Board return*~~

Data for 1.5, 1.8 and 1.10 will be sourced by Board officers from existing returns.

CHILDREN WITH DISABILITIES SERVICE AREA

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	**How many adults or children were referred to Hospital Social Workers for assessment during the period?**	6028	2023	N/A
1.2	**Of those reported at 1.1 how many assessments of need were undertaken during the period?**	6028	2023	*N/A*
1.3	**How many adults or children are on Hospital Social Workers caseloads at 31st March?**	497	203	N/A

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

CHILDREN WITH DISABILITIES SERVICE AREA

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

CHILDREN WITH DISABILITIES SERVICE AREA

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	**Number of referrals to Physical/Learning/Sensory Disability during the reporting period.**	**160**
	Number of Disabled people known as at 31st March.	**677**
3.2	**Number of assessments of need carried out during period end 31st March.**	**160**
3.3	**This is intentionally blank**	
	Narrative	
3.4	**Number of assessments undertaken of disabled children ceasing full time education.**	**0**

CHILDREN WITH DISABILITIES SERVICE AREA

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

4.1	**Number of Article 15 (HPSS Order) Payments**	23
	Total expenditure for the above payments	£3,539.74
4.2	**Number of TRUST FUNDED people in residential care**	0
4.3	**Number of TRUST FUNDED people in nursing care**	0
4.4	**How many of those at 4.3 received only the £100 nursing care allowance?**	0
4.5	**How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?**	5

CHILDREN WITH DISABILITIES SERVICE AREA

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65 +
5.1	**Number of adult carers offered individual carers assessments during the period.**	**0**	**160**	**0**
5.2	**Number of adult individual carers assessments undertaken during the period.**	**0**	**158**	**0**
5.3	**Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?**	**0**	**158**	**0**
5.4	**Number of adult carers receiving a service @ 31st March**	**0**	**677**	**0**
5.5	**Number of young carers offered individual carers assessments during the period.**	**18**		
5.6	**Number of young carers assessments undertaken during the period.**	**16**		
5.7	**Number of young carers receiving a service @ 31st March**	**nk**		
5.8	**(a) Number of requests for direct payments during the period 1st April – 31st March**	**24**		
	(b) Number of new approvals for direct payments during the period 1st April – 31st March 2016	**24**		
	(c) Number of adults receiving direct payments @ 31st March	**132 (parents/carers in receipt obo children)**		
5.9	**Number of children receiving direct payments @ 31st March**	**See 5.8 (c) above**		
5.9.a	**Of those at 5.8 how many of these payments are in respect of another person?**	**132**		
5.10	**Number of carers receiving direct payments @ 31st March**	**8 Within Above Figure**		
5.11	**Number of one off Carers Grants made in-year.**	**257**		

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

Commentary

Number of adult carers offered individual carers reassessments during the period.	**0**	**50**	**0**
Number of adult individual carers reassessments undertaken during the period.	**0**	**40**	**0**
Number of young carers under 16 offered a reassessment	**23**		
Number of young carers under 16 reassessments undertaken	**22**		

CHILDREN WITH DISABILITIES SERVICE AREA

DATA RETURN 6

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

DATA RETURN 7

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 8

CORPORATE RETURN SUBMITTED BY SOCIAL SERVICES LEARNING AND DEVELOPMENT SERVICE

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

CHILDREN WITH DISABILITIES SERVICE AREA

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

Admission for Assessment Process Article 4 and 5		TRUST ASW	RESWS ASW
9.1	**Total Number of Assessments made by ASWs under the MHO**	3	1
9.1.a	**Of these how many resulted in an application being made by an ASW under (Article 5.1b)**	3	0
9.1.b	**How many assessments required the input of a second ASW (Article 5.4a)**	0	0
	Comment on any trends or issues in respect of requests for ASW assessment or ASW applications		
9.1.c	**Number of applications made by the nearest relative (Article 5.1.a)**	1	
	Comment on any trends or issues in respect of Nearest Relative applications for admissions		
9.1.d	**Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge.**	The Service Area is compliant with its duties in this regard.	
Use of Doctors Holding Powers (Article 7)			
9.2	**How many times did a hospital doctor use holding powers?**	0	
9.2a	**Of these, how many resulted in an application being made?**	0	
	Comment on any trends or issues on the use of holding powers		
ASW Applicant reports			
9.3	**Number of ASW applicant reports completed**	3	
9.3.a	**How many of these were completed within 5 working days**	3	
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken.		
Social Circumstances Reports (Article 5.6)			
9.4	**Total number of Social Circumstances reports completed.** *This should equate to number given at 9.1c. If it does not please provide an explanation.*	1	
9.4.a	**Number of completed reports which were completed within 14 days**	1	
	Please provide an explanation for any Social Circumstances Reports that were not completed within the requisite timescale, and / or any discrepancy between the number of Nearest Relative applications accepted and the number of Social Circumstances Reports completed, and what remedial action was taken.		

Mental Health Review Tribunal

9.5 **Number of ~~referrals~~ applications to MHRT in relation to detained patients**

Requested by	Number MHRT requested	MHRT Hearings completed	Number of patients re-graded > 6weeks before hearing	Number of patients re-graded < 6 weeks before hearing	Number unexpectedly discharged by MRHT
Trust	2	2	0	0	0
Patient	0	0	0	0	0
Nearest Relative	0	0	0	0	0
Other	0	0	0	0	0
Total	2	2	0	0	0

Comment on any trends or issues in respect of Mental health Review tribunals

9.5.a **This is intentionally blank**

Guardianships (Article 18)

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

Approved Social Worker (ASW) Register

9.7	**Number of newly appointed Approved Social Workers during period**	0

9.7.a	**Number of Approved Social Workers removed during period**	0
9.7.b	**Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)**	1
	CORPORATE COMMENTARY There has been a steady decrease in the number of ASWs available to participate in the Trust's Day Time Rota over the past number of years. There are concerns that the Trust, under the present arrangements, will not have capacity to meet the statutory requirement set out in Article 115 of the Mental Health (NI) Order 1986 (the Order) in respect of the availability of ASWs to discharge the range of statutory functions as specified in the Order. While four social workers from the Trust are currently participating in the Regional ASW Training Programme and hopefully will be assessed as competent, they will not be available for appointment by the Trust until October 2016 and will then be required to undertake a period of "shadowed practice" before they can operate as autonomous practitioners. Therefore this could result in them not being on the Daytime Rota until January 2017. The potential addition of these four social workers will not fully offset the number of ASWs lost through retirement/those who have moved to other posts/other Trusts/ RESWS. Of the cohort of twenty-eight, one has already indicated that, due to demands of work as a Team Leader, they will be withdrawing and another has indicated they will be retiring in June 2016. The Trust has twenty-eight ASW trained staff currently on the Daytime Rota. Training of additional ASW staff has been identified as a priority within the Service Area. Nominations for the 2016/17 Regional ASW Training Programme are presently being collated. Additional ASW duties include Guardianship-related functions and inputs into MHRT cases in light of their knowledge, skills and experience in this area. ASWs also provide a consultation role to those teams/services which do not have ASWs or social workers. Service Area ASWs participate in refresher training throughout the year and re-approval training every three years. Due to the pressures of the ASW rota the 'floater' has been replaced as a third member on the ASW rota. This is because it is a regular occurrence that all three ASWs on the Rota on a daily basis are called out to assess patients. On a regular basis there can be multiple ASW assessments requested on the same day. It is now a regular occurrence that ASWs on the Daytime Rota have to wait substantial lengths of time for the ambulance and PSNI to support the conveyance of service users to hospital in those circumstances in which significant risks to the service user or others are extant. These situations are exacerbated by difficulties in accessing beds in the Trust's area. This results in ASWs having to accompany those requiring admissions to	

	hospital to units across the region. Such episodes can significantly impact on the ASWs' ability to fulfil the requirements of their core posts. An inter-agency group involving representatives from the PSNI, the NI Ambulance Service and Trust's Unscheduled Care, GP Out of Hours and ASW Services has been established to address interface matters relating to their respective responsibilities and pathway processes pertaining to assessments for admission under the Order. The Trust has completed a review of ASW activity. The Review highlighted a number of key organisational, logistical and professional issues impacting on the delivery of the ASW Daytime Rota including: the diminution over a number of years of the complement of designated social work posts in the Mental Health Service Area; the increase in demands on available social work resources of the exponential increase in adult safeguarding activity and, in particular, the projected and current impact to date of the Revised Adult Safeguarding Policy determination that social work will be the lead profession in safeguarding service delivery; the increasing complexity of ASW-related activities; the impact of the difficulties of out- of -Trust admissions; the difficulties associated with interfaces across the PSNI, Ambulance Service, Unscheduled Care and ASWs in respect of assessments for admission; the need to develop a robust workforce planning approach to social work requirements in Mental Health (including ASWs) incorporating the implications of the Mental Capacity legislation; and the resourcing of and supports for staff engaged in the Regional ASW Training Programme. The Review's proposal for the establishment of a hybrid ASW core team to address the immediate pressures on service delivery and to ensure the Trust's capacity to discharge its statutory functions has been agreed and is currently being actioned. The Principal Social Worker (PSW) in Mental Health with operational responsibility for the co-ordination of the Rota works closely with the Regional ASW Group in relation to the review of documentation to ensure a consistent approach across the region. In addition, the PSW has also revised local ASW documentation relating to alternative care planning for patients who have been assessed as not requiring detention for assessment under the Order. Breakaway training has also been scheduled for June 2016 for all ASWs on the Daytime Rota. In-house bespoke training has also been completed on the Regional Interagency Protocol in February 2016. ASWs have been appraised of the PSNII risk assessment process for thresholding and prioritising referrals and have been advised of the importance of providing clear and factual information in respect of assessed risks when requesting PSNI assistance. The PSW has reviewed as a priority the provision of reflective	

	practice supervision sessions for ASW staff. These are now "up and running" and take place on a 6-8 weekly basis. The PSW has also re-launched the ASW Forum which meets twice a year. Attendance at the ASW Forum alternates with the reflective practice groups and attendance is mandatory (i.e. 75% attendance). The Trust will continue to review and develop supports to its ASW workforce. The Regional Audit of Assessments for Admission under the Mental Health (NI) Order 1986 was launched in March 2016. The Report will contribute to an ongoing Trust focus on improving ASW organisational and service delivery arrangements and the management of internal and external interfaces. Trust senior management are reviewing a number of interface issues across the RESWS and the Daytime Rota. The Trust has robust administration structures in place to monitor ASW numbers, accreditation and re-accreditation arrangements	

9.8	**Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If so please provide detailed explanation for each and every instance including their age and relevant powers used. The returns in respect of detention for Treatment all relate to children under the age of 18:**	

Age	Mental Health presentation	Location of assessment and Powers used
14	Physical aggression	Community Assessment Forms 2, 3 completed, admitted to Iveagh
15	Physical aggression	Assessed at Mater A&E Forms 2, 3 completed, admitted to Iveagh
16	Physical aggression	Community Assessment Forms 2, 3 completed, admitted to Iveagh

9.9*	**How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?**	0
	Issues or trends relating to notifications to the office of care and protection and on-going management of such arrangements N/A	

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50 A(6).

Schedule 2A Supervision and Treatment Orders.

9.10	**Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March**	
9.11	**Of the Total shown at 9.10 how many have their treatment required as:**	0
	Treatment as an in-patient	0
	Treatment as an out patient	0
	Treatment by a specified medical practitioner.	

		0
9.12	**Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)**	0
9.13	**Of the total shown at 9.10 how many of these supervision and treatment orders were *made* during the reporting period.**	0
	Commentary *(include any difficulties associated with such orders, obtaining treatment or liaison with specified medical practitioners, access to the supervised person while an in-patient*	

Exhibit 89

2016

Belfast Health and Social Care Trust
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Minutes of Trust Board Meeting
held on Thursday 7 July 2016 at 11.00 am
in the Boardroom, Trust Headquarters, A Floor
Belfast City Hospital

Present

Mr Peter McNaney	Chairman
Dr Michael McBride	Chief Executive
Mr Gordon Smyth	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Martin Bradley	Non-Executive Director
Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Mr Cecil Worthington	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Shane Devlin	Director Performance, Planning and Informatics
Ms Catherine McNicholl	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Unscheduled and Acute Care
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mrs Angela Muldoon	Minute Taker

Apologies

Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Patrick Loughran,	Non-Executive Director
Dr Cathy Jack	Medical Director
Mrs Jennifer Welsh	Director Surgery and Specialist Services
Mr Damian McAlister	Director Human Resources/ Organisational Development
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health (Interim)

31/16 Minutes of Previous Meeting

Minutes of previous meeting were approved subject to minor amendments.

32/16 Matters Arising

There were no matters arising.

33/16 Chairman's Business

a. Conflicts of Interests

There were no conflicts of interest noted.

b. Chairman's Awards

Mr McNaney was pleased to report that there were over one hundred applications for the Chairman's Awards, the shortlisting panel are meeting on Friday 7 July. There are 3 in each category, visits have been organised for the Chairman over the summer, these visits give a good feel for the complexity of the organisation and realise the work that goes on in the service. Mr McNaney will share the information regarding the visits and advised that any of the Non-Executive Directors wishing to do so, would be welcome to join him for the visits.

34/16 Chief Executive's Business

a. Future configuration of Health and Social Care - Dr Rafael Bengoa

Dr McBride advised it is anticipated that the DHSSPS will receive Dr Bengoa's Report within the next few weeks, this report was commissioned as a result of recommendations from Sir Liam Donaldson's report. The Department will consider the report and the next steps, the report will then go into the public domain for consultation. Dr McBride will keep Trust Board fully informed.

b. Medical Staffing Rates

Dr McBride reported the latest update from NIMDTA in relation to medical staffing rates for August intake indicate that there will be a number of vacancies across various specialties. This issue will be discussed at the meeting convened by the HSCB/PHA on the 7 July 2016, Mrs Bernie Owens and Mr Ray Hannon attending for Belfast Trust.

c. Glenmona Resource Centre

Dr McBride noted that due to the extensive efforts by Messrs Worthington, Dillon, and McAlister, together with members of their teams involved, and working closely with the HSCB, the Trust had signed and secured the Heads of Agreement and Transfer of Glenmona Resource Centre to Belfast Trust. Mr Worthington will keep the Board appraised of any further issues/developments in relation to Glenmona. Dr McBride formally noted the hard work colleagues undertook to safeguard the service for those dependant on the Centre. Non-Executive Directors were content to note the hard work and satisfactory outcome.

d. Paediatric Congenital Cardiac Services

Dr McBride updated Trust Board on the announcement in respect of the development of an all-island CHD Network that is intended to provide high quality and timely access to specialist cardiac services for all children and young people on the island of Ireland. This is very welcome news for families in Northern Ireland and recognition was noted for the hard work and effort by Dr Frank Casey, Consultant in the RBHSC. The development of the centre will allow urgent and elective cases to be carried out in Dublin and then return patients to the Paediatric team in Belfast for care.

35/16 Safety and Quality

a. Discharge of Statutory Functions Report

Mr McNaney welcomed Mr John Growcott Co-Director, Social Work Governance to the meeting and acknowledged the hard work that goes into the completion of the suite of reports that provide an overview of activity, challenges and issues of emerging significance pertaining to the Trust's delivery of statutory social care services and the related governance arrangements in respect of same. The report is prepared on a HSCB template that is used by all five Trusts.

It addresses the assurance arrangements underpinning the delivery of these services across the individual Service Areas, outlines levels of compliance with the standards specified in the Scheme for the Delegation of Statutory Functions and identifies on-going and future challenges in the provision of such services.

Members were reminded that the Trust, as a corporate entity, is responsible in law for the discharge of statutory social care functions delegated to it under the Health and Personal Social Services (NI) Order 1994.

The Trust is accountable to the HSCB for the discharge of such functions and is obliged to establish sound organisational and related assurance arrangements to ensure their effective discharge. The Scheme for Delegation provides the overarching assurance framework for the discharge of statutory social care functions.

There is now a Social Care Committee in place chaired by Ms Anne O'Reilly, Non-Executive Director and attended by Professor Martin Bradley. After an enquiry from Mr McNaney, Ms O'Reilly commented that there were concerns with regard to the lengthy recruitment process, Dr McBride advised that this now sits with the Business Services Organisation and that all service areas are reporting delays in recruitment, Human Resources are working hard to remedy the situation and staff from the HR Directorate in Belfast meet weekly with BSO to assist with the recruitment issues.

Any pause in the rollout of the recruitment function would dilute the service. A recovery plan is being developed and the situation appears to be improving, workforce leads provide updates for the weekly meeting.

Ms O'Reilly advised that the 6-page summary document within the papers is resultant from the work of the Social Care Committee coming together. The process is working well with the energy and action type approach and the paper provides the Trust Board and Executive Team with an opportunity to check out certain areas that require attention.

Mr Growcott advised that there is dialogue, good engagement with the Non-Executive Directors and excellent feedback from staff.

There is a massive amount of work involved and appreciation was noted for Mr Worthington, Mr Growcott and the teams for the on-going work that reflects the gruelling and progressive nature of the work.

36/16 Deputy Chief Executive/Director of Finance, Estates and Capital Planning

a. Financial Planning 2016/17

Dr McBride commented that the situation in 2016/17 is indicative of the wider cuts process and promises to be a challenging year. Mr Dillon advised we are still awaiting the outcome of the June monitoring monies, although the Department of Health received £67 m the Minister for Health is still considering the allocation of funds to Trusts.

The financial situation still requires the Trust to maintain workforce controls and savings. The Trust Board will be appraised accordingly and the Chairman and Non-Executive Directors can be assured of the commitment of the entire Executive Team to deliver services within the savings required.

b. Charitable Trust Funds

The recommendations for Trust Board approval from Charitable Funds Advisory Committee were noted and approved.

37/16 Audit Committee

a. Minutes

Mr Smyth presented the minutes of the Audit Committee meeting held on 11 April, 2016 for information.

Members noted and approved the minutes.

b. Terms of Reference – Annual Review

Members noted the Audit Committee and carried out the required annual review of the Terms of Reference and there had been no revisions made. The Terms of Reference were noted and approved.

38/16 Social Care Committee

a. Minutes 23 February 2016

Ms O'Reilly presented the minutes of the Social Care Committee meeting held on 23 February 2016 for information.

Members noted and approved the minutes.

39/16 Any Other Business

a. Nursing Media Stories

Dr McBride highlighted some of the activities over the last few months, it has been a good year for Nursing with a number attending an event hosted by Belfast City Council, eight nurses were selected to receive framed scrolls from the Lord Mayor Arder Carson, on behalf of the nursing community to mark the Freedom of the City being granted to Belfast Nurses.

There was a programme aired by the BBC hosted by Myleene Klass at the Royal Victoria Hospital, Myleene got a chance to see first-hand the invaluable work carried out by both local nursing staff and nursing staff from overseas for the service. Bronagh can send on the link.

Another piece was aired on the One Show on BBC in relation to the air conditioning units used in the RVH designed locally by Harland and Wolff.

Dr McBride commented that it is great to see good news stories that reflect the excellent work that goes on in the Trust.

b. Changing the Culture

Miss Creaney advised that there are still a few copies available of the Changing the Culture document that can be distributed if requested.

40/16 Date of next meeting

Members noted the next meeting was scheduled for 6 October 2016

Belfast Health and Social Care Trust

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LEGAL SERVICES AND CORONIAL MATTERS

ANNUAL REPORT

1 APRIL 2015 – 31 MARCH 2016

PART 1: PROFESSIONAL NEGLIGENCE CLAIMS

PART 2: CORONIAL MATTERS

PART 3: EMPLOYERS & OCCUPIERS LIABILITY CLAIMS

About the Litigation Management Office

Claims investigation

The Litigation Management Office provides a claims investigation and management service in relation to claims lodged against the Trust in respect of:

- Clinical Negligence Claims
- Employer's and Occupier's Liability Claims
- Other associated matters

It is the aim of our litigation staff to ensure that best advice is available to Trust employees and that legal representation is provided to assist the Trust in the defence of such claims.

The service is currently based across 3 Trust sites. Each site can assist with general legal enquiries, and have specific responsibility as follows:

Bostock House, RGH site: Responsible for the management of all Clinical Negligence Claims relating to the RGH, Mater, MPH and Muckamore Abbey hospitals. Coroner's Inquests relating to the above hospitals are also managed from this office.

A Floor, BCH Tower: Responsible for the management of all Clinical Negligence claims relating to clinical areas of BCH and "legacy" S&E sites. Coroner's Inquests relating to the above hospitals are also managed from this office.

McKinney House, MPH: Responsible for the management of all Employer's and Occupier`s Liability claims across all Trust sites and Community facilities.

Each office also maintains a uniform "Datix" database for the recording, analysis and dissemination of statistics relevant to each of the aforementioned areas of law and the costs associated with same. There is close liaison between the Litigation offices and the wider Risk and Governance departments in order to highlight matters of clinical and non-clinical risk which have been identified during the process of claims investigation.

Liaison with the Coroner's Office / PSNI acting in Coronial Matters

Trust Coroner's liaison staff are the first point of contact for Coroner's staff and/or PSNI officers when seeking information/ witness statements and other associated documentation on behalf of the Coroner or when seeking information/ witness statements in potential criminal matters where the alleged victim is deceased and had been a patient of the Trust.

LEGAL SERVICES AND CORONIAL MATTERS

ANNUAL REPORT

1 APRIL 2015 – 31 MARCH 2016

PART 1: PROFESSIONAL NEGLIGENCE CLAIMS

Legal Services Summary Report (Professional Negligence Litigation) 01 April 2015 – 31 March 2016

NEW CLAIMS

For the purposes of this report, the term “professional negligence” is defined as:
“A breach of duty of care by members of the health care and social professions employed by HSC organisations or by others consequent on decision or judgments made by members of those professions acting in the course of their employment, and which are admitted as negligent by the employer or determined as such through the legal process.”

In keeping with the above definition, this section of the report relates to claims lodged against Belfast Health and Social Care Trust in relation to treatment provided to patients by professional staff employed by HPSS, as well as those "non-professionally qualified" staff providing direct care and services to clients, for example, nursing assistants applying dressings or monitoring care; staff providing personal care or other services in users' homes; residential care staff; and social services staff. This includes any direct services provided by health and social care staff and also indirect services, for example, laboratory reporting or screening services.

For a Plaintiff to successfully argue a professional negligence claim, his/her legal advisers must establish 3 legal requirements. Firstly, the Plaintiff must establish that the Defendant owed them a legal duty of care; secondly the Plaintiff must demonstrate that the Defendant breached that duty of care, as a result of which the Plaintiff sustained harm *caused* by the breach; thirdly, the type of harm caused by the Defendant’s breach should have been reasonably foreseeable. It is for the Plaintiff to prove each and every element pleaded in the Statement of Claim and the legal maxim in this respect is “*he who asserts must prove*”.

The aggregate reserve estimated against 241 new cases is £1,223,250.00
However, these reserves will be subject to change when the Trust’s position on liability becomes clearer as investigations progress. Many of the cases brought against the Trust will not succeed, settlement may be negotiated without an admission of liability on the part of the Trust or Plaintiffs may opt to withdraw their claim in the face of unfavourable medical expert opinion.

As stated above, during the period 01 April 2015 – 31 March 2016 the Litigation Management Office opened a total of 241 new Professional Negligence cases. Although these cases relate to a wide range of treatment dates, it may be worth considering these numbers in the context of the services delivered by the Trust each year. The following extract has been taken from the Directors Report in the Trust's Annual Report for 2015/2016:-

Belfast Trust is the largest integrated health and social care Trust in the United Kingdom. We deliver integrated health and social care to approximately 340,000 citizens in Belfast and provide the majority of regional specialist services to all of Northern Ireland. We have an annual budget of £1.3bn and a workforce over 20,000 (full time and part time). Belfast Trust also comprises the major teaching and training hospitals in Northern Ireland. Adult Emergency Department Services (ED) saw 162,535 people this year and we delivered 6,141 babies. In the community we are corporate parents to 742 children in care, the majority in fostercare. We provide 10,000 hours of home care support per week to clients through our in house services. We provide 7,355 care packages, 739 through residential care, 1797 through nursinghome care and 4, 819 through domiciliary care. We are corporate parents to 750 children in care,the majority in foster care. We provide over 8,000 meals per day in our canteens and receive over1,800 requests for porters. We have also produced 35 million lab tests and manage a Trust estateof 8 million square feet of floor space.

To allow comparison with new claims received in previous years, the table below displays details of new professional negligence claims received by the Trust from 01 April **2012** to 31 March 2016.

TABLE 1

NEW PROFESSIONAL NEGLIGENCE CLAIMS OPENED ANNUALLY BETWEEN 01 APRIL 2011 - 31 MARCH 2015					
YEAR OPENED	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
2012/2013	49	51	64	40	**204**
2013/2014	70	41	57	67	**235**
2014/2015	59	77	75	100	**311**
2015/2016	50	76	66	49	**241**

Again, to allow comparison with new claims received in previous years, the table below (continued over) provides details of new professional negligence claims received by the Trust from 01 April 2012 to 31 March 2016, against the Service Groups and Specialties to which they have been assigned.

TABLE 2

NEW PROFESSIONAL NEGLIGENCE CLAIMS	2012 - 2013				2013 - 2014				2014 - 2015				2015 - 2016			
APRIL 2011 - MARCH 2016	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Social and Primary Care																
CAMHS																
CAMHS	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Learning Disability																
Day Services	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Muckamore Abbey Hospital	0	1	0	0	0	0	0	0	0	0	2	0	0	0	0	0
Residential and Supported Living	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Mental Health																
Acute Services	0	0	0	0	2	1	1	2	1	1	1	0	0	0	0	0
Primary Mental Health Care	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	0
Recovery Services	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Older Peoples Service - NW and Elderly Care wards RVH and MIH																
Hospital Services	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Community Facilities	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Treatment Room Services	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Older Peoples Service - SE & Elderly Care wards BCH																
Hospital Services	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Specialist Hospitals & Women's Health																
Acute and Community Paediatrics																
Childrens Hospital (RBHSC)	0	1	3	2	2	0	4	3	2	0	1	1	1	1	3	0
Community Paediatrics	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Dental Services																
Dentistry	0	0	0	0	0	3	0	0	1	1	3	7	1	1	1	0
ENT Services																
ENT Services	0	0	0	0	0	1	0	0	0	0	2	0	1	2	3	0
Trauma and Orthopaedics																
ICATS	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0
Orthopaedics	8	5	10	3	10	7	11	5	3	9	7	12	9	7	8	11
Regional Disablement Service	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0
Trauma (Fractures)	0	1	2	1	1	1	3	3	3	4	8	6	4	6	3	2
Women's and Maternity																
Genito Urinary Medicine	0	0	0	1	0	0	0	0	0	0	0	2	1	1	1	0
Gynaecology and Sexual and Reproductive Healthcare	4	1	3	2	2	3	0	3	7	5	7	1	1	4	0	2
Maternity Services	8	5	6	6	10	4	10	8	9	11	13	16	8	8	7	5

(continued):

Table showing new professional negligence claims received between April 2012 and March 2016 by Service Group/Specialty to which they have been assigned

TABLE 2 continued

NEW PROFESSIONAL NEGLIGENCE CLAIMS	2012 - 2013				2013 - 2014				2014 - 2015				2015 - 2016			
APRIL 2011 - MARCH 2016	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Surgery and Specialist Services																
Cancer Services																
Clinical Haemotology	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Haemophilia	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Medical and Clinical Oncology	2	2	0	0	1	0	0	0	0	0	0	1	1	0	0	2
Radiotherapy	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0
Laboratories Services																
Blood Transfusion and Stem Cell Bank	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Genetics	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Immunology	0	0	0	0	0	0	0	1	0	0	0	2	0	0	1	0
Immunology Day Centre	8	3	2	2	3	0	4	4	1	0	0	0	0	0	1	0
Tissue Pathology	0	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0
Specialist Medicine																
Dermatology	0	0	0	1	0	0	0	0	0	1	1	1	1	0	1	1
Nephrology and Transplant Service	0	1	0	0	1	0	0	2	1	2	1	0	0	0	0	0
Palliative Care	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Rheumatology	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0
Surgery																
Breast Surgery	0	0	0	0	0	0	1	0	0	2	0	0	1	0	0	1
Burns and Plastic Surgery	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0
Cardiac Surgery	0	0	1	0	2	0	0	2	3	2	0	2	1	2	2	1
General Surgery	4	4	8	1	2	1	4	4	5	9	4	7	4	6	8	1
Ophthalmology	1	3	2	2	1	3	2	1	4	1	1	0	0	2	0	3
Outpatients Services	1	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0
Paediatric Cardiac Surgery	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Thoracic Surgery	0	0	1	1	2	1	0	0	0	1	0	1	1	1	1	0
Urology	1	0	0	1	1	2	1	1	3	4	3	4	2	0	0	1
Vascular Surgery	0	1	0	1	1	1	2	0	0	0	0	2	0	2	1	1
Unscheduled and Acute Care																
ACCTSS																
Anaesthetics	0	3	4	0	8	0	0	0	2	0	0	1	0	1	0	0
Critical Care	0	0	0	1	0	0	1	0	0	0	1	0	0	0	0	1
Pain Service	2	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0
Resuscitation Team	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Sterile Services	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Theatres	2	1	1	1	2	0	1	5	1	0	1	1	0	0	0	2
Allied Health Professionals																
Occupational Therapy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Emergency Dept, Medical & Cardiology Services																
Acute Admissions	0	0	0	0	1	0	0	0	0	0	0	1	0	2	2	0
Adult Cardiology Services	0	0	0	0	0	0	0	5	0	2	0	2	0	1	1	0
Paediatric Cardiology	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Emergency Departments	4	6	11	4	7	3	7	4	6	9	9	14	4	6	14	8
General Medicine	3	4	1	1	4	4	3	5	1	2	3	0	2	8	4	1
Out of Hours Service	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Imaging																
Radiology	0	2	1	1	0	2	1	3	0	1	0	0	0	2	1	1
Neurosciences																
Acute Neurology	0	0	0	0	0	0	0	1	0	2	2	2	1	4	0	0
Neurosurgery	0	0	0	1	3	1	1	2	3	2	2	4	0	1	0	0
Children's Community Services																
Family and Child Care																
Child Protection / Gateway	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Children's Disability	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Fostering, Adoption, Early Years	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Residential Care	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Safeguarding/ Family Support	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0
Social Work Care																
Social Work Care	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0	1
OTHER																
Performance, Planning & Informatics																
Information Management	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0
NOT YET CLEAR	0	3	5	3	0	0	0	0	1	0	1	0	0	0	1	1

NOTE: For cases marked “not yet clear” the Plaintiffs’ solicitors have not yet provided sufficient detail to confirm which specialties were involved in the relevant episodes of care.

It should be noted that clinical/social care negligence cases may not be lodged for several years after the date of the alleged incident. Whilst this is seen most often in cases relating to pregnancy and childbirth, it also occurs in cases where there may have been a delay in recognising that a disease or disorder has brought about particular clinical prognosis and so the Plaintiff may not have realised that he/she had a cause of action until a significant amount of time had elapsed since their initial episode of care.

For the claims brought against the Trust between **01 April 2015 and 31 March 2016**, the table below shows the year in which the hospital treatment in question was provided:

TABLE 3

Year of treatment	No. of claims	Year of treatment	No. of claims
Before April 2001	15	2009/2010	7
2001/2002	1	2010/2011	8
2002/2003	1	2011/2012	20
2003/2004	2	2012/2013	36
2004/2005	2	2013/2014	47
2005/2006	2	2014/2015	48
2006/2007	6	2015/2016	30
2007/2008	3	Not yet known	8
2008/2009	5	**Total**	**241**

As well as the year of treatment (as above) the following table shows the Service Groups and hospital/community locations to which the 241 new claims have been assigned :-

TABLE 4

Service Group	Site	Year of Treatment															
		< April 01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	Unknown
Adult Social and Primary Care	Muckamore Abbey Hospital Site	1																
	Royal Group of Hospitals Site										1							
Children's Community Services	Community Locations	2				1										2		
	Musgrave Park Hospital Site														1			
	Royal Group of Hospitals Site	1																
Specialist Hospitals & Women's H	Belfast City Hospital Site												1			2		
	Independent Sector						1	1					1	2	1	1		1
	Mater Hospital Site										1			1	2	1	1	
	Musgrave Park Hospital Site		1					3	1	1		2	2	2	5	8	1	
	Royal Group of Hospitals Site	5		1			1				3	1	5	13	9	12	6	3
	Unknown																	1
Surgery and Specialist Services	Belfast City Hospital Site	1			1							1	1	2	5	1	3	
	Independent Sector												1					
	Mater Hospital Site												2	2				2
	Royal Group of Hospitals Site	5			1	1		1	2		1		2	5	9	3	3	
Unscheduled and Acute Care	Belfast City Hospital Site									1						1		
	Community Locations																1	
	Mater Hospital Site									1			1		3	5	3	
	Musgrave Park Hospital Site											1						
	Royal Group of Hospitals Site							1		2	1	2	4	9	11	12	12	
Performance, Planning & Informa	Belfast City Hospital Site														1			
Acute Services (code retired Apr	Belfast City Hospital Site											1						
Service not yet known	Royal Group of Hospitals Site																	1

The next two tables show the nature of the allegations raised against the Trust by the Plaintiffs, and which Service Groups are said to have been involved. Please note that, for all cases marked “Unknown” or “Other”, the solicitors representing the Plaintiffs have not yet provided sufficient detail to allow classification of their client’s claims.

TABLE 5

New Claims 01 April 2015 - 31 March 2016 by Service Group and Nature of Claim	
Adult Social and Primary Care (2 claims)	
Assault by Trust staff	1
Lack of/difficulties with follow-up arrangements	1
Children's Community Services (7 claims)	
Assault by Trust staff	1
Inappropriate treatment/ procedure	1
Inadequate nursing care/ observations/monitoring	1
Lack of or difficulties with follow up arrangements	1
Sexual abuse	1
Not specified	2
Specialist Hospitals & Women's Health (103 claims)	
Application of excess force	1
Birth defects/ injury/ unexpected outcome - BABY	5
Birth defects/ injury/ unexpected outcome - MOTHER	2
Cross infection	2
Delay in performing operation	1
Equipment malfunction	5
Failed to supervise	1
Failure/delay in treatment	30
Hospital associated infection - MRSA	1
Hospital associated infection - other	3
Inadequate monitoring pre-, intra-, or post-operatively	1
Failure to diagnose pre-eclampsia	1
Lack of adequate facilities/equipment	1
Lack of/difficulties with follow-up arrangements	3
Failure to recognise complication of treatment	3
Delay in transfer/admission to hospital/facility	1
Failure/delay in diagnosis	8
Inappropriate case selection	1
Inappropriate treatment/ procedure	7
Not specified	15
Operator error	4
Poor application of plaster cast	2
Procedure on wrong patient/body part	1
Tooth injury resultant from positioning for anaesthesia	1
Wrong diagnosis made	3

Table continued from previous page:

TABLE 5 continued

New Claims 01 April 2015 - 31 March 2016 by Service Group and Nature of Claim	
Surgery and Specialist Services (55 claims)	
Delay in performing operation	2
Failed to supervise	1
Failure/delay in treatment	14
Failure of communicaton/documentationto patients/clier	1
Failure to perform clinical diagnostic test or screening	1
Failure to recognise complication of treatment	2
Consent issues	2
Failure to perform xray	1
Failure/delay in diagnosis	7
Hospital associated infection - MRSA	1
Hospital associated infection - other	2
Inadequate monitoring pre-, intra-, or post-operatively	2
Inadequate nursing care/ observations/monitoring	1
Inappropriate treatment/ procedure	4
Operator error	5
Performance of a procedure that was not indicated/contra	1
Surgical foreign body left in situ	1
Wrong diagnosis made	3
Not specified	4
Unscheduled and Acute Care (71 claims)	
Error with agent/dose/route/selection	3
Failure/delay in treatment	23
Failed to supervise	5
Failure/delay in diagnosis	13
Failure to properly interpret/act on clinical diagnostic test	2
Failure to recognise complication of treatment	1
Failure of communicaton/documentationto patients/clier	2
Foreign body left in situ	2
Hospital associated infection	1
Inadequate monitoring pre-, intra-, or post-operatively	1
Inadequate nursing care/ observations/monitoring	1
Inappropriate treatment/ procedure	3
Lack of adequate facilities/equipment	1
Lack of assistance/care	1
Lack of/difficulties with follow-up arrangements	1
Medication error	2
Operator error	1
Problems with medical records	1
Wrong diagnosis made	1
Not specified	6
Performance, Planning & Informatics (1 claim)	
Other	1
Service Group not yet known (2 claims)	
Incident type not yet known	2

CLAIMS EXPENDITURE

Expenditure between 01 April 2015 and 31 March 2016 relating to professional negligence litigation cases (both ongoing and settled cases) was £12,506,225.06

The detail of this expenditure is provided over the following tables, but can be summarised as follows:

TABLE 6

Claims expenditure (PNC) 01 April 2015 - 31 March 2016	No. of cases	Total expenditure
Settled with damages paid in-year	90	£8,152,987.49
Trust agreed to bear its own costs to secure Discontinuance	3	£9,186.00
Settled by another Party. Trust bore own costs only	1	£500.00
Payments related to claims settled with Periodical Payment Orders	7	£1,081,999.83
Payments related to ongoing cases / residual costs re closed cases	multi	£3,261,551.74
Total expenditure (includes damages, costs and PPO payments)		£12,506,225.06

The table below shows expenditure in previous years for comparison:-

TABLE 7

EXPENDITURE IN RESPECT OF SETTLED AND ONGOING PROFESSIONAL NEGLIGENCE CLAIMS	
2012 - 2013	£9,383,639.69
2013 - 2014	£15,986,634.62
2014 - 2015	£13,011,257.21
2015 - 2016	£12,506,225.06

Excluding cases with combined damages/periodical payment settlements, there were **90** cases wherein damages were paid to Plaintiffs during 2015/2016.

Of these cases, **10** were settled by negotiation prior to the issue of proceedings, **78** were settled by negotiation after proceedings had been issued. Damages in the remaining **2** cases were awarded by the Court.

Damages paid in respect of these **90** cases amounted to £7,023,197.96.

Costs associated with these cases during the current year totalled £1,129,789.53.

Expenditure can be attributed to Service Groups/Specialties as follows:

TABLE 8

SERVICE GROUP & AREA	SPECIALTY	DAMAGES	COSTS	TOTAL
Adult Social & Primary Care Services				
Older People & Physical Disability	South & East Belfast locality (1 claim)	£10,000.00	£2,130.00	£12,130.00
Learning Disability	Muckamore Abbey Hospital (1 claim)	£30,000.00	£0.00	£30,000.00
Specialist Hospitals & Women's Health				
Acute and Community Paediatrics	Childrens Hospital (RBHSC) (2 claims)	£445,000.00	£37,093.99	£482,093.99
Dental Services	Dentistry (2 claims)	£192,500.00	£68,709.20	£261,209.20
Dental Services	Paediatric Surgery (1 claim)	£42,500.00	£3,843.96	£46,343.96
ENT Services	ENT Services (2 claims)	£10,000.00	£12,702.99	£22,702.99
Trauma and Orthopaedics	Orthopaedics (16 claims)	£241,007.32	£59,322.91	£300,330.23
Trauma and Orthopaedics	Trauma (Fractures) (1 claim)	£17,000.00	£0.00	£17,000.00
Women's and Maternity	Gynaecology and Sexual and Reproductive Healthcare (4 claims)	£395,000.00	£115,537.26	£510,537.26
Women's and Maternity	Maternity Services (13 claims)	£2,012,906.00	£168,726.49	£2,181,632.49
Surgery and Specialist Services				
Cancer & Specialist Medicine	Haematology (1 claim)	£15,000.00	£13,746.53	£28,746.53
Laboratories Services	Immunology Day Centre (2 claims)	£222,500.00	£64,588.95	£287,088.95
Pharmacy & Laboratories Service	Tissue Pathology (1 claim)	£8,750.00	£0.00	£8,750.00
Surgery	General Surgery (11 claims)	£626,453.22	£124,072.59	£750,525.81
Surgery	Ophthalmology (1 claim)	£19,000.00	£4,668.00	£23,668.00
Surgery	Urology (5 claims)	£215,000.00	£113,168.42	£328,168.42
Unscheduled and Acute Care				
ACCTSS	Anaesthetics (1 claim)	£1,500.00	£1,392.00	£2,892.00
ACCTSS	Theatres (1 claim)	£5,000.00	£5,274.00	£10,274.00
Emergency Dept, Medical & Cardiology Services	Emergency Departments (11 claims)	£460,036.75	£94,887.89	£554,924.64
Emergency Dept, Medical & Cardiology Services	General Medicine (5 claims)	£211,044.67	£80,167.90	£291,212.57
Imaging	Imaging Services (2 claims)	£1,490,000.00	£92,771.68	£1,582,771.68
Neurosciences	Neurology (2 claims)	£15,000.00	£52,929.15	£67,929.15
Neurosciences	Neurosurgery (2 claims)	£332,500.00	£10,797.62	£343,297.62
Performance, Planning & Informatics				
Information Management	Information Management (2 claims)	£5,500.00	£3,258.00	£8,758.00
	TOTALS:	**£7,023,197.96**	**£1,129,789.53**	**£8,152,987.49**

***** It should be noted that several of these cases settled close to year-end; therefore invoices in respect of Plaintiff and Defence costs had not yet been submitted to the Trust's legal advisers by third parties for payment during the period covered by this report. The same applies to £0 values recorded in the tables on pages 13 and 14 (over).

TABLE 9 The nature of allegations relating to payment of damages is as follows:

NATURE OF ALLEGATIONS	HOSPITAL SITE/LOCATION	SPECIALTY	DAMAGES	COSTS	TOTAL
Adult Social & Primary Care Services					
Failure of follow-up arrangements	Musgrave Park Hospital	South & East Belfast locality	£10,000.00	£2,130.00	£12,130.00
Failed to supervise	Muckamore Abbey Hospital Site	Muckamore Abbey Hospital	£30,000.00	£0.00	£30,000.00
Performance, Planning & Informatics					
Other	Belfast City Hospital Site	Information Management	£3,500.00	£1,965.20	£5,465.20
Other	Belfast City Hospital Site	Information Management	£2,000.00	£1,292.80	£3,292.80
Specialist Hospitals & Women's Health					
Bacterial infection	Royal Group of Hospitals Site	Childrens Hospital (RBHSC)	£20,000.00	£0.00	£20,000.00
Birth defects/ injury/ unexpected outcome - BABY	Royal Group of Hospitals Site	Maternity Services	£200,000.00	£14,115.60	£214,115.60
Birth defects/ injury/ unexpected outcome - BABY	Royal Group of Hospitals Site	Maternity Services	£24,000.00	£0.00	£24,000.00
Birth defects/ injury/ unexpected outcome - MOTHER	Royal Group of Hospitals Site	Maternity Services	£15,000.00	£0.00	£15,000.00
Consent issues	Mater Infirmorum Hospital	Maternity Services	£5,000.00	£750.00	£5,750.00
Equipment malfunction	Royal Hospitals	Paediatric Surgery	£42,500.00	£3,843.96	£46,343.96
Failure to carry out adequate post-operative observations	Musgrave Park Hospital	Orthopaedics	£6,000.00	£2,471.40	£8,471.40
Failure to recognise complication of treatment	Royal Hospitals	Maternity Services	£45,000.00	£32,305.75	£77,305.75
Failure/delay in diagnosis	Belfast City Hospital Site	Gynaecology and Sexual and Reproductive Healthcare	£150,000.00	£450.00	£150,450.00
Failure/delay in diagnosis	Royal Hospitals	Maternity Services	£40,000.00	£9,443.74	£49,443.74
Failure/delay in diagnosis	Royal Hospitals	Maternity Services	£15,000.00	£25,787.00	£40,787.00
Failure/delay in diagnosis	Royal Hospitals	Dentistry	£17,500.00	£1,588.80	£19,088.80
Failure/delay in diagnosis	Royal Group of Hospitals Site	Dentistry	£175,000.00	£67,120.40	£242,120.40
Failure/delay in diagnosis	Royal Hospitals	ENT Services	£9,000.00	£7,467.59	£16,467.59
Failure/delay in diagnosis	Mater Infirmorum Hospital	Gynaecology and Sexual and Reproductive Healthcare	£40,000.00	£24,824.60	£64,824.60
Failure/delay in treatment	Mater Infirmorum Hospital	Gynaecology and Sexual and Reproductive Healthcare	£30,000.00	£34,254.66	£64,254.66
Failure/delay in treatment	Musgrave Park Hospital Site	Orthopaedics	£12,500.00	£1,182.00	£13,682.00
Failure/delay in treatment	Musgrave Park Hospital Site	Orthopaedics	£1,375.00	£1,580.00	£2,955.00
Failure/delay in treatment	Musgrave Park Hospital Site	Orthopaedics	£8,333.33	£1,120.00	£9,453.33
Failure/delay in treatment	Musgrave Park Hospital Site	Orthopaedics	£5,500.00	£2,357.50	£7,857.50
Failure/delay in treatment	Musgrave Park Hospital Site	Orthopaedics	£8,250.00	£1,641.06	£9,891.06
Failure/delay in treatment	Musgrave Park Hospital Site	Orthopaedics	£10,000.00	£0.00	£10,000.00
Failure/delay in treatment	Royal Group of Hospitals Site	Orthopaedics	£92,111.49	£23,537.20	£115,648.69
Foreign body left in situ	Musgrave Park Hospital Site	Trauma (Fractures)	£17,000.00	£0.00	£17,000.00
Inappropriate treatment/ procedure	Musgrave Park Hospital Site	Orthopaedics	£3,437.50	£206.25	£3,643.75
Inappropriate treatment/ procedure	Royal Group of Hospitals Site	Maternity Services	£65,000.00	£5,347.00	£70,347.00
Failure/delay in treatment	Royal Hospitals	Orthopaedics	£5,000.00	£3,841.50	£8,841.50
Failure/delay in treatment	Royal Group of Hospitals Site	Maternity Services	£1,423,906.00	£2,100.00	£1,426,006.00
Failure/delay in treatment	Royal Group of Hospitals Site	Maternity Services	£27,500.00	£5,618.00	£33,118.00
Failure of follow-up arrangements	Musgrave Park Hospital Site	Orthopaedics	£7,500.00	£1,117.00	£8,617.00
Failure to recognise complication of treatment	Musgrave Park Hospital Site	Orthopaedics	£11,000.00	£8,980.70	£19,980.70
Inadequate monitoring pre-, intra- or post-operatively	Musgrave Park Hospital Site	Orthopaedics	£8,750.00	£9,002.00	£17,752.00
Inappropriate treatment/ procedure	Musgrave Park Hospital	Orthopaedics	£43,750.00	£1,179.30	£44,929.30
Intra-operative problems	Royal Group of Hospitals Site	Childrens Hospital (RBHSC)	£425,000.00	£37,093.99	£462,093.99
Intra-operative problems	Royal Group of Hospitals Site	ENT Services	£1,000.00	£5,235.40	£6,235.40
Intra-operative problems	Royal Hospitals	Gynaecology and Sexual and Reproductive Healthcare	£175,000.00	£56,008.00	£231,008.00
Lack of/difficulties with follow-up arrangements	Royal Group of Hospitals Site	Maternity Services	£30,000.00	£19,258.30	£49,258.30
Lack of/difficulties with follow-up arrangements	Royal Group of Hospitals Site	Maternity Services	£22,500.00	£0.00	£22,500.00
Operate on the wrong patient/wrong body part	Musgrave Park Hospital	Orthopaedics	£7,500.00	£1,107.00	£8,607.00
Perineal Tear - 1st, 2nd, 3rd degree	Mater Hospital Site	Maternity Services	£100,000.00	£54,001.10	£154,001.10
Surgical foreign body left in situ	Musgrave Park Hospital Site	Orthopaedics	£10,000.00	£0.00	£10,000.00

TABLE 9 (continued)

NATURE OF ALLEGATIONS	HOSPITAL SITE/LOCATION	SPECIALTY	DAMAGES	COSTS	TOTAL
Surgery and Specialist Services					
Assault by Trust staff	Royal Group of Hospitals Site	General Surgery	£17,500.00	£2,040.00	£19,540.00
Error with agent/dose/route/selection	Belfast City Hospital Site	Haematology	£15,000.00	£13,746.53	£28,746.53
Error with agent/dose/route/selection	Mater Hospital Site	Ophthalmology	£19,000.00	£4,668.00	£23,668.00
Error with agent/dose/route/selection	Royal Group of Hospitals Site	General Surgery	£60,000.00	£43,232.55	£103,232.55
Failure/delay in diagnosis	Belfast City Hospital	General Surgery	£200,000.00	£17,260.80	£217,260.80
Failure/delay in diagnosis	Belfast City Hospital Site	General Surgery	£16,203.22	£8,608.10	£24,811.32
Failure/delay in diagnosis	Mater Hospital Site	General Surgery	£10,000.00	£4,503.99	£14,503.99
Failure/delay in diagnosis	Mater Hospital Site	Urology	£100,000.00	£2,628.88	£102,628.88
Failure/delay in diagnosis	Royal Hospitals	Immunology Day Centre	£87,500.00	£31,386.45	£118,886.45
Failure/delay in treatment	Mater Infirmorum Hospital	General Surgery	£15,000.00	£0.00	£15,000.00
Failure to recognise complication of treatment	Belfast City Hospital Site	General Surgery	£151,500.00	£8,360.00	£159,860.00
Inappropriate discharge	Mater Hospital Site	General Surgery	£115,000.00	£14,170.00	£129,170.00
Intra-operative problems	Belfast City Hospital	Urology	£25,000.00	£34,241.70	£59,241.70
Intra-operative problems	Royal Group of Hospitals Site	General Surgery	£25,000.00	£22,078.55	£47,078.55
Lack of assistance/care	Royal Hospitals	Tissue Pathology	£8,750.00	£0.00	£8,750.00
Medication error	Belfast City Hospital	Urology	£25,000.00	£0.00	£25,000.00
Medication error	Belfast City Hospital Site	Urology	£20,000.00	£48,819.04	£68,819.04
Operator error	Belfast City Hospital Site	Urology	£45,000.00	£27,478.80	£72,478.80
Operator error	Belfast City Hospital Site	General Surgery	£10,000.00	£3,818.60	£13,818.60
Surgical foreign body left in situ	Mater Hospital Site	General Surgery	£6,250.00	£0.00	£6,250.00
Wrong diagnosis made	Royal Group of Hospitals Site	Immunology Day Centre	£135,000.00	£33,202.50	£168,202.50
Unscheduled and Acute Care					
Delay in referral to hospital/facility	Royal Group of Hospitals Site	Emergency Departments	£1,000.00	£5,590.00	£6,590.00
Intra-operative problems	Royal Hospitals	Imaging Services	£1,450,000.00	£79,146.08	£1,529,146.08
Diathermy burns/reaction to prep agent	Royal Hospitals	Theatres	£5,000.00	£5,274.00	£10,274.00
Equipment malfunction	Royal Group of Hospitals Site	General Medicine	£3,500.00	£3,306.60	£6,806.60
Equipment malfunction	Royal Group of Hospitals Site	Emergency Departments	£1,000.00	£0.00	£1,000.00
Fail to Supervise	Royal Hospitals	Neurology	£10,000.00	£600.00	£10,600.00
Failure/delay in diagnosis	Belfast City Hospital Site	General Medicine	£35,866.00	£23,398.00	£59,264.00
Failure/delay in diagnosis	Belfast City Hospital Site	Imaging Services	£40,000.00	£13,625.60	£53,625.60
Failure/delay in diagnosis	Royal Hospitals	Emergency Departments	£84,500.00	£11,425.10	£95,925.10
Failure/delay in diagnosis	Royal Group of Hospitals Site	Neurosurgery	£7,500.00	£3,780.12	£11,280.12
Failure/delay in treatment	Mater Infirmorum Hospital	General Medicine	£22,033.50	£4,870.00	£26,903.50
Failure/delay in treatment	Mater Hospital Site	Emergency Departments	£1,500.00	£4,538.00	£6,038.00
Failure/delay in treatment	Mater Hospital Site	Emergency Departments	£15,000.00	£22,014.65	£37,014.65
Failure/delay in treatment	Mater Hospital Site	General Medicine	£25,000.00	£37,594.30	£62,594.30
Failure/delay in treatment	Royal Group of Hospitals Site	Emergency Departments	£8,107.00	£0.00	£8,107.00
Failure/delay in treatment	Royal Group of Hospitals Site	Emergency Departments	£20,000.00	£0.00	£20,000.00
Failure to recognise complication of treatment	Royal Group of Hospitals Site	Acute Neurology	£5,000.00	£52,329.15	£57,329.15
Hospital associated infection - MRSA	Royal Group of Hospitals Site	Neurosurgery	£325,000.00	£7,017.50	£332,017.50
Hospital associated infection - Other	Mater Hospital Site	Emergency Departments	£146,429.75	£22,118.24	£168,547.99
Inappropriate treatment/ procedure	Mater Infirmorum Hospital	Emergency Departments	£4,000.00	£1,711.20	£5,711.20
Inappropriate treatment/ procedure	Royal Group of Hospitals Site	Emergency Departments	£3,500.00	£3,741.40	£7,241.40
Tooth injury cases and patient positioning problem	Musgrave Park Hospital	Anaesthetics	£1,500.00	£1,392.00	£2,892.00
Treatment stopped too soon	Royal Hospitals	General Medicine	£124,645.17	£10,999.00	£135,644.17
Wrong diagnosis made	Mater Hospital Site	Emergency Departments	£175,000.00	£23,749.30	£198,749.30
			TOTALS	**£7,023,197.96**	**£1,129,789.53**	**£8,152,987.49**

There were **138** cases closed without payment of damages or costs. The reasons for having closed these files are set out below:-

TABLE 10

CASES CLOSED WITHOUT PAYMENT OF DAMAGES	
Reason for closure	**No. of cases**
Closed on advice of solicitor as no activity	57
Dismissed by Court	3
Judgement entered in favour of the Defence	9
Redirected or taken over by Third Party	4
Statute barred	10
Case withdrawn by Plaintiff	54
Withdrawn - payment - Trust pays share of costs	1
TOTAL:	**138**

For the 138 cases closed without payment, the tables below show the period of time that elapsed between the date the case was instigated and the date upon which the file was closed, followed by the percentage of cases settled/closed against each reason for closure.

TABLE 11

CASES CLOSED WITHOUT PAYMENT AGE OF CLAIM AT TIME OF CLOSING				
< 1 year	8		7-8 years	5
1-2 years	21		8-9 years	8
2-3 years	20		9-10 years	7
3-4 years	25		10-11 years	0
4-5 years	21		11-12 years	0
5-6 years	13		> 12 years	2
6-7 years	8		TOTAL:	138

TABLE 12

CASES SETTLED OR CLOSED DURING THE PERIOD 01/04/15 - 31/03/16		
Determination of Case	**Number of cases**	**Percentage of total**
Case withdrawn by Plaintiff	54	23.68%
Closed on advice of solicitor as no activity	57	25%
Dismissed by Court	3	1.32%
Judgement entered in favour of the Defence	9	3.95%
Redirected or taken over by Third Party	4	1.75%
Settled by negotiation after proceedings issued	78	34.21%
Settled by negotiation before proceedings issued	10	4.39%
Statute barred	10	4.39%
Damages awarded by court	2	0.88%
Withdrawn - Trust pays share of costs	1	0.44%

Structured Settlements / Periodical Payment Orders (PPOs)

A structured settlement is an arrangement whereby the Plaintiff receives periodic payments on an agreed schedule rather than as a lump sum, that is, it provides a stream of future payments (tax-free) guaranteed for the lifetime of the Plaintiff. The decision on whether to proceed with receiving a settlement as a lump sum or through structured payment is voluntary. To date only a few Plaintiffs have opted for this arrangement in Northern Ireland; however it is now offered in all high-value settlements and so the number of these cases will continue to increase. Litigation files relating to structured settlements will, of necessity, require to remain open for the lifetime of each Plaintiff, as there will be administrative input to validate payments on a quarterly/annual basis as dictated by the terms of the Periodical Payment Order attached to each case.

The Trust is solely responsible for ensuring periodical payments in 6 cases. In one further case the Trust contributes to ongoing PPO payments along with two other co-Defendants.

The following table sets out expenditure during the period 01 April 2015 – 31 March 2016 relevant to all 7 PPO cases.

TABLE 13

Expenditure relating to Periodical Payment Cases	
Aids & equipment & annual holiday fee	£2,531.00
Annual case management costs	£16,250.00
Care costs fee	£48,115.00
Case management & therapies fee	£8,735.00
Deputyship fee	£10,000.00
Interim Plaintiff BL fee	£40,000.00
Interim Plaintiff QC fee	£60,000.00
Periodical payments	£767,791.10
Plaintiff Solicitors fee	£123,377.73
Psychology services fee	£5,200.00
Total:	**£1,081,999.83**

Of the total £12,506,225.06 expenditure during the period of the report, the remaining £3,271,237.74 relates to:

a. payments against ongoing litigation cases in order to obtain medical expert advice

b. payment of residual costs in respect of claims that were settled by the Trust in previous financial years.

LEGAL SERVICES AND CORONIAL MATTERS

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PART 2: CORONIAL MATTERS

TABLE 14

Coronial Matters

During the period 01 April 2015 – 31 March 2016, there were 68 new Coroner's cases opened, as follows:

NEW CORONER'S CASES OPENED 1 APRIL 2015 - 31 MARCH 2016					
Unscheduled and Acute Care (50 cases)	**Q1**	**Q2**	**Q3**	**Q4**	**TOTALS**
ICU	9	8	8	6	31
AMU	1	0	0	0	1
Emergency Department	2	6	3	2	13
Theatres	0	1	0	0	1
Cardiology	0	1	0	1	2
Medical Specialties	0	0	0	1	1
Neurosurgery	0	0	0	1	1
Specialist Hospitals, Women and Children's Health Services (10 cases)					
PICU	1	1	1	1	4
Orthopaedics	1	1	0	2	4
Paediatric ED	0	1	0	0	1
Obstetrics	0	0	0	1	1
Surgery and Specialist Services (6 cases)					
Cardiac Surgery	1	0	0	0	1
General Surgery	1	1	0	1	3
Urology	1	0	0	0	1
Thoracic Surgery	0	0	0	1	1
Adult Social & Primary Care Services (2 cases)					
Mental Health Acute Services	0	1	1	0	**2**

It should be noted that the opening of a Coroner file does not necessarily lead to full Inquest proceedings. During the course of investigations, and on receipt of involved clinician reports, it is more often the case that the Coroner will be satisfied that he/ she has sufficient information to issue a formal death certificate and avoid a formal Court Inquest hearing. The following cases were closed without Inquest:-

CORONER'S CASES CLOSED ON FORM 17 (without Inquest) 1 APRIL 2015 - 31 MARCH 2016					
Unscheduled and Acute Care (24 cases)	**Q1**	**Q2**	**Q3**	**Q4**	**TOTALS**
ICU	N/A	3	1	6	10
Anaesthetics	N/A	0	0	1	1
Emergency Department	N/A	2	5	3	10
Theatres	N/A	0	1		1
Cardiology	N/A	1	0		1
Neurosurgery	N/A	0	0	1	1
Specialist Hospitals, Women and Children's Health Services (5 cases)					
PICU	N/A	1	0	1	2
Orthopaedics	N/A	0	0	2	2
Paediatric ED	N/A	1	0	0	1
Surgery and Specialist Services (2 cases)					
Cardiac Surgery	N/A	0	0	1	1
Not assigned	N/A	0	0	1	1
Adult Social & Primary Care Services (1 case)					
Learning Disability	N/A	0	0	1	**1**

There were 6 Inquests heard during the period of this report. The Coroner's Verdicts were shared with the Clinicians involved in the cases following the Inquests.

CORONER'S CASES CLOSED AFTER INQUESTS HEARD - 1 APRIL 2015 - 31 MARCH 2016					
Unscheduled and Acute Care (3 cases)	**Q1**	**Q2**	**Q3**	**Q4**	**TOTALS**
Emergency Department	N/A	0	0	1	1
Medical Specialties	N/A	0	1	0	1
Neurosurgery	N/A	0	1	0	1
Specialist Hospitals, Women and Children's Health Services (1 case)					
PICU	N/A	1	0	0	1
Surgery and Specialist Services (2 cases)					
General Surgery	N/A	0	1	0	1
Urology	N/A	0	1	0	1

LEGAL

SERVICES AND CORONIAL MATTERS

ANNUAL REPORT

1 APRIL 2015 – 31 MARCH 2016

PART 3: EMPLOYERS & OCCUPIERS LIABILITY CLAIMS

Litigation Management Office

This report covers the year 01/04/2015 – 31/03/2016 covering the following areas of responsibility of the Litigation Management Office.

1. Employers Liability claims
2. Occupiers Liability claims

1 - Employers Liability Claims

An employer is responsible for the health and safety of employees while they are at work and if a member of staff is injured as a result of an accident at work, or becomes ill as a result of his/her work, they may seek compensation for the injuries sustained. The Belfast Trust does not purchase insurance cover in this area and all compensation payments are therefore payable directly from public funds.

New EL claims files opened during the period 01.04.2015 to 31.03.2016

During this year a total of 82 Employer's Liability claims were lodged against The Belfast Health & Social Care Trust.

TABLE 15

1st quarter	2nd quarter	3rd quarter	4th quarter	Total for year
23	24	15	20	82

The claims are related to accidents/incidents/exposures which occurred in the following financial years:

TABLE 16

Year of incident	Number of incidents
77/78	1
82/83	1
12/13	2
13/14	6
14/15	27
15/16	42
Unknown	3
Totals:	82

The table below sets out the type of incident which gave rise to claims lodged during the year covered by this report:

TABLE 17

Incident type by Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total For year
Injury/harm to others by patient	5	4	7	4	20
Fall/Slip/trip on same level	5	5	2	8	20
Needlestick/sharps injury	5	4	2	6	17
Injured while handling/ lifting/carrying (patient)	2	4			6
Hit by a moving, flying or falling object	1	2	1		4
Cut by sharp material/object - non-clinical	1	1	1		3
Other	1	1		1	3
Exposed to/in contact with a harmful substance - inc skin disorders	2				2
Contact with hot surface/substance			1	1	2
Injured while handling/ lifting/carrying (non-patient)		2			2
Contact with moving machinery or material being machined		1	1		2
Hit against something fixed or stationary	1				1
Total	**23**	**24**	**15**	**20**	**82**

The table below sets out the type of incident which gave rise to Employers Liability claims lodged across the Belfast Trust during the past three years from 2013-2016.

Claims by Incident type Grouped Year Claim is opened
TABLE 18

	13/14	14/15	15/16	Total
Fall/Slip/trip on same level	15	19	20	54
Injury/harm to others by patient	12	15	20	47
Needlestick/sharps injury	11	17	17	45
Hit by a moving, flying or falling object	10	7	4	21
Injured while handling/ lifting/carrying (patient)	2	1	6	9
Other	3	3	3	9
Exposed to/in contact with a harmful substance - inc skin disorders	4	1	3	8
Contact with hot surface/substance	3	1	2	6
Hit against something fixed or stationary	2	3	1	6
Injured while handling/ lifting/carrying (non-patient)	2	1	2	5
Cut by sharp material/object - non-clinical	1	1	2	4
Injury caused by appliance, machinery or plant	1	2	0	3
Repetitive Strain Injury	2	1	0	3
Contact with moving machinery or material being machined	0	0	2	2
Equipment malfunction	2	0	0	2
Exposed to electricity/electrical discharge	2	0	0	2
Fall from chair	1	1	0	2
Fall from height	2	0	0	2
Fall on stairs	1	1	0	2
Assault by relative	1	0	0	1
Hit by a moving vehicle/road traffic accident	1	0	0	1
Totals:	**78**	**74**	**82**	**234**

As you can see Slips Trips and Falls have the highest number again but it has only increased by 1 since last year. Injury harm to others by patient has also the highest number increasing by 5 from the previous year.

Needlestick or sharps injury have remained the same for the second year

New EL Claims by Service Area and Incident type grouped by Directorate

TABLE 19

	Injury/harm to others by patient	Contact with moving machinery or material being machined	Cut by sharp material/object - non-clinical	Exposed to/in contact with a harmful substance - inc skin disorders	Contact with hot surface/substance	Fall/Slip/trip on same level	Hit against something fixed or stationary	Hit by a moving, flying or falling object	Injured while handling/ lifting/carrying (non-patient)	Injured while handling/ lifting/carrying (patient)	Other	Needlestick /sharps injury	Total
Adult Social and Primary Care	**10**		**1**			**3**				**3**			**17**
CAMHS	1					1							2
Learning Disability	6					1							7
Mental Health	3									2			5
Older Peoples Service - NW and Elderly Care wards RVH and MIH			1			1							2
Older Peoples Service - SE & Elderly Care wards BCH										1			1
Children's Community Services	**3**					**1**							**4**
Children's Disability	1												1

Family and Child Care	2					1							3
Finance				**2**							**1**		**3**
Estates				2							1		3
Nursing and User Experience		**1**	**1**		**2**	**5**	**1**	**3**	**1**	**2**		**4**	**20**
Patient and Client Support Services - Belfast City Hospital			1			1		1		1		2	6
Patient and Client Support Services - North and West and Mater						2						1	3
Patient and Client Support Services - Royal					2	2	1	2		1		1	9
Patient and Client Support Services - South and East and Greenpark		1							1				2
Performance, Planning & Informatics						**1**							**1**
Information Management						1							1
Specialist Hospitals & Women's Health				**1**		**5**				**1**	**1**	**2**	**10**

Acute and Community Paediatrics				1								1	2
Trauma and Orthopaedics						3				1			4
Women's and Maternity						2					1	1	4
Surgery and Specialist Services								**1**				**4**	**5**
Cancer Services												1	1
Pharmacy and Medicines Management								1					1
Surgery												3	3
Unscheduled and Acute Care	**7**	**1**				**5**			**1**		**1**	**7**	**22**
ACCTSS		1				1						2	4
Allied Health Professionals											1		1
Emergency Dept, Medical & Cardiology Services	7					3			1			4	15
Neurosciences						1						1	2
Totals:	**20**	**2**	**2**	**3**	**2**	**20**	**1**	**4**	**2**	**6**	**3**	**17**	**82**

Employers Liability Claims closed during the period 01.04.2015 – 31.03.2016

There were 62 Employers Liability claims closed during the last year.

18 claims were closed with the Trust having incurred no expense. Of these cases

TABLE 20

Redirected or taken over by Third Party	2
Withdrawn - no payment - case withdrawn by plaintiff	4
Statute barred	12
Totals:	18

2 claims were settled with the Trust having to pay Defence Costs only totaling: £2,997.40

42 claims were closed with Damages paid to Plaintiffs.

The cost to bring 44 Employers Liability **(includes 2 claims Defence Cost only paid)** claims to settlement were as follows

TABLE 21

	Damages paid to Plaintiffs	**Legal costs associated with claims**	**Total Expenditure for year**
1st Quarter	£53,375.00	£40,440	£93,815
2nd Quarter	£161,705.20	£94,645.48	£256,350.68
3rd Quarter	£98,004.75	£66.281.73	£164,286.48
4th Quarter	£65,425.00	£59,862.00	£125,287.00
Total for year	**£378,509.95**	**£194,947**	**£639,739**

TABLE 22

Total payments Claims by Service Area and Incident type grouped by Directorate

	58. Injury/harm to others by patient	Exposed to/in contact with a harmful substance - inc skin disorders	Contact with hot surface/substance	Fall/Slip/trip on same level	Hit against something fixed or stationary	Hit by a moving, flying or falling object	Injury caused by appliance, machinery or plant	Injured while handling/ lifting/carrying (non-patient)	70. Other	Cut by sharp material non clinical	70. Needlestick/sharps injury	Total
Adult Social and Primary Care	**£85,618.45(6)**			**£6,367.60(1)**		**£6,266.69(1)**					**£3,228.79(1)**	**£101,481.53(9)**
Learning Disability	£72,695.80(4)					£6,266.69(1)						£78,962.49(5)
Mental Health	£12,922.65(2)			£6,367.60(1)								£19,290.25(3)
Older Peoples Service - Intermediate Care and Mental Health &Elderly Care wards KHP & MPH											£3,228.79(1)	£3,228.79(1)
Children's Community Services	**£66,234.68(2)**											**£66,234.68(2)**
Children's Disability	£66,234.68(2)											£66,234.68(2)
Finance						**£3,745.25(1)**	**£21,948.17(2)**		**£4,038.11(1)**			**£29,731.53(4)**
Accounting and Financial Services							£14,797.10(1)					£14,797.10(1)
Estates						£3,745.25(1)	£7,151.07(1)		£4,038.11(1)			£14,934.43(3)
Nursing and User Experience			**£6,733.48(1)**								**£10,128.44(2)**	**£136,433.84(4)**
Patient and Client Support Services - Belfast City Hospital											£931.80(1)	£931.80(1)
Patient and Client Support Services - Royal			£6,733.48(1)								£9,196.64(1)	£15,930.12(2)
Planning, performance innovation & catering										£119,571.92(1)		£119,571.92(1)
Specialist Hospitals & Women's Health		**£674.40(1)**		**£56,298.02(3)**		**£54,217.51(2)**					**£10,464.77(2)**	**£121,654.70(8)**
Trauma and Orthopaedics				£12,292.61(1)								£12,292.61(1)
Women's and Maternity		£674.40(1)		£44,005.41(2)		£54,217.51(2)					£10,464.77(2)	£109,362.09(7)
Surgery and Specialist Services			**£5,907.35(1)**		**£2,322.96(1)**						**£14,404.13(3)**	**£22,634.44(5)**
Cancer Services					£2,322.96(1)							£2,322.96(1)
Surgery			£5,907.35(1)								£14,404.13(3)	£20,311.48(4)
Unscheduled and Acute Care	**£28,107.20(2)**	**£5,242.43(1)**		**£83,985.69(3)**				**£20,240.35(1)**			**£23,991.92(5)**	**161,567.59(12)**
ACCTSS		£5,242.43(1)		£66,023.49(2)				£20,240.35(1)			£5,930.87(1)	£97,437.14(5)
Emergency Dept, Medical & Cardiology Services	£28,107.20(2)										£18,061.05(4)	£46,168.25(6)
Imaging				£1,7962.20(1)								£17,962.20(1)
Totals:	£179,960.33(10)	£5,916.83(2)	£12,640.83(2)	£146,651.31(7)	£2,322.96(1)	£64,229.45(4)	£21,948.17(2)	£20,240.35(1)	£4,038.11(1)	£119,571.92(1)	£62,218.05(13)	£639,738.31(44)

Nursing & User Experience (PCSS) had 4 Claims closed during the year, however a further 17 claims in which PCSS staff sustained injury after an incident/accident or are PCSS related also closed. These 17 claims occurred in four other Service Areas,

Claims by Service Area grouped by Directorate

TABLE 23

	No of claims
Adult Social and Primary Care	**1**
Mental Health	1
Specialist Hospitals & Women's Health	**4**
Women's and Maternity	4
Surgery and Specialist Services	**4**
Specialist Medicine	1
Surgery	3
Unscheduled and Acute Care	**8**
ACCTSS	3
Emergency Dept, Medical & Cardiology Services	5
Totals:	17

The total number of Belfast Trust Employer Liability Cases ongoing as of 31st March 2016 total 223

For comparison the following table shows the Total expenditure for Employer Liability Claims for previous financial years.

TABLE 24

Year	Damages paid to Plaintiffs	Legal costs associated with claims	Total Expenditure for year	No of EL claims settled with Damages paid	No of New EL claims
2013-2014	**£295,581.00**	**£311,741.50**	**£607,322.50**	**72**	**78**
2014-2015	**£431,872.00**	**£339,825.00**	**£771,697.00**	**73**	**72**
2015-2016	**£378,509.95**	**£194,947**	**£639,739**	**42**	**82**

2 – Occupiers Liability Claims

An employer is responsible for the health and safety of visitors to their premises. If a visitor is injured they may seek compensation for the injuries sustained. The Belfast Trust does not purchase insurance cover in this area and all compensation payments are therefore payable directly from public funds.

New OL claims files opened during the period 01.04.2015 – 31.03.2016

There were 23 Occupiers Liability Claims lodged against The Belfast Health & Social Care Trust during the period 1 April 2015 to 31 March 2016.

TABLE 25

Number of claims 1st Quarter	2nd Quarter	3rd Quarter	4th quarter	Total for year
4	10	6	3	23

The claims are related to accidents/incidents/exposures which occurred in the following financial years:

TABLE 26

Year of incident	Number of incidents
12/13	2
13/14	1
14/15	8
15/16	11
Unknown	1
Totals:	23

The types of incidents giving rise to these claims are as follows:

TABLE 27

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total for year
Fall/Slip/trip on same level		4	2	1	7
Hit by a moving, flying or falling object		2	3	1	6
Fall from chair	1			1	2
Other		2			2
Injury/harm to others by patient	1				1
Assault by Trust staff			1		1
Contact with hot surface/substance		1			1
Fall from height		1			1
Injured while handling/ lifting/carrying (patient)	1				1
Needlestick/sharps injury	1				1
Totals:	4	10	6	3	23

The table below sets out the type of incident which gave rise to Occupiers Liability claims lodged across the Belfast Trust during the past three years from 2013-2016.

TABLE 28

	13/14	14/15	15/16	Total
Fall/Slip/trip on same level	6	7	7	20
Hit by a moving, flying or falling object	2	3	6	11
Hit against something fixed or stationary	3	1	0	4
Other	2		2	4
Equipment malfunction	2	1		3
Fall from chair	1		2	3
Fall from height	2		1	3
Injury/harm to others by patient			1	1
Assault by Trust staff			1	1
Exposed to electricity/electrical discharge		1		1
Exposed to/in contact with a harmful substance - inc skin disorders		1		1
Contact with hot surface/substance			1	1
Fall on stairs	1			1
Injury caused by appliance, machinery or plant		1		1
Injured while handling/ lifting/carrying (patient)			1	1
Patient/client Injured by another patient/client	1			1
Needlestick/sharps injury			1	1
Trapped inside, or by something collapsing	1			1
Totals:	21	15	23	59

As you can see Slips Trips and Falls have the highest number of incidents but have not increased from the previous year. Hit by a moving, flying or falling object is second highest in number increasing by 3 on the previous year.

TABLE 29

New EL Claims by Service Area and Incident type grouped by Directorate

	Injury/harm to others by patient	Assault by Trust staff	Contact with hot surface/substance	Fall from chair	Fall from height	Fall/Slip/trip on same level	Hit by a moving, flying or falling object	Injured while handling/ lifting/carrying (patient)	Other	Needlestick /sharps injury	Total
Adult Social and Primary Care	**1**			**1**			**1**	**1**			**4**
CAMHS								1			1
Learning Disability	1										1
Older Peoples Service - NW and Elderly Care wards RVH and MIH							1				1
PHD and Sensory Support				1							1
Children's Community Services						**1**	**1**				**2**
Community Child Health						1	1				2
Finance					**1**	**2**	**3**				**6**
Estates					1	2	3				6
Nursing and User Experience						**1**			**1**	**1**	**3**
Corporate Nursing										1	1
Patient and Client Support Services - Royal						1					1
Patient and Client Support Services - South and East and Greenpark									1		1
Specialist Hospitals & Women's Health			**1**			**2**	**1**				**4**
Acute and Community Paediatrics			1								1
Trauma and Orthopaedics						1	1				2
Women's and Maternity						1					1
Surgery and Specialist Services				**1**							**1**
Cancer Services				1							1
Unscheduled and Acute Care		**1**				**1**			**1**		**3**
Emergency Dept, Medical & Cardiology		1							1		2
Imaging						1					1
Totals:	**1**	**1**	**1**	**2**	**1**	**7**	**6**	**1**	**2**	**1**	**23**

Occupiers Liability Claims closed during the period 01.04.2015 – 31.03.2016

There were 12 Occupiers Liability claims closed during the above period.

7 claims were closed with the Trust having incurred no expense. Of these cases

TABLE 30

	Total
Redirected or taken over by Third Party	1
Statute barred	3
Withdrawn - no payment - case withdrawn by plaintiff	3
Totals:	7

5 claims were closed with Damages paid to Plaintiffs.

The cost to bring 5 Occupiers Liability Claims to settlement were as follows:

TABLE 31

	Damages paid to Plaintiffs	Legal costs associated with claims	Total Expenditure for year
1st Quarter	£5,375.00	£6,695.44	£12,070.44
2nd Quarter	£15,000	£3,269	£18,269.00
3rd Quarter	£55,000	£53,403	£108,403
4th Quarter	£1,250.00	£4,425.00	£5,675.00
Total for year	**£76,625.00**	**£67,792.44**	**£144,417.44**

TABLE 32

OL Total payments Claims by Service Area and Incident type grouped by Directorate				
	Needlestick	**Fall/Slip/trip on same level**	**Hit by a moving, flying or falling object**	**Total**
Finance		**£114,077.84(2)**		**£114,077.84(2)**
Estates		£114,077.84(2)		£ 114,077.84
Nursing and User Experience	**£ 931.80**		**£ 18,269.10**	**£19,200.90(2)**
Patient and Client Support Services - Belfast City Hospital	£ 931.80		£ 18,269.10	£19,200.90
Specialist Hospitals & Women's Health			**£ 11,138.64**	**£11,138.64(1)**
Women's and Maternity			£ 11,138.64	£ 11,138.64
Totals:	**£931.80(1)**	**£114,077.84(2)**	**£29,407.74(2)**	**£144,417.38(5)**

The total number of Belfast Trust Occupiers Liability Cases ongoing as of 31st March 2016 total is 62

For comparison the following table shows the Total expenditure for OL Claims for previous 3 Financial years.

TABLE 33

Year	Damages paid to Plaintiffs	Legal costs associated with claims	Total Expenditure for year	No of OL claims settled with payments	No of New OL claims lodged
2013-2014	£87,875	£78,320	£166,195	14	19
2014-2015	£59,684	£43,573	£103,257	19	16
2015-2016	£76,625.00	£67,792.44	£144,417.44	5	23

TRUST INCIDENT REPORT
1st APRIL 2014 TO 31ST MARCH 2015
(as at 28TH May 2015)

1. INTRODUCTION

During the period between 1st April 2014 and 31st March 2015 a total of 27,337[1] reported incidents occurred Trust-wide, including those reported by Independent Sector nursing homes and domiciliary providers. In comparison, during the period from 1st April 2013 to 31st March 2014, a total of 26,014 reported incidents occurred. This represents a slight increase of 5%.

Fig. 1

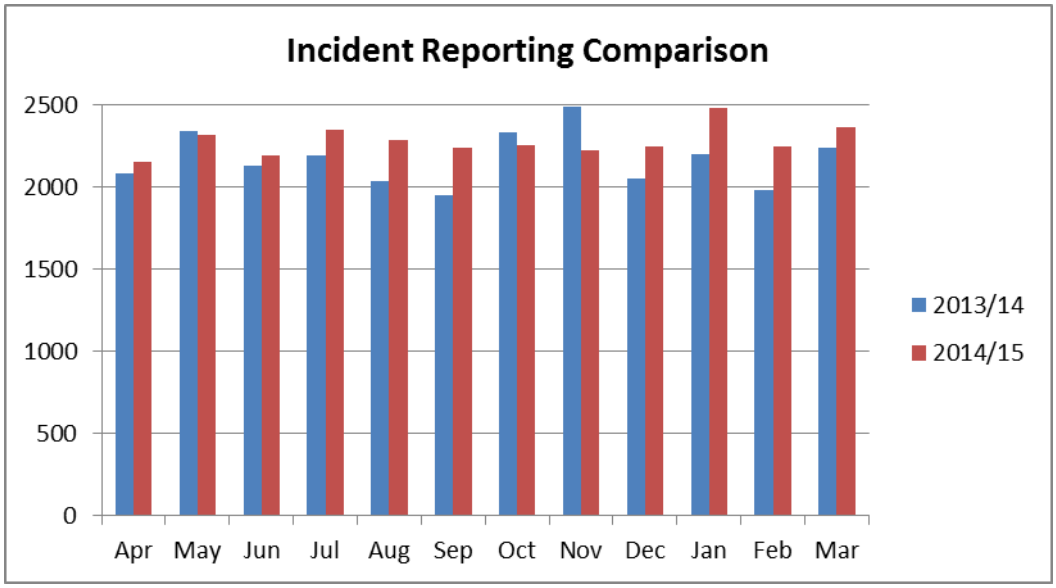


Fig. 1 shows the monthly comparison of incident reporting figures between the two periods in 2013/14 and 2014/15.

[1] It should be noted that quality assurance of data is ongoing, therefore statistics throughout this report are presented subject to alteration.

2. INCIDENT BREAKDOWN

2.1 INCIDENTS BY TYPE

Fig. 2

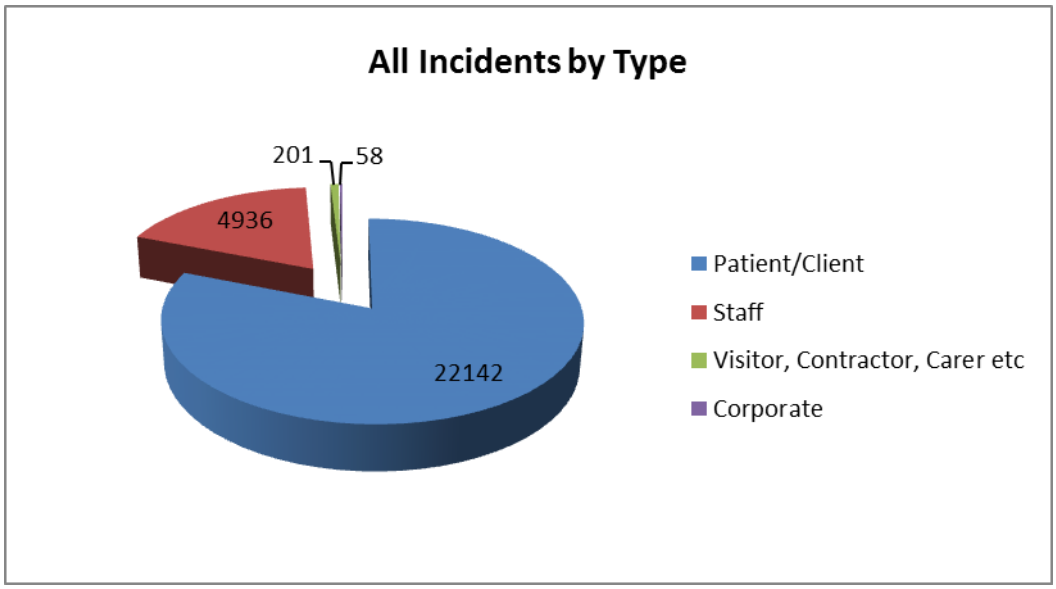


Figure 2 shows that 22,142 (81%) of reported incidents affected patients or clients while 4,936 (18%) affected staff. Only 201 (0.7%) incidents affected visitors, contractors or carers and 58 (0.2%) were corporate incidents (where no particular person type was, or could have been, affected).

There was no significant change in the percentage breakdown above for the same period in 2013/14.

2.2 INCIDENTS BY DIRECTORATE

Fig. 3

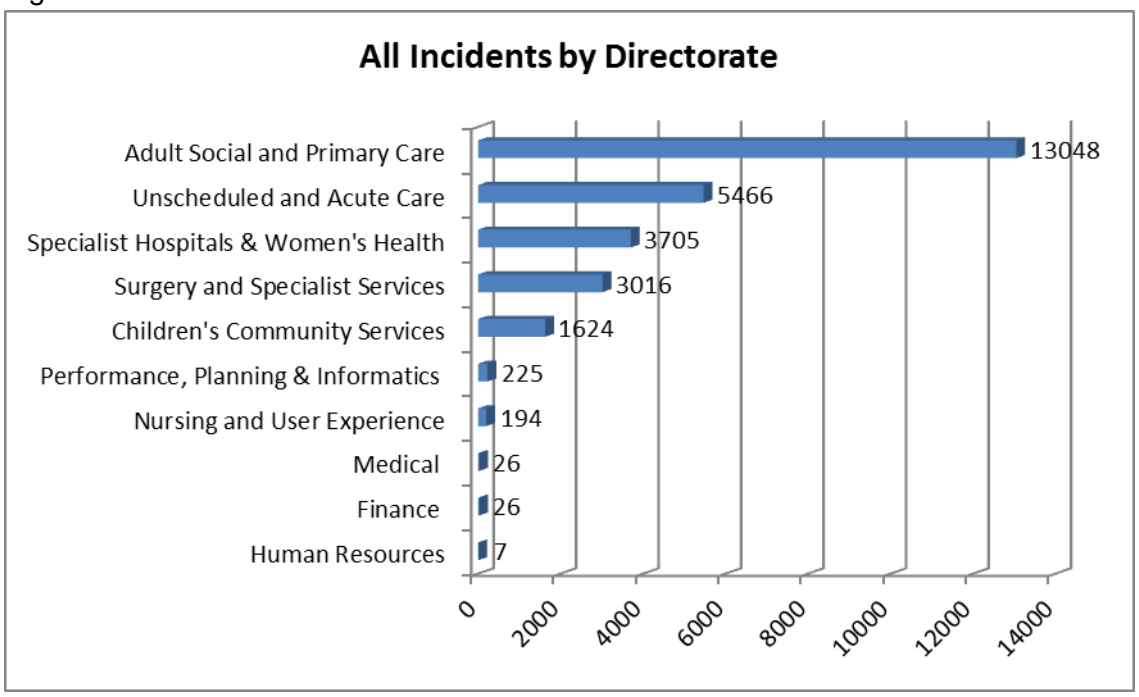


Figure 3 shows that the Directorates with the most reported incidents are Adult Social and Primary Care with 13,048 (48%) incidents and Unscheduled and Acute Care with 5,466 (20%) incidents.

The figures above show a very similar pattern to those for the same period in 2013/14.

2.3 INCIDENTS BY SEVERITY

Fig. 4

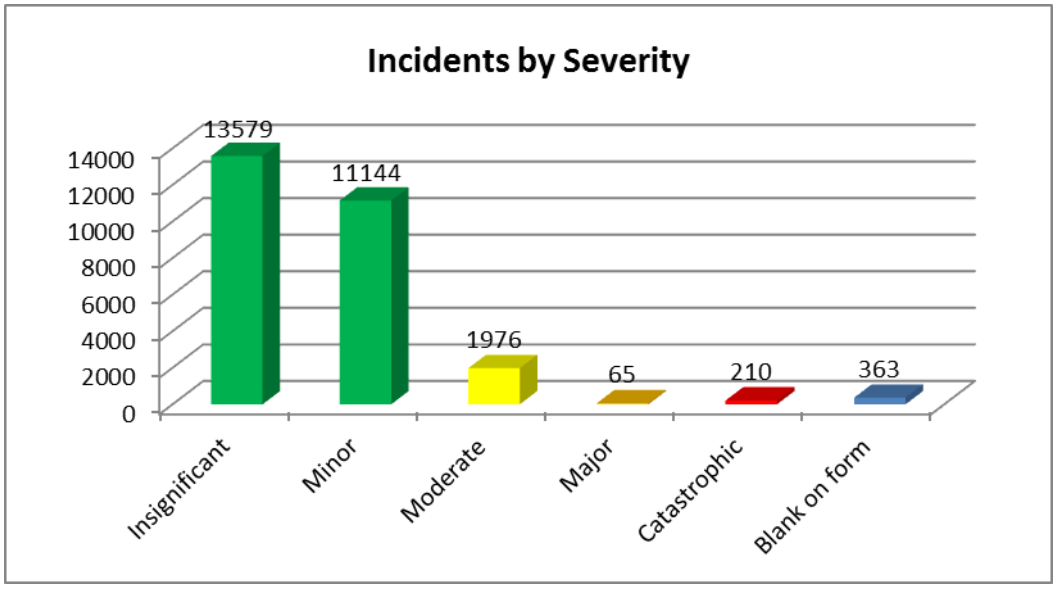


Figure 4 indicates that 24,723 (90%) of incidents were assessed as having a severity rating of insignificant or minor while 210 (0.8%) were rated as catastrophic. The severity rating indicates *actual* harm or damage as a result of the incident rather than potential risk.

It should be noted that the severity grading of incidents is still not always clearly understood by staff therefore the data in figure 4 should be considered as a general overview. There will be some incidents currently graded as moderate, major or catastrophic in severity which should be graded at a lower level.

The Corporate Governance Dept have a number of measures in place to follow-up on major or catastrophic severity incidents to ensure appropriate grading.

<u>Catastrophic severity incidents</u>

Of the 210 incidents with a severity of catastrophic;

- 122 (58%) were reported as SAIs (Serious Adverse Incidents) and are subject to full investigation under this process.
- 36 (17%) were cardiac arrests. There was no indication of concern with treatment or care leading up to the arrests. The process for reporting cardiac arrests as incidents is under review.
- 26 (12%) were queried as SAIs. The relevant service reviewed these incidents and determined that they did not meet the reporting criteria.
- 16 (8%) were stillbirths which were discussed and investigated at ALERT meetings.
- 4 (2%) were reported as Interface Incidents and are subject to full investigation under this process.

- 4 (2%) were other deaths with no concerns re treatment
- 2 incidents have been recoded following further quality assurance / follow-up processes.

Blank on form incidents

363 (1.3%) of incidents did not have the severity field completed (blank on form). Governance and Quality Managers are notified of these incidents via the regular monthly reports. There is an improvement from the same period in 2013/14 when 4% of all incidents were not given a severity rating. The introduction of Datixweb, where completion of the severity field is mandatory, has contributed to this improvement.

2.4 INCIDENTS BY CATEGORY

Incidents are coded using a 3 tier coding structure called CCS (Common Classification System) which is built into the Datix software and is standard across all Datix users world-wide. Tier 1 of the coding structure is the 'Category' and these consist of broad domains of incidents, tier 2 is 'Subcategory' which are subordinate domains and tier 3 is 'Detail' and provides further breakdown. The Corporate Governance admin team code each incident using these 3 tiers.

Fig. 5

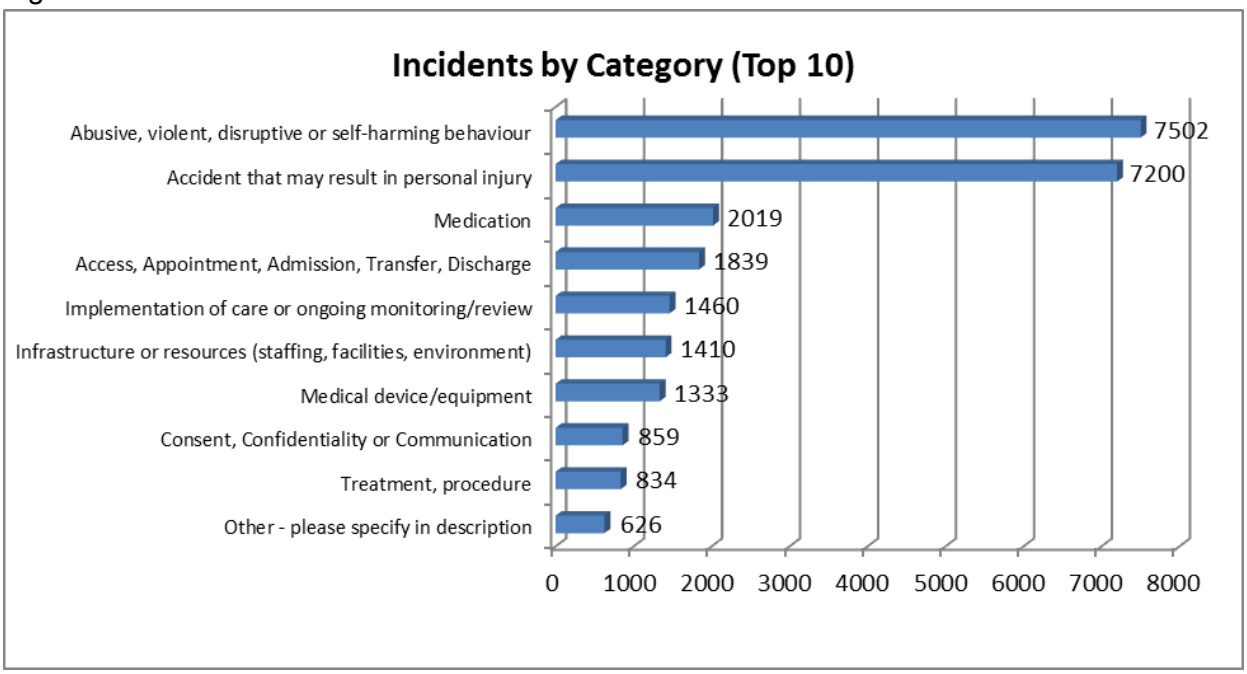


Figure 5 shows that the most commonly reported incident category is 'Abusive, violent, disruptive or self-harming behaviour' with 7,502 (27%) incidents.

It should be noted that 79% of these behavioural incidents are reported from the Adult Social & Primary Care Directorate and many of these incidents occur as a result of the patient/clients challenging behaviour inherent in their medical condition.

The 2nd most commonly reported category is 'Accidents that may result in personal injury' with 7,200 (26%) incidents.

These figures show a very similar pattern to those for the same period in 2013/14.

Fig. 6

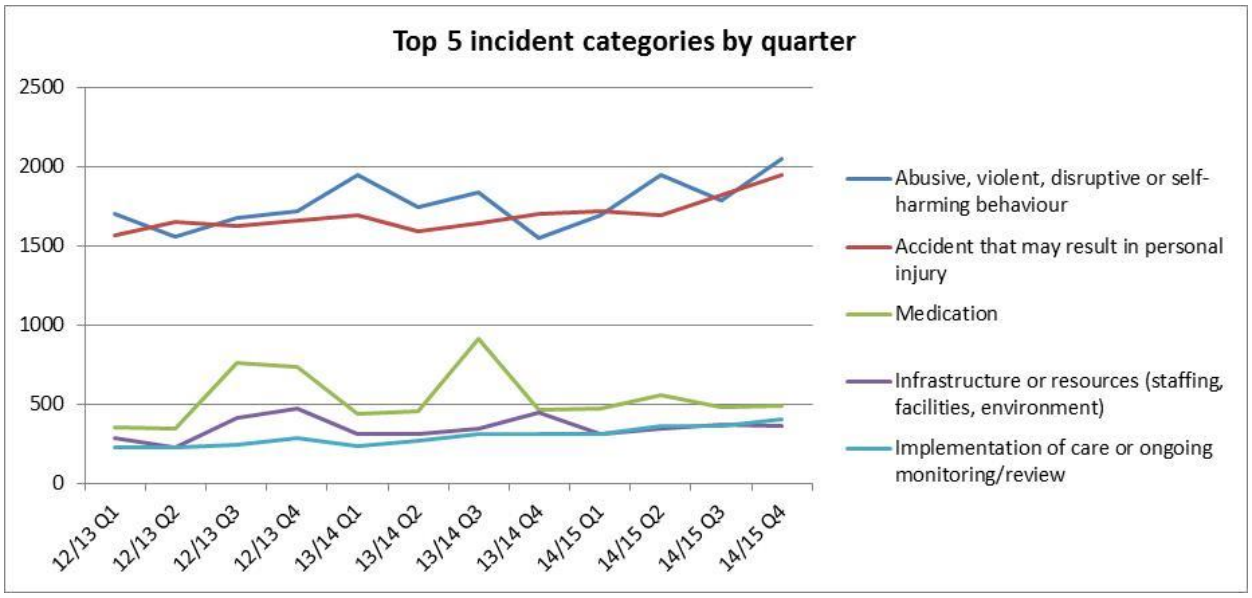


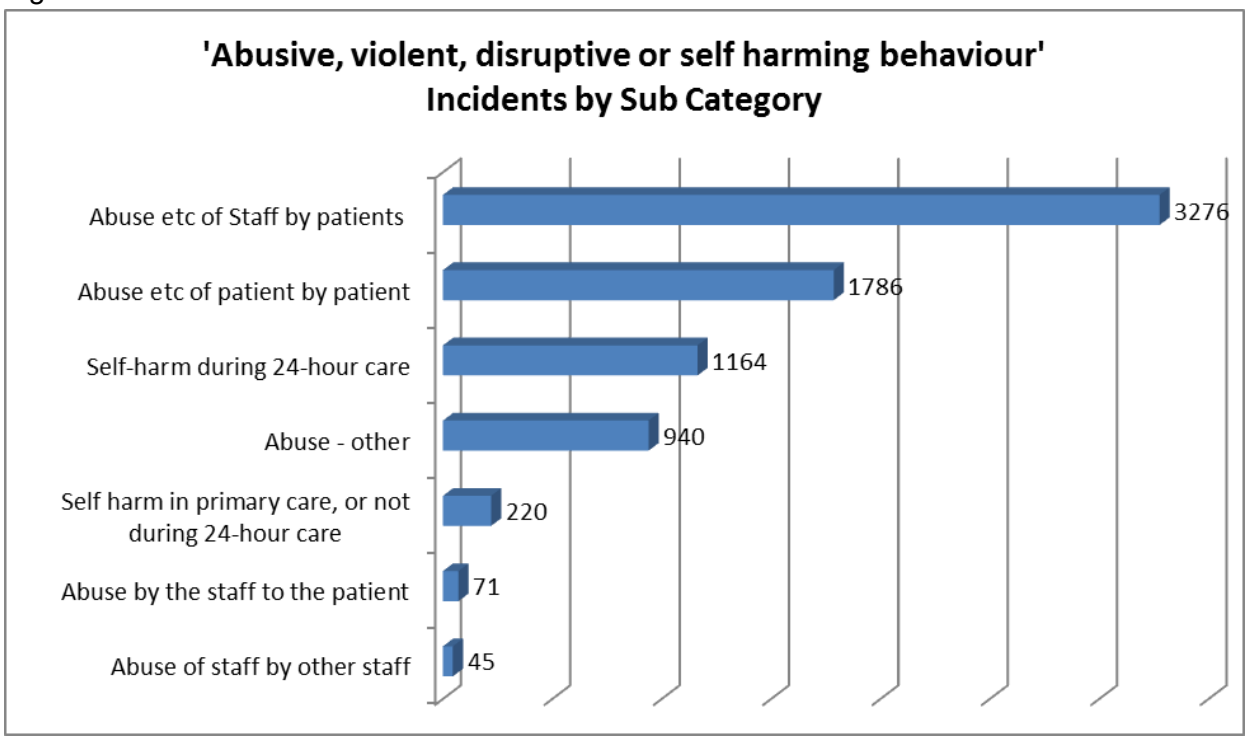
Figure 6 shows the top 5 incident categories over the last three years by financial quarter. The top 3 categories rarely change position whilst the categories taking up fourth and fifth positions have varied over time.

Figure 6 shows relatively little change in reporting trends over three years except for an increase in medication incident numbers during quarters 3 and 4 of 2012/13 and again in quarter 3 of 2013/14. These were due to week long initiatives where pharmacy staff were encouraged to report **all** the incidents they encountered on wards or in the dispensaries. This cannot be achieved on a day-to-day basis due to the volume involved.

Further breakdown of these top 5 incident categories is shown below. Each category is broken down by subcategory or detail and also by severity.

2.4.1 FURTHER BREAKDOWN OF 'ABUSIVE, VIOLENT, DISRUPTIVE OR SELF HARMING BEHAVIOUR' INCIDENTS

Fig. 7



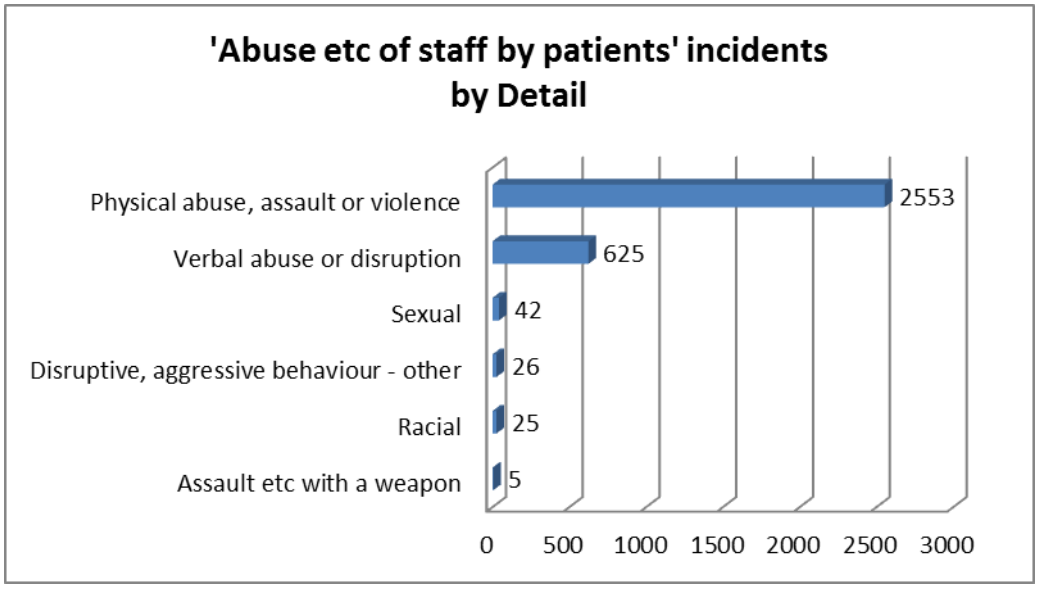
Further breakdown of 'Abusive, violent, disruptive or self harming behaviour' incidents as shown in figure 7 shows that 3,276 (44%) of these incidents are directed by patients/clients against staff and 1,786 (24%) are directed by patients/clients against other patients/clients.

The top 3 sub categories above are further broken down in the following graphs and tables (figures 8 – 13).

It should be noted that 'abusive' incidents often feature more than one type of abuse within the one incident e.g. physical and verbal. Where this is the case, the incident is coded to the more 'serious' aspect e.g. physical rather than verbal.

'Sexual' abuse incidents include inappropriate advances and /or touching.

Fig. 8

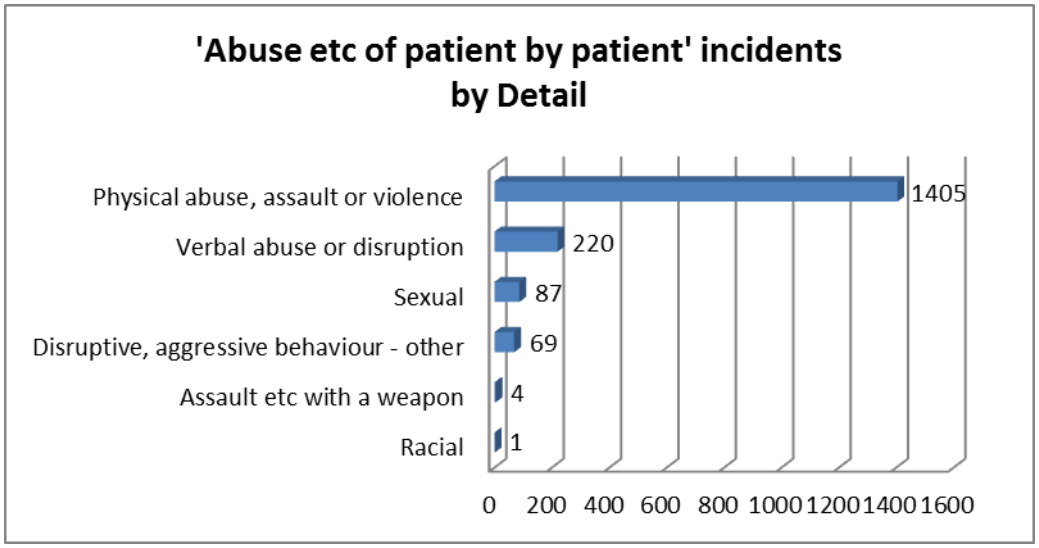


'Abuse etc of staff by patients' incidents are also displayed by Top 5 locations within the Trust along with their corresponding Service Areas in figure 9 below:

Fig. 9

Location (exact)	Service Area	
Iveagh	Learning Disability	451
Neurobehavioural Rehabilitation Unit - NRU (formerly Maine) KB	Mental Health	212
Killead (MAH)	Learning Disability	127
Moylena (MAH)	Learning Disability	119
Shannon - Ward 1	Mental Health	118
Totals:		1027

Fig. 10

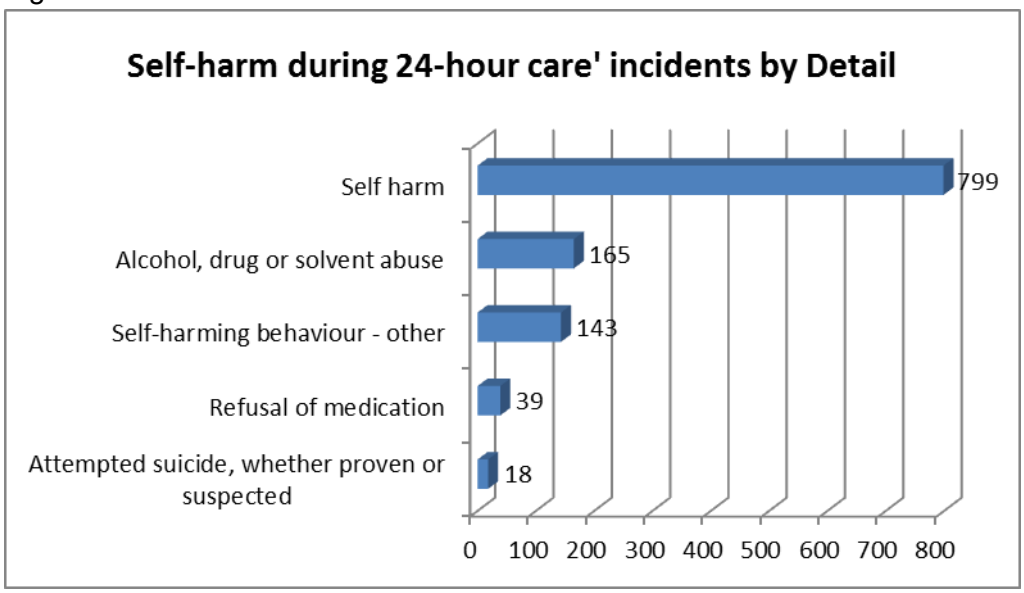


'Abuse etc of patient by patient' incidents are also displayed by Top 5 locations within the Trust along with their corresponding Service Areas in figure 11 below:

Fig. 11

Location (exact)	Service Area	
Cranfield Women (MAH)	Learning Disability	229
Neurobehavioural Rehabilitation Unit - NRU (formerly Maine) KB	Mental Health	155
Moylena (MAH)	Learning Disability	100
Killead (MAH)	Learning Disability	99
Shannon - Ward 1	Mental Health	86
Totals:		669

Fig. 12



'Self-harm during 24-hour care' incidents are also displayed by Top 5 locations within the Trust along with their corresponding Service Areas in figure 13 below:

Fig. 13

Location (exact)	Service Area	
Beechcroft - Children's Unit Ward 2 (FGH)	CAMHS	155
Iveagh	Learning Disability	113
Rathlin Ward (KHCP)	Mental Health	93
Beechcroft - Adolescent Unit Ward 1 (FGH)	CAMHS	81
Shannon - Ward 2	Mental Health	77
Totals:		519

Fig. 14

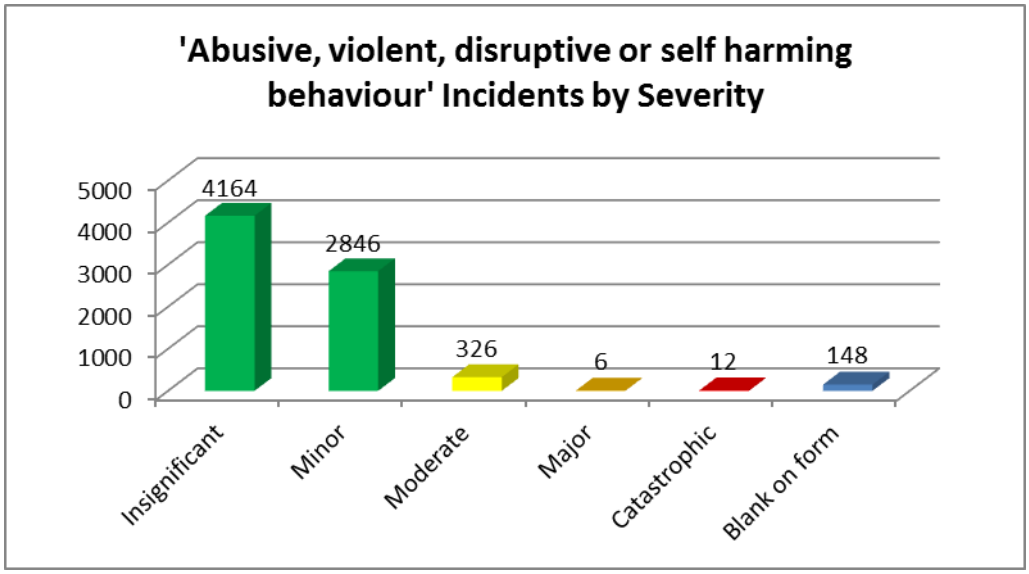


Figure 14 shows that the majority of incidents in this category (7,010 or 93%) were of insignificant or minor severity. There were 18 (0.2%) graded as major or catastrophic.

Summary of Major / Catastrophic incidents

Major:

- Ref: BHSCT/SAI/15/030 - W56319 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/14/069 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/14/143 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/14/161 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/15/028 - Followed up via the SAI procedure.
- Ref: 169717 – Non-accidental injury to Southern HSC Trust child reported by Regional Emergency Duty Team.

Catastrophic:

- 12 incidents - Followed up via the SAI procedure.

2.4.2 FURTHER BREAKDOWN OF 'ACCIDENT THAT MAY RESULT IN PERSONAL INJURY' INCIDENTS

Fig. 15

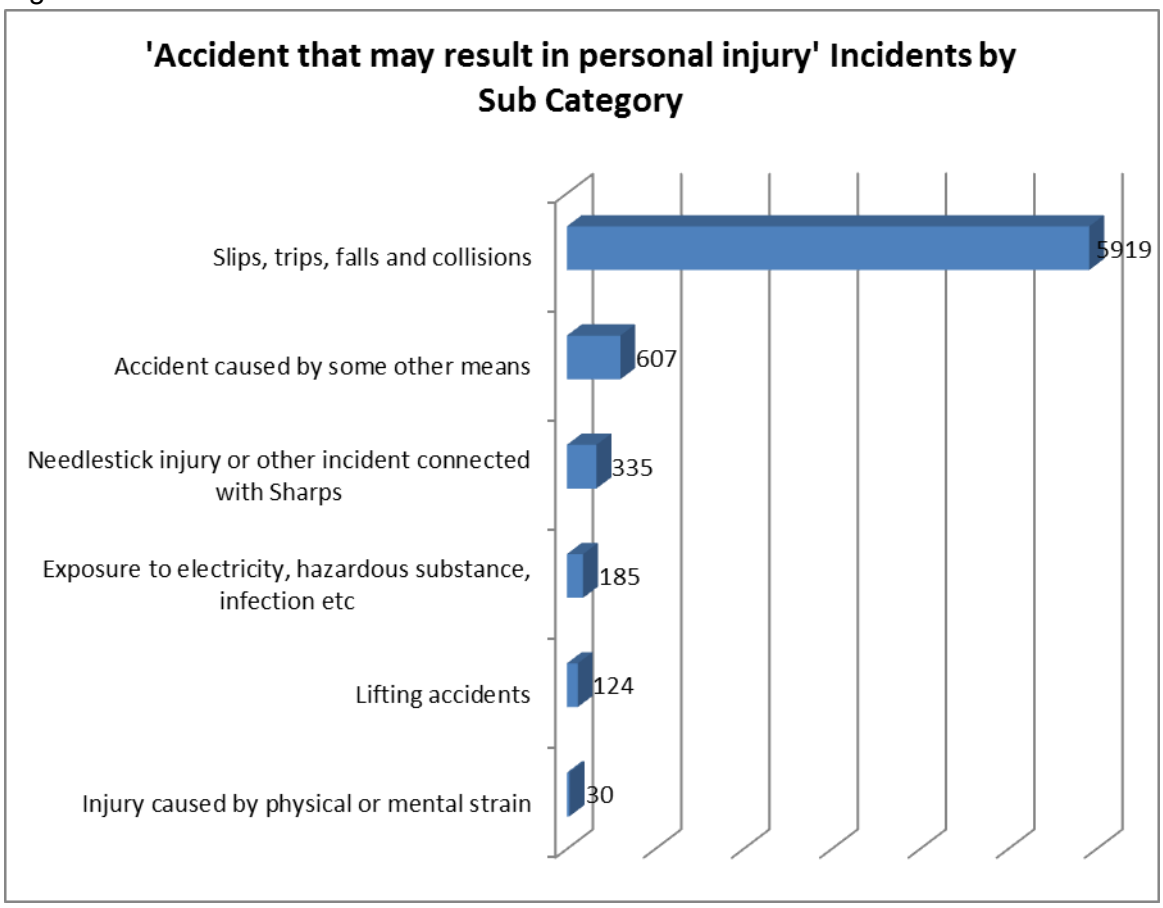
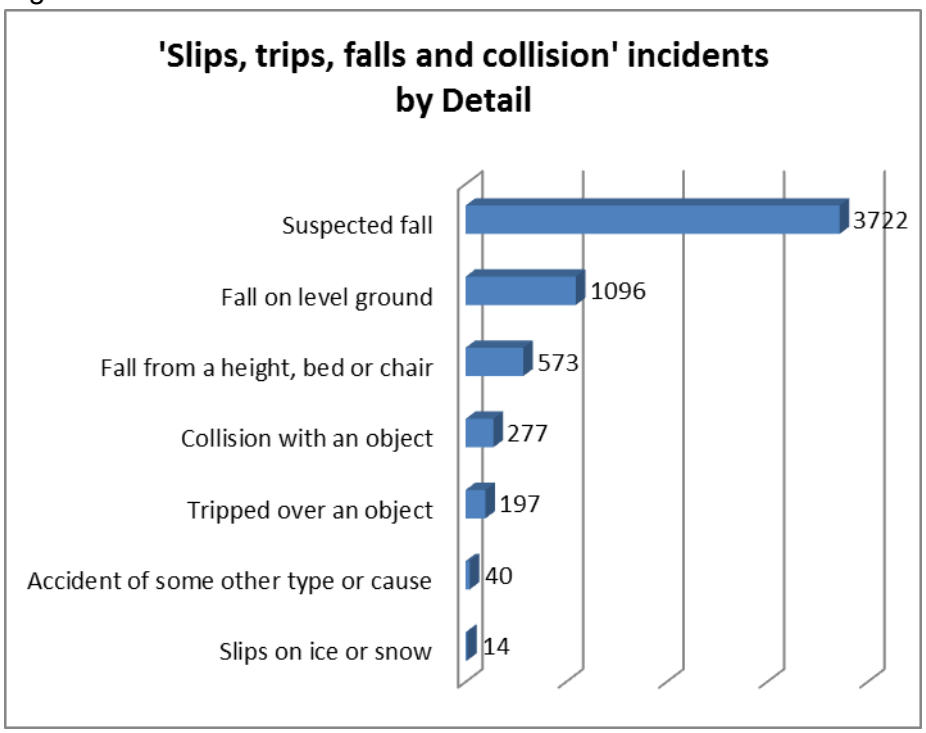


Figure 15 indicates that 'Slips, trips, falls and collisions' are by far the most commonly reported accident with 5,919 incidents. This represents 82% of all accidents.

The top 3 sub categories above are further broken down in the following graphs and tables (figures 16 to 25).

Fig. 16



'Slips, trips, falls and collision' incidents by the type of person affected:

Fig. 17

Patient/Client	5571
Staff	287
Visitor, Contractor, Carer etc	61
Corporate	0
Totals:	5919

Patient / client ‘Slips, trips, falls and collision’ incidents by **Trust** Location (Top 10):

Fig. 18

Killynure House	135
Patients/ Client's Home	132
Ward 06D (RVH)	93
Meadowlands Ward 3 (MPH)	89
Ward 07B (Acute Medical Unit) (RVH)	84
Ward D (MAT)	82
Ward 04E (RVH)	80
Meadowlands Ward 2 (MPH)	79
Ward 07C (Acute Medical Unit) (RVH)	79
07 South (BCH)	77

Patient / client ‘Slips, trips, falls and collision’ incidents by **Independent Sector (Nursing Home / Domicilary Provider)** Location (Top 10):

Fig. 19

Somerton Nursing Home (77 Somerton Rd)	81
Faith House Nursing Home	73
Limetree House Residential Home	62
The Somme Nursing home	60
Our Lady's Nursing Home	54
Manor Lodge Nursing Home	43
Abingdon Manor Nursing Home	36
Faith House	33
Cairnmartin House (Ballygomartin Rd)	32
Corkey House	31

Patient / client 'Slips, trips, falls and collision' incidents by time period (where time has been recorded on the incident form and excluding Independent Nursing Home and Domicilary providers):

Fig. 20

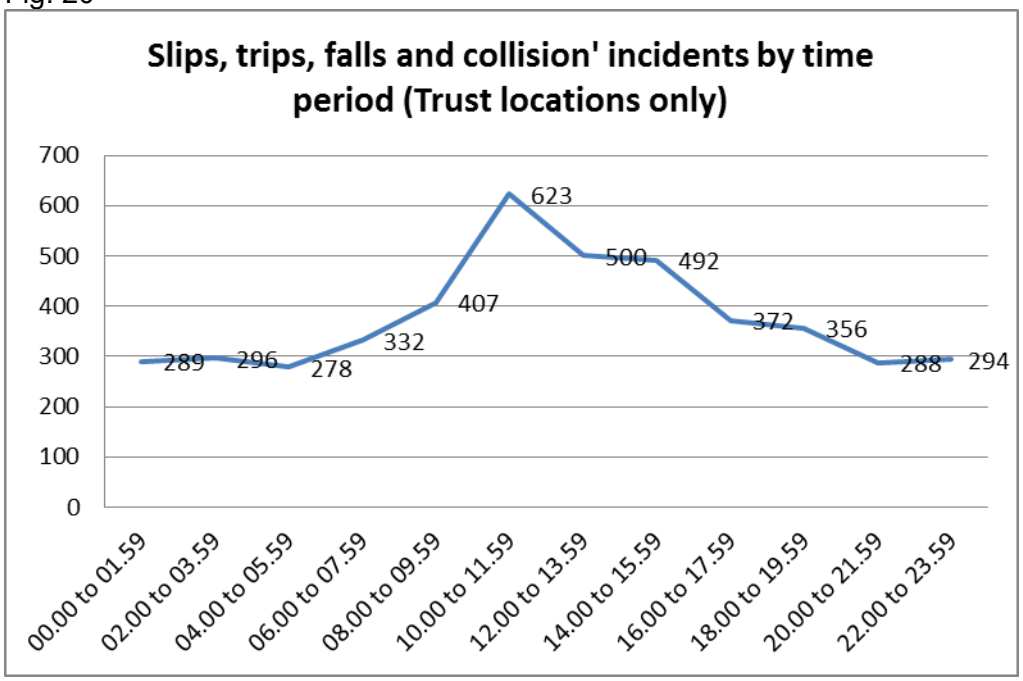


Fig. 21

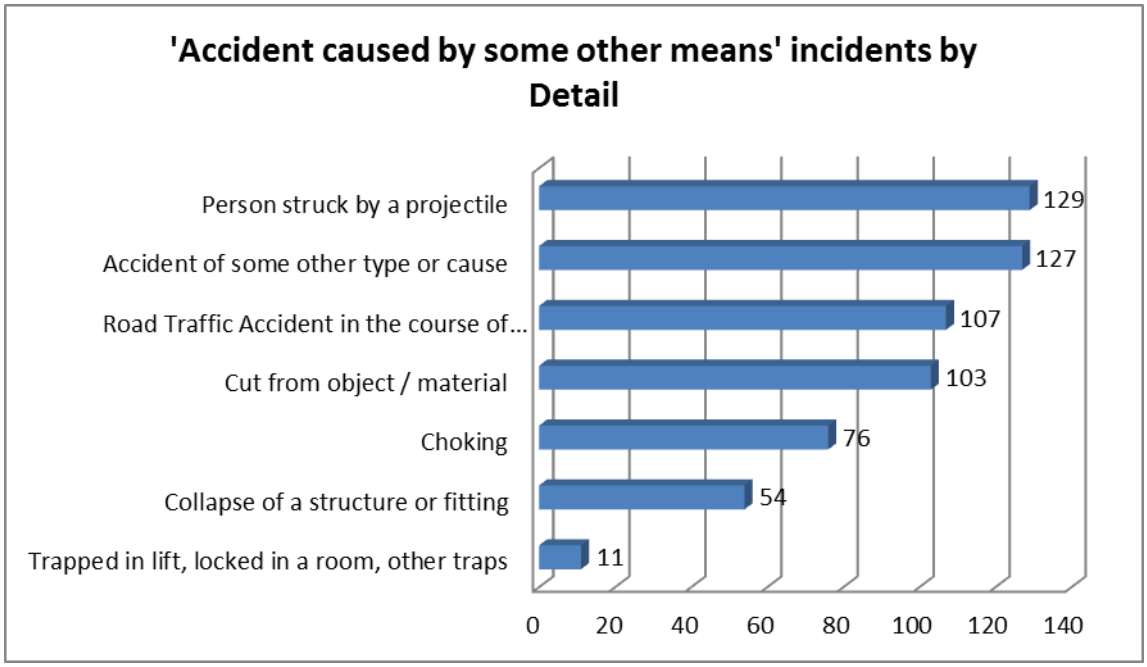
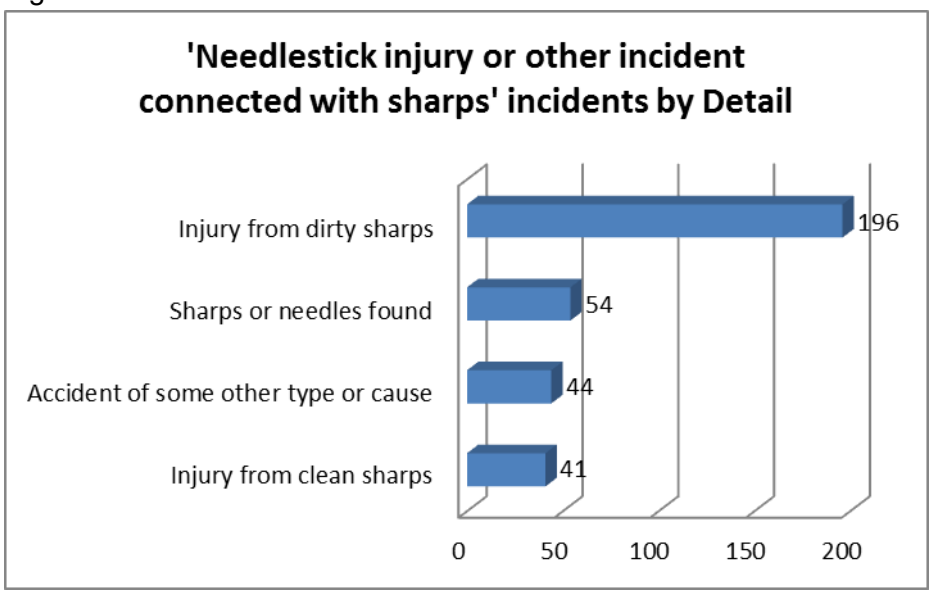


Fig. 22



'Injury from clean or dirty sharps' incidents by the staff type affected (Top 3):

Fig. 23

Staff - Nursing/ Midwifery	116
Staff - Medical	37
Staff - Ancillary and Support	32

‘Needlestick injury or other incident connected with sharps’ incidents by Location (Top 15):

Fig. 24

CDU (RVH)	16
Patients/ Client's Home	16
Emergency Department (A&E) (RVH)	13
Plenum Building (RVH) - Victoria Pharmaceuticals	10
CON (Dental Hospital)	7
Delivery Suite (RJMH)	7
Ward 07C (Acute Medical Unit) (RVH)	6
Non Trust/ Non Healthcare setting	5
Public Area e.g. Public Toilet, Reception, Shop	5
Ward 02E (RVH)	5
Neonatal Intensive Care Unit (NICU) (RJMH)	5
Emergency Department (A&E) (MAT)	4
Ward 04C (RVH) (previously short stay and spinal; moved to 4d Nov 2014)	4
Ward 06D (RVH)	4
Cath Labs (RVH)	4

‘Needlestick injury or other incident connected with sharps’ incidents by time period (where time has been recorded on the incident form):

Fig. 25

00:00 - 07:59	12
08:00 - 17:59	248
18:00 - 23:59	55

Fig. 26

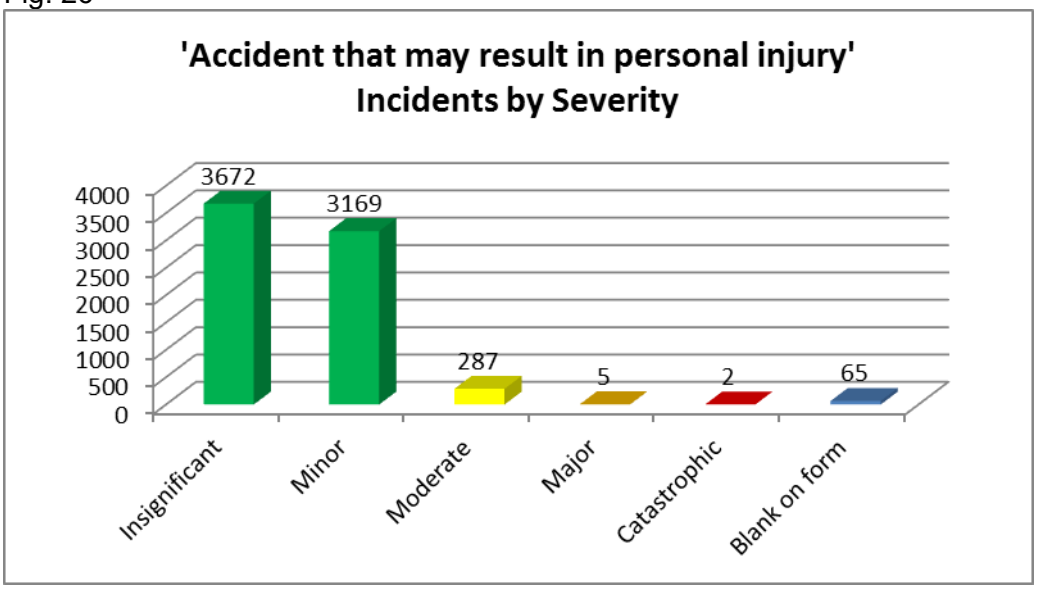


Figure 26 shows that the majority of incidents in this category (6,840 or 95%) were of insignificant or minor severity. There were 7 (0.1%) graded as major or catastrophic.

Summary of Major / Catastrophic incidents

Major:

- Ref: W62349 – Patient fall resulting in fractured neck of femur.
- Ref: W66718 – Patient fall resulting in fractured neck of femur.
- Ref: W57987 – Patient fall resulting in head injury and period of unconsciousness.
- Ref: W74970 – Patient fall resulting in fractured pelvis.
- Ref: W79943 – Patient fall resulting in fractured hip and shoulder.

Catastrophic:

- Ref: BHSCT/SAI/14/078 - W57865 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/14/162 - W70029 - Followed up via the SAI procedure.

2.4.3 FURTHER BREAKDOWN OF 'MEDICATION' INCIDENTS

Fig. 27

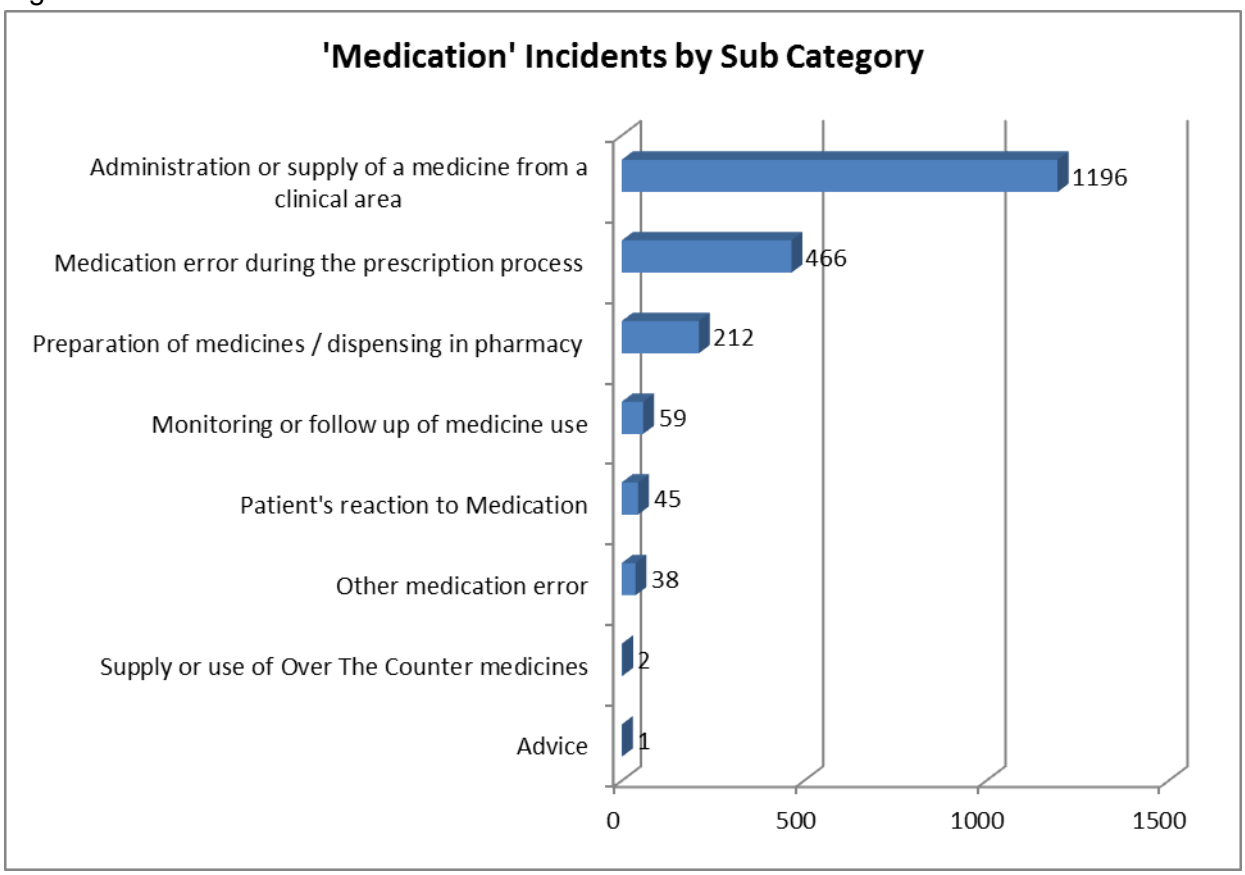


Figure 27 shows that the majority of reported incidents regarding medications occur during the administration stage, with 1,196 (59%) incidents.

‘Medication’ incidents by Location (Top 15):

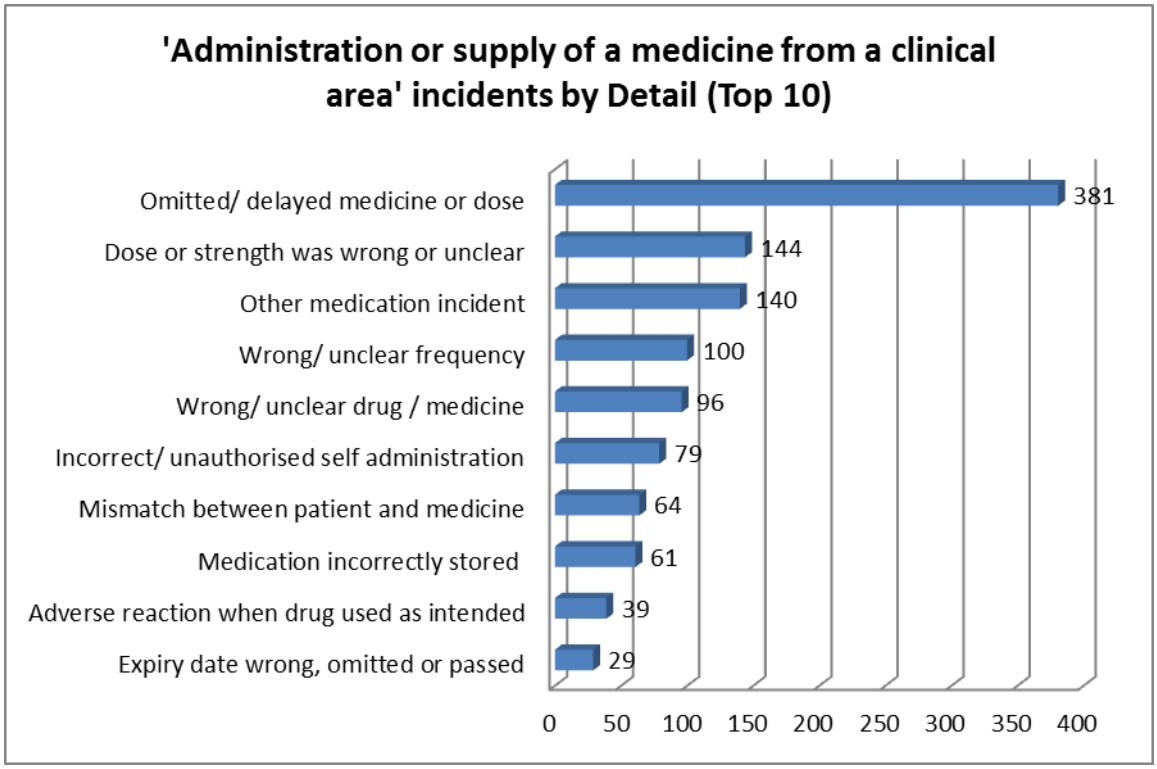
Fig. 28

Patients/ Client's Home	180
Ward 07B (Acute Medical Unit) (RVH)	113
Ward 07C (Acute Medical Unit) (RVH)	92
Ward 07A (RVH)	73
Pharmacy (RVH)	50
Bridgewater Oncology (BCH)	38
PICU (RBHSC)	30
Ward Allen (RBHSC)	29
Emergency Department (A&E) (RVH)	29
Neonatal Intensive Care Unit (NICU) (RJMH)	28
Intensive Care Unit (BCH)	27
Hemsworth Court	27
Ward 05D (RVH)	25
Pharmacy Ground-Floor Tower (BCH)	24
Ward Barbour (RBHSC)	23

Fig. 28 shows comparitively high levels of medication incidents reported in wards 07B and 07C in RVH. RVH dispensary had identified a trend in errors from these wards and additional pharmacy staff were allocated to the wards for a week long period to quantify the problem. The vast majority of the incidents recorded were ‘Medication errors during the prescription process’ and resulted in no harm to patients. A report on the results of the audit including recommendations has been shared with the Clinical Director for the area.

The top 3 sub categories above are further broken down by ‘Detail’ in the following 3 graphs.

Fig. 29



There is quite a high proportion of incidents in figure 29 coded as ‘Other medication incident’ however these are regularly checked by the Medicines Governance Pharmacists and there is no other suitable code currently available.

Fig. 30

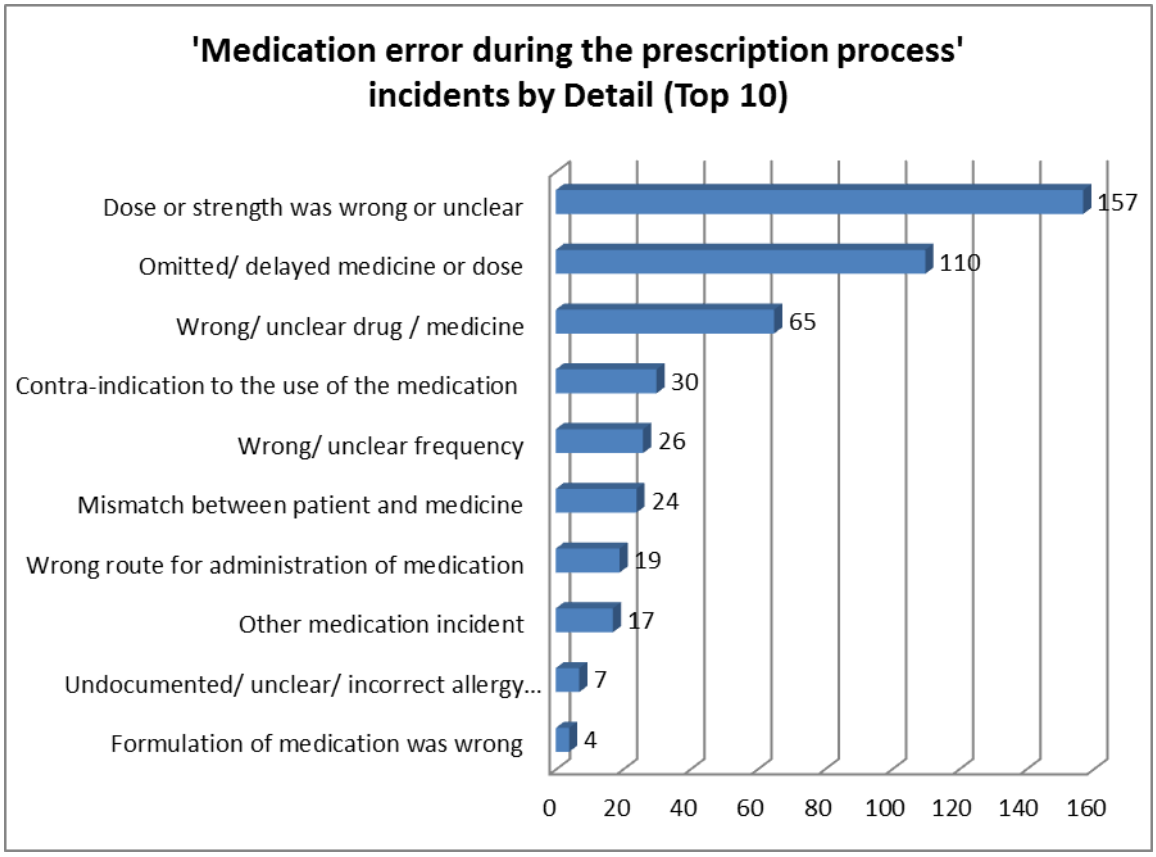

'Medication error during the prescription process' incidents by Detail (Top 10)
Dose or strength was wrong or unclear
157
Omitted/ delayed medicine or dose
110
Wrong/ unclear drug / medicine
65
Contra-indication to the use of the medication
30
Wrong/ unclear frequency
26
Mismatch between patient and medicine
24
Wrong route for administration of medication
19
Other medication incident
17
Undocumented/ unclear/ incorrect allergy...
7
Formulation of medication was wrong
4
0
20
40
60
80
100
120
140
160

Fig. 31

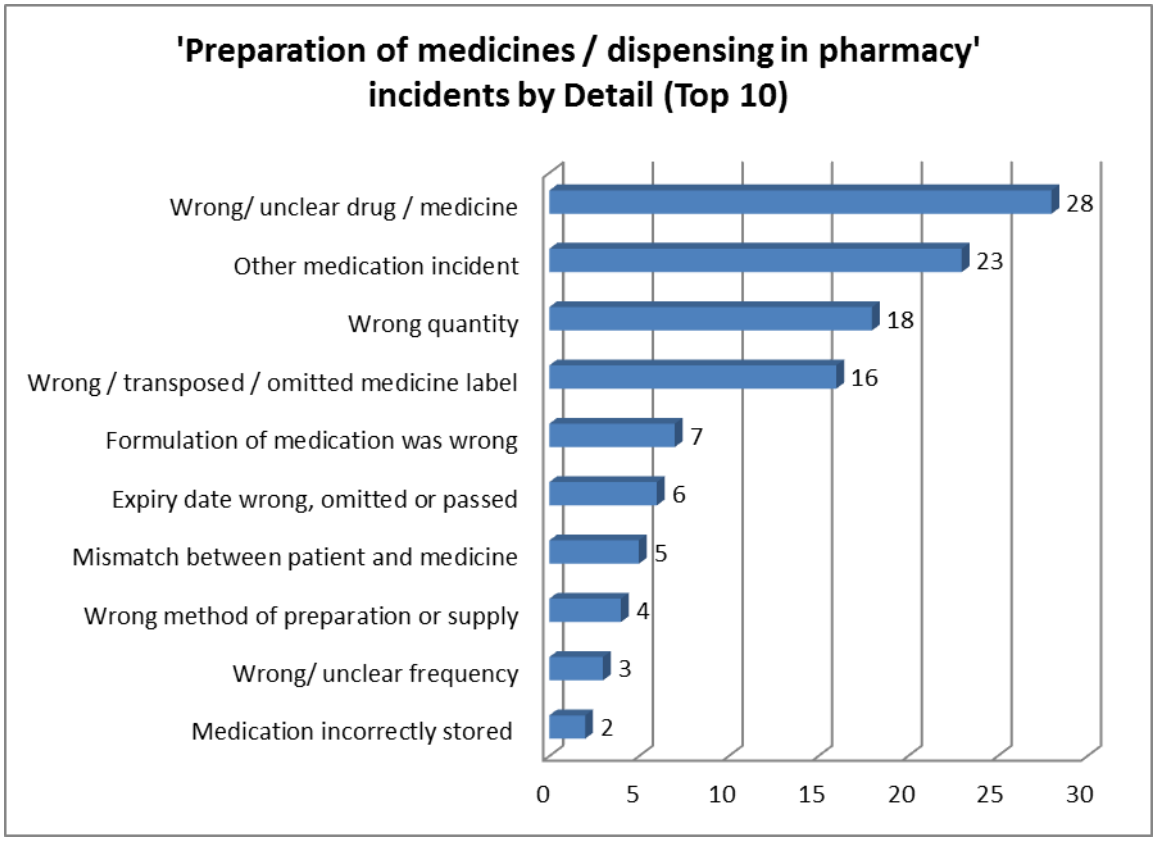

'Preparation of medicines / dispensing in pharmacy' incidents by Detail (Top 10)
Wrong/ unclear drug / medicine
28
Other medication incident
23
Wrong quantity
18
Wrong / transposed / omitted medicine label
16
Formulation of medication was wrong
7
Expiry date wrong, omitted or passed
6
Mismatch between patient and medicine
5
Wrong method of preparation or supply
4
Wrong/ unclear frequency
3
Medication incorrectly stored
2
0
5
10
15
20
25
30

Fig.32

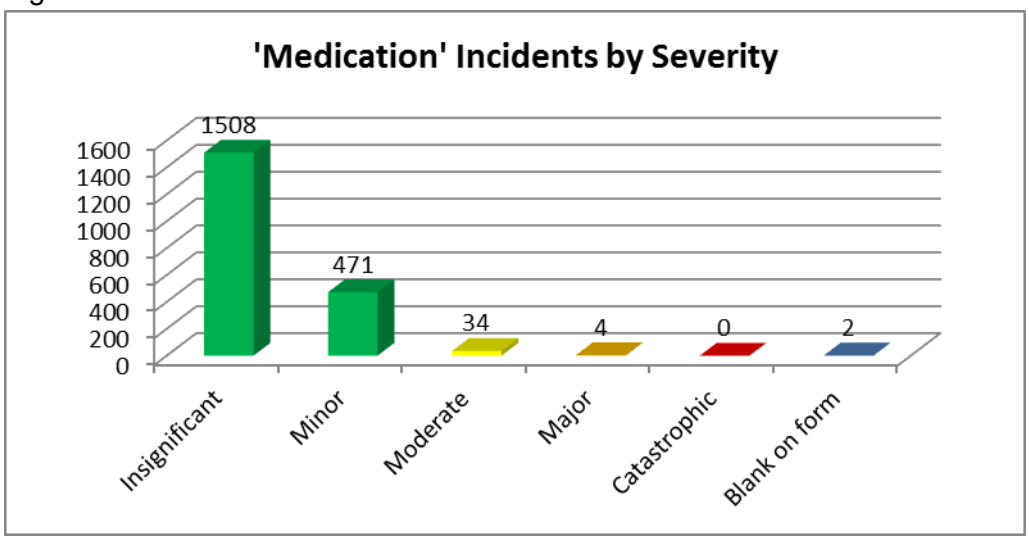


Figure 32 shows that the vast majority of incidents in this category (1,979 or 98%) were of insignificant or minor severity. There were 4 (0.2%) graded as major and none as catastrophic.

Summary of Major / Catastrophic incidents

Major:

- Ref: BHSCT/SAI/14/087 -W57667/ W57686 – Followed up via the SAI procedure.
- Ref: BHSCT/SAI/14/107 - W60722 – Followed up via the SAI procedure.
- Ref: QSAI/W61370 - being queried as an SAI.
- Ref: QSAI/W56081 - being queried as an SAI.

2.4.4 FURTHER BREAKDOWN OF 'ACCESS, APPOINTMENT, ADMISSION, TRANSFER, DISCHARGE' INCIDENTS

Fig. 33

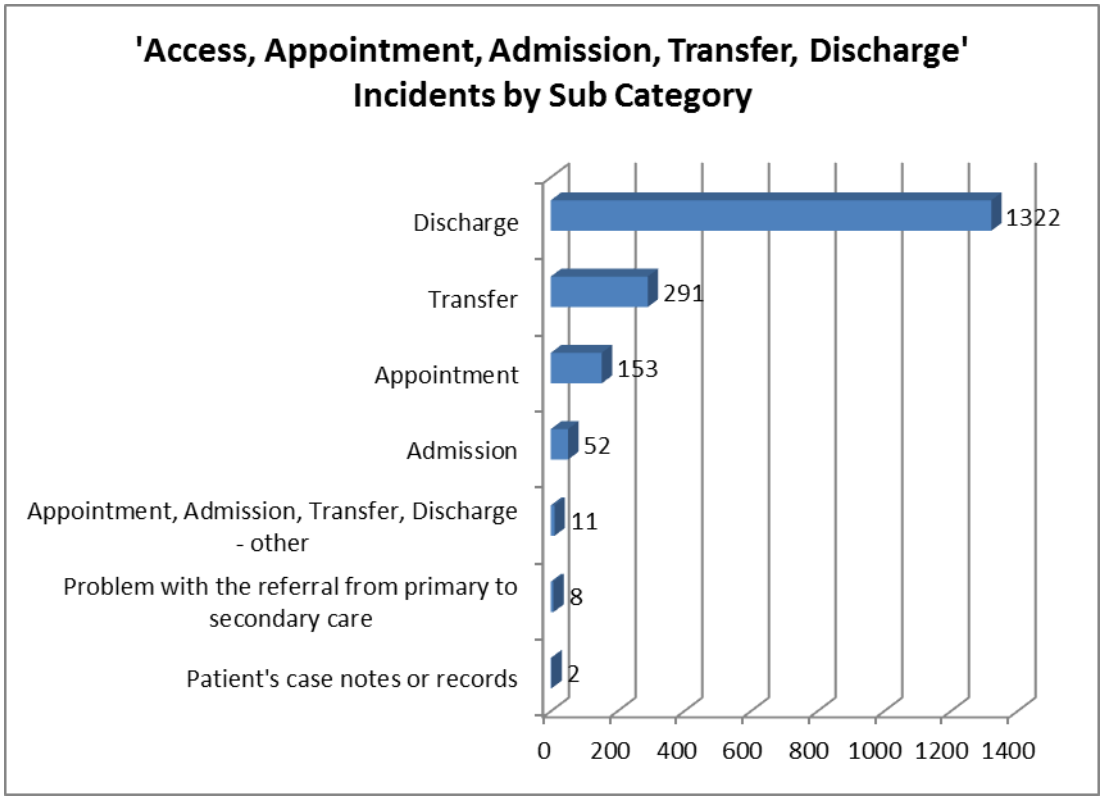


Figure 33 indicates that the majority of incidents in this category, 1,322 (72%), fall into the 'Discharge' subcategory. Of these incidents, 1,148 relate to absconder/missing patient. The code for 'Absconder/missing patient' is only accessible under the 'Discharge' subcategory code therefore any incidents of this nature, whether related to discharge or not, appear here.

Further breakdown of these sub categories are not provided in this report as numbers are relatively small.

Fig. 34

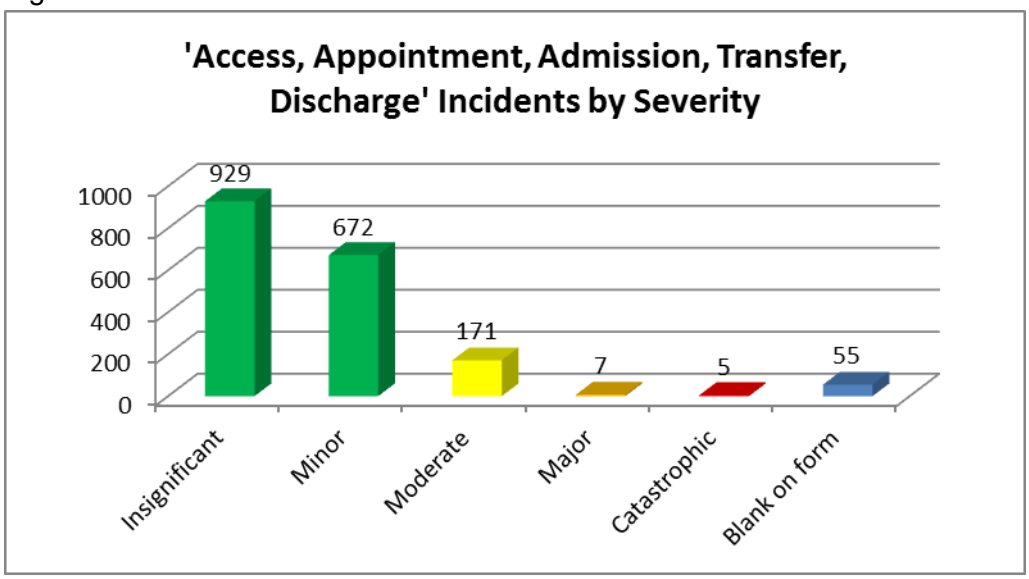


Figure 34 shows that the majority of incidents in this category (1,601 or 87%) were of insignificant or minor severity. There were 12 (0.6%) graded as major or catastrophic.

Summary of Major / Catastrophic incidents

Major:

- Ref: BHSCT/SAI/14/179 - W71086 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/15/014 - W72816 - Followed up via the SAI procedure.
- Ref: BHSCT/II/14/16 - W72361 - Followed up as an interface incident.
- Ref: BHSCT/II/15/06 - W77665 - Followed up as an interface incident.
- Ref: QSAI/W77657 – being queried as an SAI.
- Ref: W74001 – request for investigation sent to NHSCT.
- Ref: W78112 – grading currently being queried.

Catastrophic:

- Ref: BHSCT/II/14/07 - W62342 – Followed up as an interface incident.
- Ref: BHSCT/II/15/05 - Followed up as an interface incident.
- Ref: QII/W78936 – being queried as an interface incident.
- Ref: W69624 – Cardiac arrest of patient following late evening transfer from HDU to ward.
- Ref: W77423 – grading currently being queried.

2.4.5 FURTHER BREAKDOWN OF 'IMPLEMENTATION OF CARE OR ONGOING MONITORING/REVIEW' INCIDENTS

Fig. 35

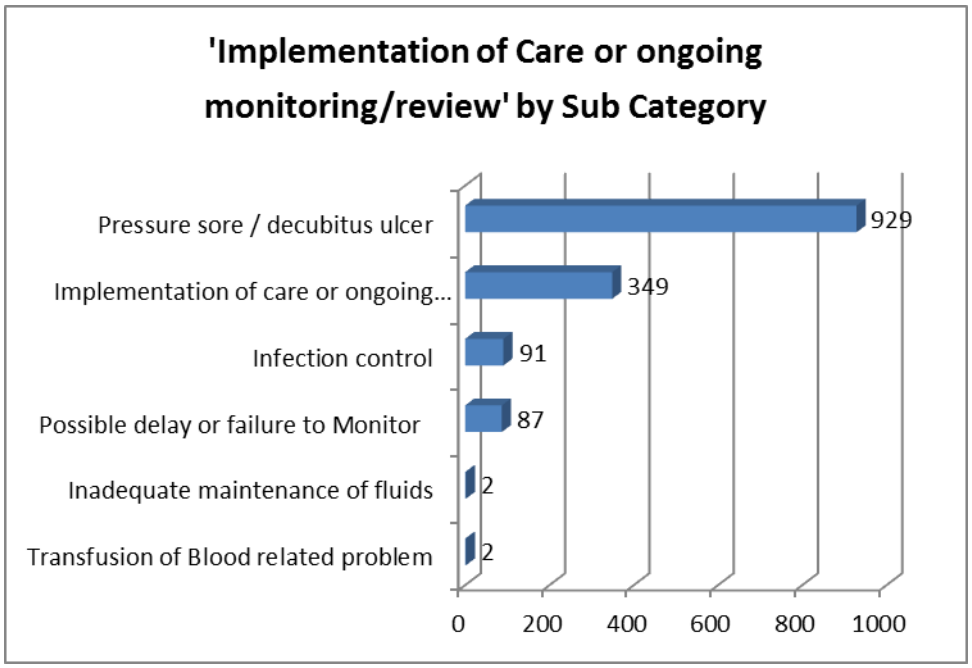


Figure 35 shows that 'Pressure sore / decubitus ulcer' are the most commonly reported incident in this category with 929 incidents. This represents 64% of the incidents in this category.

Further breakdown of these sub categories are not provided in this report as numbers are relatively small.

Fig. 36

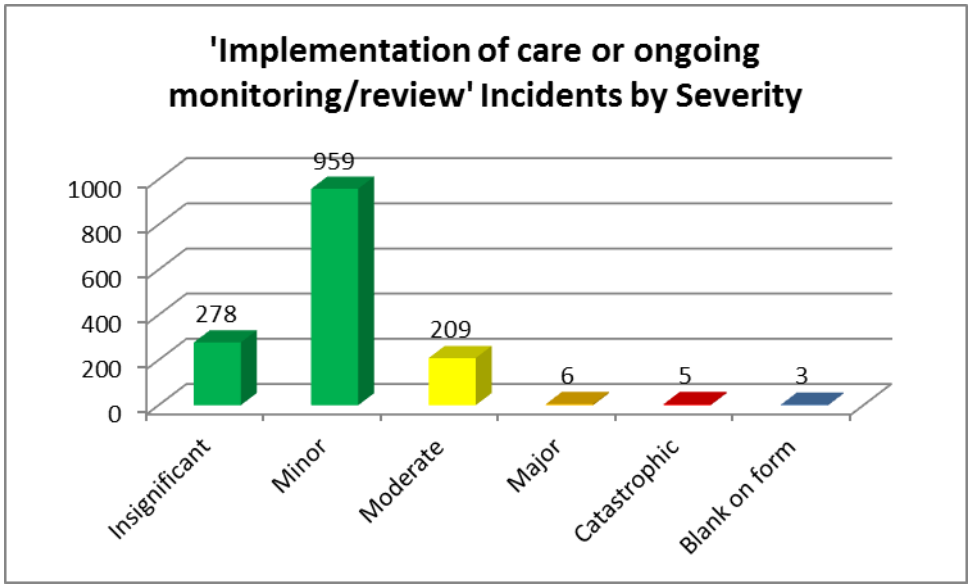


Figure 36 shows that the majority of incidents in this category (1237 or 85%) were of insignificant or minor severity. There were 11 (0.7%) graded as major or catastrophic.

Summary of Major / Catastrophic incidents

Major:

- Ref: BHSCT/SAI/14/058- Followed up via the SAI procedure.
- Ref: BHSCT/SAI/14/095 - W60689 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/15/006 - W70258
- Ref: BHSCT/II/14/09 - Followed up via the SAI procedure.
- Ref: QSAI/W71159 – Being queried as an SAI.
- Ref: W61381 – confirmed MRSA Bacteraemia.

Catastrophic:

- Ref: BHSCT/II/14/12 - W67404 – Followed up as an Interface incident.
- Ref: BHSCT/SAI/14/176 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/15/032 - W78431 - Followed up via the SAI procedure.
- Ref: BHSCT/SAI/14/174 - W71750 - Followed up via the SAI procedure.
- Ref: W64057 – Sudden cardiac arrest of patient who had not been reviewed by medical staff on previous day. Obs stable all day and nursing staff had no concerns.

3. LEARNING

Corporate Governance are currently working on enhancement of the incident investigation section in Datixweb so that approving managers can record contributory factors, learning themes and how learning is being shared. This new section has been piloted in four areas within the Trust and the results of the pilot will be analysed in June 2015.

4. CONCLUSION

Figures throughout this report indicate an increasingly open culture with regard to incident reporting, and improved systems and processes have contributed to increasingly robust data. Incident data is used by a number of specialist groups e.g. Invasive Intervention, Health & Safety, Management of Aggression, Safety Improvement Team to help identify trends and areas requiring focus, and to allow measurement of the impact of incident reduction programmes within the

remit of these groups. Directorates are encouraged to make use of the information to inform trend analysis within their own areas.

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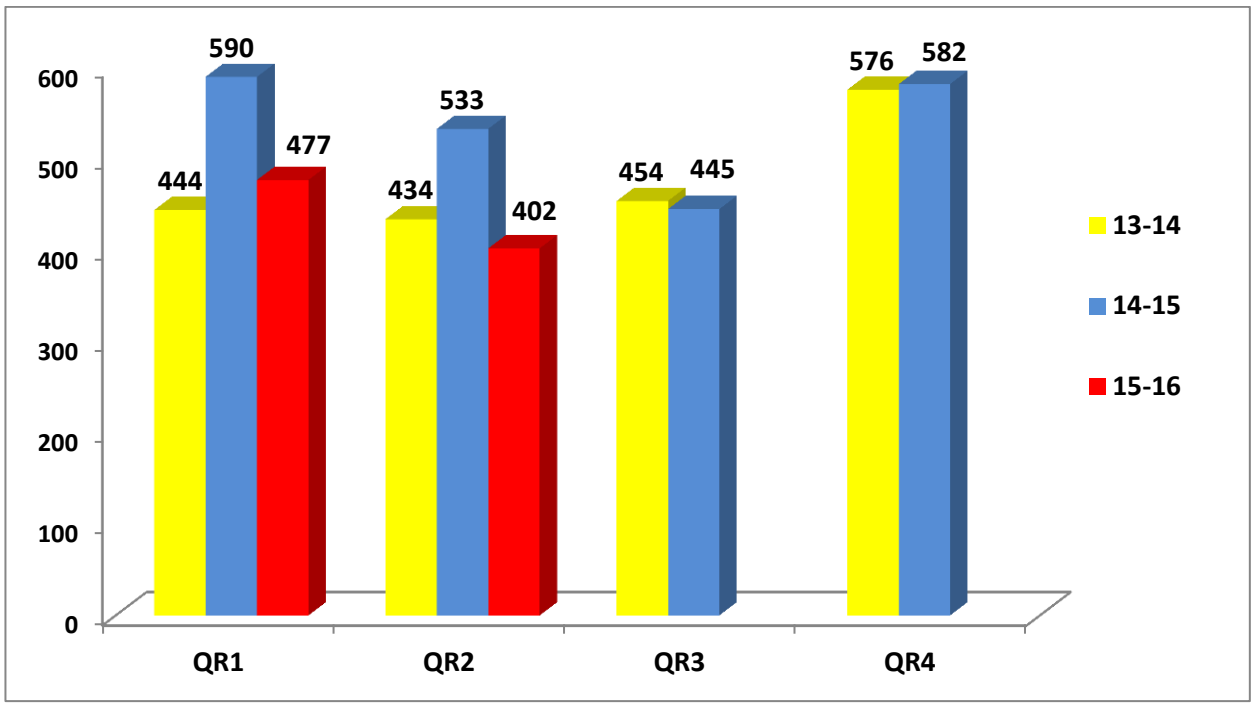
COMPLAINTS & COMPLIMENTS
SUMMARY REPORT
JULY - SEPT 2015

- **A total of 464** formal complaints were received by the complaints team during July – September 2015, QR2. Consent is pending for 54 complaints (12%). A total of 8 complaints relating to the Independent Sector (ISP) were received.. For the purpose of this report complaints without consent and ISP complaints are not included; therefore for statistical purposes information will be provided on 402 complaints.
- Formal complaints for QR2 have decreased by 75 (16%) since the previous quarter**.** On the comparative QR2 2014-15, 465 formal complaints were received which reflects a decrease of 14%.
- The Complaints Department QR2 two working day acknowledgement rate was 96%.
- 157 enquiries were received this quarter representing an increase of 6 (4%).
- 69 complaints were resolved locally by the Service Area which is a decrease of 4 from the previous quarter. The Complaints Department acknowledge an under-reporting of local resolution and will continue to encourage all Service Directorates to complete and forward the Local Resolution forms available via the HUB.
- 2 new Children's Order Complaints were received in QR2 and none revisited.
- 74 formal complaints were revisited during the quarter representing a decrease of 7 (9%) from the previous quarter. 9 enquiries were revisited within this quarter which is a decrease of 5 (36%) from the previous quarter.
- 78 formal complaints were closed over 30 working days. This remains unchanged since the previous quarter. 48 formal complaints remain open over 30 working days (at 18 November 2015) which represents a decrease of 8% from the previous quarter.
- 1435 compliments were received during the quarter which represents an increase of 101 (8%) from the previous quarter. The Complaints Department continues to encourage all areas to report compliments.
- The Complaints Department staff facilitate meetings between Service Groups and Complainants. There have been many positive outcomes from holding meetings with complainants and service group representatives.

The graph below demonstrates the number of complaints received each quarter from Quarter 1, 2013/14 - Quarter 2, 2015/16.



Formal Complaints Response Rates QR2 2015/16

***Figures exclude complaints without consent and ISP complaints 18.11.15**

Service Directorate	No of Formal Complaints Received	No replied to in 20 Working days	No. replied to up to 30 working days	Number QR2 Complaints open at 18.11.15
Specialist Hospitals & Women's Health	150 (-1)	72% (=)	82% (-1%)	19 (+10)
Unscheduled & Acute Care	96 (-44)	38% (-1%)	55% (-3%)	21 (-4)
Surgery & Specialist Services	80 (-18)	63% (+18%)	72% (+13%)	6 (-7)
Adult Social & Primary Care Services	32 (-7)	50% (-6%)	69% (-6%)	0 (-4)
Nursing & User Experience	16 (+3)	44% (-6%)	63% (-20%)	0 (=)
Children's Community Services	12 (-10)	33%(-20%)	67% (-1%)	0 (-1)
Performance Planning & Informatics	10 (-5)	90% (+40%)	100% (+25%)	0(=)
Finance	5 (-4)	20% (-30 %)	20% (-68%)	2 (+2)
Corporate Communications	1 (+1)	100%	100%	0
TOTAL/AVERAGE	402 (+75)	57% (+4%)	70% (+1%)	48 (-4)

The table below highlights the number of enquiries from Q2 2014/15 to Q2 2015/16. There are no significant changes.

Enquiries QR2 2015/16

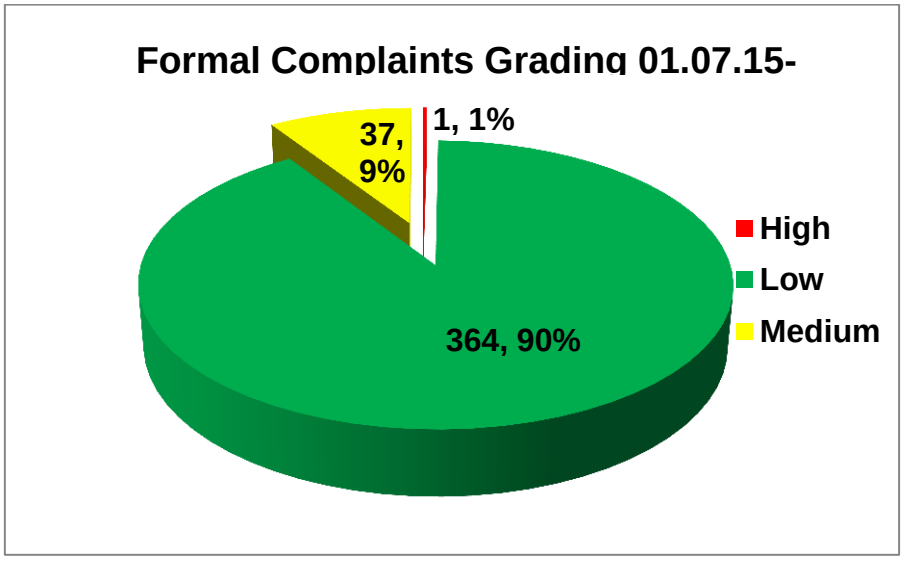
	QR2 2015-16	QR1 2015-16	QR4 2014-15	QR3 2014-15	QR2 2014-15
Adult Social & Primary Care	**37**	**46**	43	33	36
Unscheduled & Acute Care	**35**	**37**	34	24	28
Specialist Hospitals & Women's Health	**38**	**33**	49	43	49
Surgery & Specialist Services	**27**	**16**	18	23	18
Performance, Planning & Informatics	**2**	**5**	4	6	7
Children's Community Services	**7**	**4**	5	5	4
Human Resources	**3**	**4**	1	0	1
Finance	**2**	**3**	4	1	2
Nursing & User Experience	**3**	**2**	1	3	1
Unspecified/ Redirected Non Trust	**3**	**1**	3	2	0
Medical	**0**	**0**	1	2	1
Totals:	**157**	**151**	**163**	**142**	**121**

Formal Complaint Grading QR 2 2015/16

Formal complaints are graded according to the Trust Risk Matrix by Complaints Managers. Complaints Managers review the initial grading throughout the complaints process and grading may change following investigation.

Since the comparative Quarter 2 in 2014/15, there is an increase in Low risk graded complaints, a decrease in Medium graded and High risk remain relatively unchanged.

Grading 01.07.15-30.09.15	QR 2 2015-16	QR1 2015-16	QR4 2014-15	QR 3 2014-15	QR2 2014-15
Low	364 – 90%	393 – 82%	462 – 82%	325 – 73%	355 – 67%
Medium	37 – 9%	81 – 17%	97 – 17%	117 – 26%	168 – 31%
High	1 – 1%	3 -1%	8-1%	3 – 1%	10 – 2%



Formal Complaints Grading QR2 2015/16 by Directorate

Formal Complaints Grading 01.07.15-30.09.15	High	Low	Medium	Total
Adult Social and Primary Care	0	28	4	**32**
Children's Community Services	0	12	0	**12**
Finance	0	5	0	**5**
Nursing and User Experience	0	16	0	**16**
Performance, Planning & Informatics	0	10	0	**10**
Specialist Hospitals & Women's Health	0	128	22	**150**
Surgery and Specialist Services	1	74	5	**80**
Unscheduled and Acute Care	0	90	6	**96**
Corporate Communications	0	1	0	**1**
Totals:	**1**	**364**	**37**	**402**

Response Times as per Grading of Complaint QR2 2015/16

The table below represents the percentage of complaints responded to within the 20 and 30 working day timeframe based on their grading.

Response Time	Low	Medium	High
20 Working Days	**60%**	**35%**	**0%**
30 Working Days	**74%**	**43%**	**0%**

The previous quarter 20 working day timeframe response rate was 54% Low, 44% Medium and 33 % high

Subjects of Formal Complaints QR2 2015/16

The table below represents the top 5 subjects/ reasons for complaints since Q2 2014/15 until Q2 2015/16.

The top 5 subjects have remained the same over the last year, however their position in the top 5 may fluctuate.

Top 5 CH8 Subjects	QR2 15/16	QR1 15/16	QR4 14/15	QR3 14/15	QR 2 14/15
Waiting List, Delay/ Cancellation Outpatient Appointments	**97**	**77**	104	70	78
Quality of Treatment and Care	**74**	**102**	142	80	102
Communication/Information	**73**	**74**	110	80	130
Staff Attitude/ Behaviour	**61**	**73**	94	69	85
Waiting List, Delay/ Cancellation Planned Admission to Hospital	**58**	**64**	109	74	63

Directorate Top 5 Subjects QR2 2015/16

A total of **486** subjects/ reasons for complaint where identified across the Directorates.

The tables below illustrate the Top 5 Subjects for each Directorate and then according to the Service Area.

Directorate Top 5 Subjects

Adult Social & Primary Care Top Subjects 01.07.15-30.09.15 (35 Subjects raised)	CAMHS	Learning Disability	Mental Health	Older Peoples Service - Intermediate Care and Mental Health &Elderly Care wards KHP & MPH	Older Peoples Service - NW and Elderly Care wards RVH and MIH	Older Peoples Service - SE & Elderly Care wards BCH	Physical Disability	Total
Quantity of Treatment and Care	0	0	0	0	0	4	0	**4**
Staff Attitude/ Behaviour	1	1	1	0	2	0	0	**5**
Quality of Treatment and Care	1	1	1	0	1	2	1	**7**
Communication/ Information	0	0	1	1		2		**4**
Discharge/Transfer Arrangements	0	0	1	0	1	1		**3**
Property/Expenses/Finance	0	0	0	0	2		1	**3**
Totals:								**26**

Within Older People Services there are fewer complaints related to Quality and Quantity of Treatment and Care since the previous Quarter.

Children's Community Services Top 5 Subjects

Children's Community Services Top Subjects 01.07.15-30.09.15 (13 Subjects raised)	Children's Community Services Admin	Community Child Health	EDT Social Work Service	Family and Child Care	Social Work Care	Total
Staff Attitude/ Behaviour	1	1	0	4	1	**7**
Communication/ Information	0	0	0	3	1	**4**
Waiting List Delay/Cancellation Community Based Appointments	1	2	0	7	0	**10**
Totals:						**21**

The increase in subjects relating to Waiting List Delay etc. concerns children waiting for autism assessments.

Finance Top 5 Subjects

Finance Top 5 Subjects 01.07.15-30.09.15 (5 subjects raised)	Accounting and Financial Services	Estates	Total
Access to Premises	0	1	**1**
Property/ Expenses/ Finances	3	0	**3**
Environmental	0	1	**1**
Totals:			**5**

No significant change noted.

Nursing and User Experience Top Subjects

Nursing and User Experience Top Subjects 01.07.15-30.09.15 (16 Subjects Raised)	Patient and Client Support Services - Belfast City Hospital	Patient and Client Support Services - North and West and Mater	Patient and Client Support Services - Royal	Patient and Client Support Services - South and East and Greenpark	Total
Access to Premises	0	0	2	0	**2**
Staff Attitude/ Behaviour	0	1	3	1	**5**
Hotel/ Support/ Security Services (Excludes Contracted Services)	4	0	4	0	**8**
Totals:					**16**

No significant change noted.

Performance Planning and Informatics

Performance Planning and Informatics Top Subjects 01.07.15-30.09.15 (Subjects Raised)	Performance Management	Info Tech and Telecommunications	Total
Communication/ Information	5	1	**6**
Confidentiality	2	0	**2**
Waiting List, Delay/ Cancellation Outpatient Appointments	2	0	**2**
Totals:			**10**

No significant change noted.

Specialist Hospitals and Women's Health

Specialist Hospitals and Women's Health Top Subjects 01.07.15-30.09.15 (191 Subjects Raised)	Acute and Community Paediatrics	Dental Services	ENT Services	Neuro-Rehabilitation Services	Trauma and Orthopaedics	Women's and Maternity	Total
Waiting List, Delay/ Cancellation Planned Admission to Hospital	4	0	0	0	24	7	**35**
Waiting List, Delay/ Cancellation Outpatient Appointments	6	0	4	0	39	5	**54**
Quality of Treatment and Care	4	1	3	0	9	7	**24**
Communication/ Information	5	0	2	0	9	9	**25**
Staff Attitude/ Behaviour	2	0	1	0	6	7	**16**
Totals:							**154**

Waiting list, Delay/Cancellation Planned Outpatient Appointments within Trauma and Orthopaedics has increased since the previous quarter from 38 to 54.

Surgery and Specialist Services

Surgery and Specialist Services Top Subjects 01.07.15-30.09.15 (97 Subjects Raised)	Cancer Services	Laboratories Services	Specialist Medicine	Surgery	Total
Communication/ Information		4	3	15	**22**
Waiting List, Delay/ Cancellation Planned Admission to Hospital				22	**22**
Waiting List, Delay/ Cancellation Outpatient Appointments		3	6	8	**17**
Quality of Treatment and Care	1	1	1	9	**12**
Staff Attitude/ Behaviour		1		5	**6**
Totals:					**79**

Waiting list, Delay/Cancellation Planned Admission to Hospital for Surgery has reduced since the previous quarter from 32 to 22.

Unscheduled & Acute Care

Unscheduled & Acute Care Top Subjects 01.07.15-30.09.15 (114 Subjects Raised)	ACCTSS	Allied Health Professionals	Emergency Dept, Medical & Cardiology Services	Imaging	Neurosciences	Total
Quality of Treatment and Care	0	3	21	2	4	**30**
Staff Attitude/ Behaviour	0	2	17	1	0	**20**
Waiting List, Delay/ Cancellation Outpatient Appointments	0	5	6	3	8	**22**
Communication/ Information	0	0	9	2	1	**12**
Waiting Times, Outpatient Departments	1	0	7	1	1	**10**
Totals:						**94**

Quality of Treatment and care within Emergency Department, Medical & Cardiology Services has reduced since the previous quarter from 34 to 21.

Formal Complaints by Site QR2 2015/16

The table below indicates only minor changes in numbers of complaints received since July-September 2014/15.

By Site	Jul/Sept 15		Apr/Jun 15		Jan-Mar 15		Oct/Dec 14		Jul/Sept 14	
RVH	**164**	**41%**	217	46%	225	39%	177	40%	212	40%
BCH	**67**	**17%**	79	17%	107	18%	94	21%	111	21%
Community	**59**	**15%**	81	17%	95	16%	61	13%	91	17%
MPH	**83**	**21%**	65	14%	112	19%	68	15%	70	13%
Mater	**25**	**6%**	3	6%	30	5%	18	4%	31	6%
Knockbracken	**1**	**-**	2	-	5	1%	4	-	3	-
Foster Green	**2**	**-**	1	-	4	1 %	4	-	2	-
Muckamore	**1**	**-**	2	-	4	1%	4	-	3	-

Revisited Complaints QR2 2015/16

Formal complaints may be revisited either within the quarter they are raised and closed, or beyond the initial quarter. There are various reasons for revisiting a complaint which can include - disagreement with the response provided, request for additional information or for further investigation, request to meet with Trust staff and other stakeholders or the complaint may proceed to an Ombudsman consideration case.

The Complaints Department are planning to conduct an Audit within the next three months to identify the specific reasons for revisits.

The table below lists the number of revisit complaints within Directorate Specialities.

Legend:
Green: Decrease from last comparable quarter
Amber: No change from last comparable quarter
Red: Increase from last comparable quarter
N/A: No comparable figure available

Revisits - Quarter 2 (01.07.15-30.09.15)	Adult Social and Primary Care	Children's Community Services	Finance	Nursing and User Experience	Performance, Planning & Informatics	Specialist Hospitals & Women's Health	Surgery and Specialist Services	Unscheduled and Acute Care	Total	
Orthopaedics	0	0	0	0	0	15	0	0	15	
Gynaecology and Sexual and Reproductive Healthcare	0	0	0	0	0	7	0	0	7	N/A
Emergency Departments	0	0	0	0	0	0	0	3	3	
Acute Neurology	0	0	0	0	0	0	0	3	3	
Acute Services	2	0	0	0	0	0	0	0	2	
Children's Hospital (RBHSC)	0	0	0	0	0	5	0	0	5	
Maternity Services	0	0	0	0	0	4	0	0	4	
Safeguarding/ Family Support	0	2	0	0	0	0	0	0	2	
Urology	0	0	0	0	0	0	1	0	1	
Breast Surgery	0	0	0	0	0	0	1	0	1	N/A
Cardiac Surgery	0	0	0	0	0	0	1	0	1	N/A
Dermatology	0	0	0	0	0	0	1	0	1	

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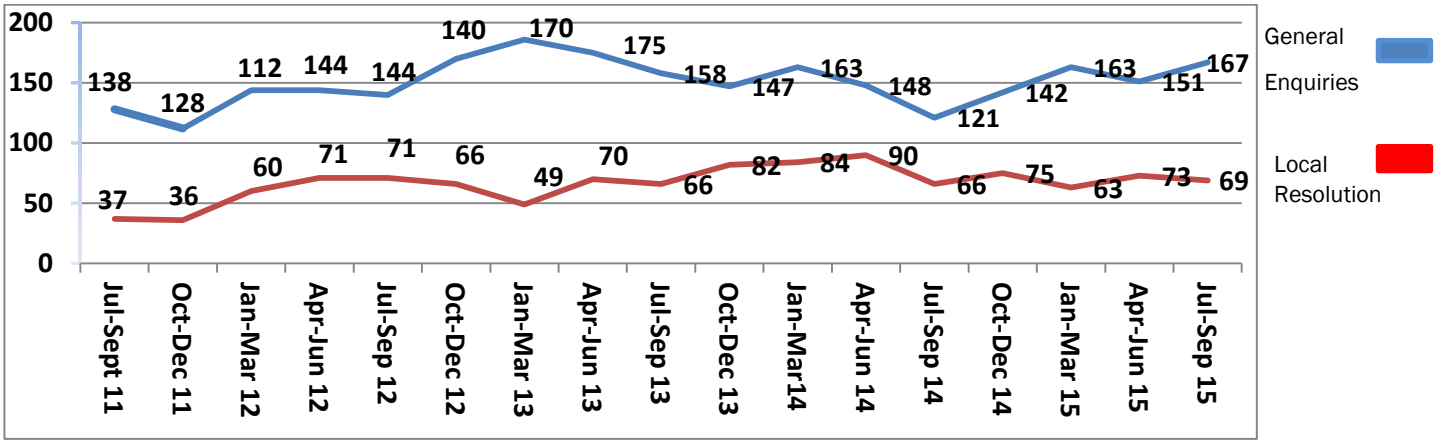
Revisits - Quarter 2 (01.07.15-30.09.15)	Adult Social and Primary Care	Children's Community Services	Finance	Nursing and User Experience	Performance, Planning & Informatics	Specialist Hospitals & Women's Health	Surgery and Specialist Services	Unscheduled and Acute Care	Total	
General Surgery	0	0	0	0	0	0	2	0	2	
LAC, Leaving and Aftercare	0	1	0	0	0	0	0	0	1	
Nursing Homecare Service	1	0	0	0	0	0	0	0	1	
Adult Cardiology Services	0	0	0	0	0	0	0	1	1	
Community Child Health	0	1	0	0	0	1	0	0	2	N/A
Care Management	1	0	0	0	0	0	0	0	1	N/A
Dentistry	0	0	0	0	0	3	0	0	3	
General Medicine	0	0	0	0	0	0	0	3	3	
Home Help Service	1	0	0	0	0	0	0	0	1	
Hospital Services	1	0	0	0	0	0	0	0	1	
Medical and Clinical Oncology	0	0	0	0	0	0	2	0	2	
Dietetics	0	0	0	0	0	0	0	1	1	N/A
Ophthalmology	0	0	0	0	0	0	2	0	2	
Pain Service	0	0	0	0	0	0	0	2	2	
Radiology	0	0	0	0	0	0	0	3	3	
Regional Disablement Service	0	0	0	0	0	1	0	0	1	
Environmental Cleanliness	0	0	0	1	0	0	0	0	1	N/A
Vascular Surgery	0	0	0	0	0	0	1	0	1	
Totals:	**6**	**4**	**0**	**1**	**0**	**36**	**11**	**16**	**74**	

Enquiries and Local Resolutions QR2 2015/16

"Enquiries" are mainly received by telephone by the Complaints Department staff. These concerns are not subject to the HSC Complaint's Procedure and may be resolved relatively quickly. Examples include; enquiries about position on the waiting list, clients unable to contact specific wards/departments and clients who specifically request that their concerns are not dealt with as a complaint.

The Trust continues to encourage staff to resolve concerns locally (Local Resolution) at "first point of contact" or service level. These concerns are recorded by the Complaints Department as "Local Resolution". However, service users may subsequently request that their concerns are further investigated formally under HSC Complaints Procedure.

The table below indicates that there has been no significant change over the last four years in the combined numbers of Enquiries and Local Resolution concerns raised.



Enquiries - Top 5 Subjects QR 2 2015/16

The table below indicates top 5 subjects for enquiries by Directorate

Enquiries 01.07.15 - 30.09.15 (Top 5 Subjects)	Adult Social and Primary Care	Children's Community Services	Finance	Human Resources	Nursing and User Experience	Performance, Planning & Informatics	Specialist Hospitals & Women's Health	Surgery and Specialist Services	Unscheduled and Acute Care	Total
Communication/ Information	0	2	0	1	0	1	8	13	8	**33**
Quality of Treatment and Care	7	2	0	0	1	0	6	3	4	**23**
Waiting List, Delay/ Cancellation Outpatient Appointments	0	0	0	0	0	0	11	4	7	**22**
Staff Attitude/ Behaviour	7	1	0	1	0	0	4		1	**14**
Quantity of Treatment and Care	11	0	0	0	0	0	0	0	0	**11**

Children Order Representation and Complaints Procedure

Complaints managed under the Children Order Representation are not subject to the HSC Complaint Procedure 20 Working Day response timeframe and these complaints are not included in the performance figures at Page 2 of this report.

Children Order Complaints are often complex and should be responded to within 28 days. They can progress to Stage 1 or Stage 2.

During the period July – September 2015, two new Children Order complaints were received in relation to bullying in a Children's Home and both have been satisfactorily resolved.

Independent Sector Complaints (ISP)

When an ISP complaint is received by the Trust, the ISP is given the opportunity in the first instance to respond to the Complainant, unless the Complainant specifically requests that the Trust should investigate their concerns.

Work continues within the Trust and regionally on how best to manage and monitor ISP complaints.

8 ISP complaints were received during the quarter; 2 were in relation to delayed treatment and 1 related to a patient's wait for his scan. 5 complaints regarding care provided by independent nursing homes were received.

Service Directorate Compliments QR2 2015/16

1435 compliments were recorded this quarter which is an increase of 8% on the previous quarter.

Proformas for staff to record compliments are available via the Trust Intranet (the Hub). Compliments are also received by email/letters/telephone call to the Complaints Department, Trust HQ and social media. The Complaints Department's internet site is currently being reviewed to enable ease of access for service users to report compliments.

Compliments received by Directorate QR2 2015/16

Directorate	QR2 15-16	QR1 15-16	QR4 14-15	QR3 14-15	QR2 14-15	QR1 14-15	QR4 13-14	QR3 13-14	QR2 13-14
Surgery & Specialist Services	202	631	400	321	574	148	167	383	393
Adult Social & Primary Care	657	400	472	483	163	159	383	413	328
SH&WH	323	196	201	648	197	323	206	517	132
Unscheduled & Acute Care	235	160	84	138	5	22	129	225	643
Children's Community Services	14	17	17	170	115	1	5	95	6
Nursing and User Experience	1	2	0	0	0	0	0	0	5
Performance, Planning & Informatics	0	1	0	0	0	1	0	0	0
Medical	3	1	1	0	0	0	2	0	0
Finance	0	0	0	0	0	0	0	0	1
Human Resources	0	0	0	0	0	0	0	0	0
TOTAL	**1435**	**1334**	**1175**	**1760**	**1054**	**654**	**892**	**1633**	**1508**

Compliments received within Adult Social & Primary Care have increased from 163 to 657, Specialist Hospitals & Women's Health have increased from 197 to 323 and Unscheduled & Acute Care have increased from 5 to 235. Surgery & Specialist Services have reduced from 574 to 202. There continues to be under reporting of compliments.

Learning from Compliments

Example 1
A compliment was received from a patient who had to receive emergency surgery and treatment on Ward 4F. The patient commented on everyone involved "they are all my heroes!" The patient was treated with the upmost respect at all times, was kept fully informed at every stage and had no doubt that all staff worked hard for his recovery. His family were kept informed and encouraged throughout by the staff. During the patient's 12 day stay on Ward 4F he observed that all patients were treated with the same caring attitude and attention to detail. Follow up care at Musgrave Park Hospital was efficient and surgical and the rehabilitation consultants were friendly, informative, encouraging and supportive.

Example 2
A compliment was received from the Northern Ireland Lay Magistrates' Association concerning training delivered by a member of Children's Services staff. 27 Lay Magistrates attended, the majority of whom sit in the Belfast Youth and Family Courts.

Example 3
Theatre staff and Ward 28 staff were commended for their professionalism whilst working under pressure.

Example 4
Patient on Ward 6A Vascular commended staff for their professional and caring attitude even though the patient observed how busy they were. The Patient wants to make a donation to the staff comfort fund in gratitude for the care received.

Example 5
The care provided by the stoma nurse in the community following surgery for bowel cancer was commended. The nurse took time to talk through the procedure, encouraged questions and explained the stoma, at no time did the patient feel rushed and the attention provided allowed to confidentially manage the bag cutting, cleaning and care of the stoma.

Example 6
This patient's daughter had previously made a complaint about her father's treatment in ED last year. She wanted to redress the balance and praise both medical and nursing staff on Ward 5D for their professionalism.

NI Ombudsman Complaints/Enquiries

Requests for Information / Consideration Stage

During QR2 2015/16 6 new complaints were received from the Ombudsman's Office:

New NI Ombudsman 01.07.15-30.09.15	Adult, Social & Primary Care	Surgery & Specialist Services	Unscheduled and Acute Care	Total
General Surgery	0	2	0	**2**
Urology	0	2	0	**2**
General Medicine	0	0	1	**1**
Community Facilities	1	0	0	**1**
Totals:	**1**	**4**	**1**	**6**

NIO Active Cases at 18.11.15	Ombudsman - Information	Ombudsman - Consideration stage	Ombudsman - Investigation stage	Total
Adult Social & Primary Care		3	2	**5**
Surgery and Specialist Services		1	1	**2**
Unscheduled and Acute Care	1	1	1	**3**
Specialist Hospitals & Women's Health		1	2	**3**
Totals:	**1**	**6**	**6**	**13**

Closed Cases QR2 2015/16

7 Ombudsman cases were closed within this quarter, 4 were not upheld and 3 were upheld.

Service Improvement/Developments QR2 2015/16

- To date 618 staff have received Complaints Awareness training. There continues to be positive feedback from participants including a greater awareness of the complaints process and the importance of "face to face" local resolution. The Complaints Department is currently exploring an electronic training package. This will enable many more of our employees to access training.

- Review of the Datix Complaints module continues. The Datix Administrator and Complaints Administrative officer are reviewing the Datix complaints module to improve data inputting procedures. This will ultimately lead to increased efficiency within the department and improve the production of reports for Service Groups. It will also contribute to the introduction of Datixweb.

- A telephone "feedback" questionnaire remains on-going. To date we have contacted 40 complainants to review their experience of the Complaints Process. The Trust's Audit Office has agreed to analyse the data and compile a report on the findings

- .Internal Audit has conducted an audit of the Complaints Procedure involving both the Complaints Department and Service Areas.

- A review of the Complaints Department by the Management Leadership Centre is expected to commence on 30 November 2015.

- An Ombudsman Workshop on 11 December 2015 is planned for Senior Clinicians.

annual report and accounts 2014/15

Belfast Health and Social Care Trust

Belfast Health and Social Care Trust
Annual Accounts
for the year ended 31 March 2015

Laid before the Northern Ireland Assembly under Article 90 (5)
of the Health and Personal Social Services (NI) Order 1972
(as amended by the Audit and Accountability Order 2003)
by the Department of Health, Social Services and Public Safety
on
30th June 2015

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This document is available in alternative formats on request

Chairman's foreword

This is the eigth annual report for Belfast Health and Social Care Trust, and I am pleased to report that we have met our financial commitments in a year of continued financial pressure.

I have been Chairman of Belfast Trust for just over a year, and during that time it has been my privilege to gain a more comprehensive insight to what is a very large and complex organisation. We are one of the largest healthcare providers in the United Kingdom providing health and social care to the population of greater Belfast and part of Castlereagh, as well as most of the regional specialties for Northern Ireland.

I have been very struck by the level of commitment from the staff sometimes in the face of intense pressure and serious media scrutiny. These are people who put the patient at the heart of decision-making and constantly strive to put patients and clients first.

For example' we have a consultant-led team working with GP colleagues to meet the acute needs of older people, with rapid assessment, advice and intervention, providing an alternative to hospital admission. If they need a hospital admission, BCH-Direct is a new service facilitating direct access for frail elderly who would otherwise have to attend the Emergency Department.

SCREAM (Standardised Critical Care Resuscitation and Emergency Airway Management) is a course developed for critical care nurses, to equip them with the necessary skills and knowledge to deal with emergency situations. It originated in the Regional Intensive Care Unit and has been so successful it is now being rolled out to other parts of the hospital.

Sometimes the innovation does not have to be high tech, but just requires a human touch. Like the support service for bereaved families instigated in the Intensive Care Unit, but being rolled out in other areas of the Trust, or the HIV users forum which actively invites views of the service users on how the HIV service could be improved.

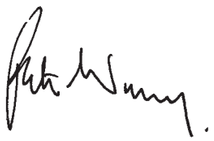
In the community we have established family support hubs across Belfast representing the implementation of one of the 'signature projects' outlined by the Office of First Minister and Deputy First Minister (OFMDFM) in keeping with the Early Intervention and 'Delivering Social Change' agenda.

These are just a few 'snapshots' of excellence and innovation. The pages that follow give a flavour

Chairman's foreword

of the wide ranging support that staff in Belfast Trust provide to the entire population of Northern Ireland. Our work ranges from helping frail elderly to maintain their independence to finding new ways of treating fractures in young children, from establishing new pathways to treat ST segment Myocardial Infarction (STEMI) more quickly, to supporting our 'looked after children' into the world of employment.

I would like to thank my non executive colleagues on the board of directors as well as the executive team for their continued support. Thank you to Martin Dillon for his caretaker role as acting Chief Executive (July 2014 – December 2014), and welcome to Dr Michael McBride who took up post as Chief Executive in December 2014.



Peter McNaney
Chairman
Belfast Trust

Chief Executive's report

I have been in the post of Chief Executive of Belfast Trust since December 2014, although having spent several years in the Royal Hospitals as Medical Director and as a practicing consultant before that, in many ways it felt like a return to familiar places and people.

The scale and complexity of this vast organisation touches the lives of so many people every day. Belfast Trust is often defined by numbers. A budget of £1.2bn with a daily spend of around £3m; 22,000 staff; 8,000 meals a day; 33,000 district nurse visits a year; 150,000 inpatients; 130,000 outpatients; 75,000 day cases; 7,000 care packages. Numbers however do not begin to tell the full story, and we must never fail to remember that behind these numbers are people, their stories and experiences.

The Belfast Trust has a clear job – to give the best possible care as a team and to provide this care with dignity and respect in a timely and safe way. We must put patients and clients first each time and every time. At the heart of what we do is a real person, a person with fears, hopes and dreams, not a statistic or a number. As an organisation we are connected by our values as caregivers. People depend on us and our values must underpin and determine all that we do.

The entire health system in Northern Ireland came under immense pressure this winter, and this was felt right across our inpatient acute and community teams. These challenges were felt most acutely by our fracture and Emergency Department (ED) teams and in RBHSC ED and paediatric intensive care, however with consequences across the Trust in all services. I saw tremendous efforts made by every team across the Trust to ensure that the sickest and most vulnerable were seen and treated as quickly as possible, a good example of a connected organisation where patient and client care came first and above all every time. Staff met, and continue to meet these challenges head-on, looking for ways to continuously improve the service that we provide.

Over the last number of months I have met with many staff across the Trust and have witnessed first hand advances in medical science, new technology, techniques and treatments that are improving the lives of those we care for. But on top of that there is the human element, the staff I have met who really do put patients first each time, every time and above all else. As one patient said to me when I was on a ward recently, '....they make me safe, in control again, as if I am the most important person that day...'

In February we launched 'Let's talk Trust' – an internal consultation to redefine what it is Belfast

Chief Executive's report

Trust stands for, what is important to us and what guides us. On the wider stage, the Donaldson Report (The Right Time, The Right Place) which was published this year offers us a unique opportunity to shape the health service of the future. The Belfast Trust has engaged fully with the consultation, as we look for scope to improve what we do. Looking forward, the demands on us continue to grow and resources will not keep pace, so we all must find innovative ways to deliver the best possible service with what is available to us.

Our overarching task is to improve the health of the population we serve, enhance the experience of care and make best use of the resources we have. Our main focus must be continuous improvement so that we are in a more resilient position next winter. Improvement is our responsibility and we need to redouble our efforts to radically overhaul how some of our services are provided. We must improve the delivery of unscheduled care and achieve a balance between scheduled and unscheduled care. It is not acceptable that one element of our service at times negatively affects another disadvantaging those awaiting elective care – this is not consistent with our values, is not sustainable, and is not improving the lives of the people who need us.

While I recognise that resources are tight, rather than dwell on what we don't have, our focus should be on what we can do with what is available. We must make every penny work for our patients and clients and not be constrained by what we can't do rather motivated by what we can do. There is no alternative – no Plan B!

I would like to pay particular tribute to Martin Dillon who more than fulfilled the role of acting Chief Executive in the months following the departure of Colm Donaghy in July 2014. Martin provided a steady hand on the tiller, and he has now reverted to his previous and valued role as Director of Finance and Deputy Chief Executive. My sincere thanks also to our Chairman Peter McNaney for his continued ambition for this organisation and his energy and support.

As Sir Liam Donaldson says: 'Daring to do the right thing is not always easy in health and social care.' I am confident that the people who make Belfast Trust what it is, have the courage and commitment to do that, and I am proud to stand with them as we continue to transform our services to give the best possible care and to provide this care with dignity and respect.

Dr Michael McBride
Chief Executive
Belfast Trust

Director's report

Introduction

Belfast Trust delivers integrated health and social care to approximately 340,000 citizens in Belfast and part of the Borough of Castlereagh. We also provide a range of specialist services to all of Northern Ireland. With an annual budget of £1.2bn and a workforce around 22,000 (full time and part time) we are one of the largest Trusts in the United Kingdom.

Adult Emergency Department Services (ED) saw 128,580 people this year; 82,959 in Royal Victoria Hospital and 45,621 in the Mater Hospital. In our hospitals in 2014/15 we delivered 6,141 babies. In the community we are corporate parents to 742 children in care, the majority in foster care. We are also responsible for 382 children on the child protection register. There were 7,355 care packages in place as of 31 March 2015 within older people services. 739 through residential care, 1,797 through nursing home care and 4,819 through domiciliary care packages.

We deliver a range of both community and hospital based care including cardiology, anaesthetics and theatre services, medicine and neurosciences, cancer services, nephrology and transplant services, rheumatology, dermatology and neurorehabilitation services, adult social and primary care incorporating learning disability, mental health services, services for older people, physical and sensory disability services and psychological services, maternity and women's services, dentistry and child health, trauma and orthopaedics, children's community services, and social work services.

Board of Directors

i. Non-Executive Directors

- Mr Peter McNaney – appointed March 2014
- Mr Les Drew
- Mr Tom Hartley
- Mr Charlie Jenkins
- Dr Val McGarrell
- Mr James O'Kane

ii Executive Directors

- Dr Michael McBride appointed December 2014; Mr Martin Dillon, Interim Chief Executive – July-December 2014; Mr Colm Donaghy, Chief Executive – resigned June 2014
- Miss Brenda Creaney, Director of Nursing and User Experience

- Mr Martin Dillon, Director of Finance and Estate Services / Deputy Chief Executive
- Mr Cecil Worthington, Director of Social Work / Children's Community Services
- Dr Cathy Jack appointed August 2014; Dr Tony Stevens, Medical Director – resigned July 2014

iii Directors

- Mr Damian McAlister appointed August 2014; Mrs Marie Mallon, Deputy Chief Executive/ Director Human Resources – retired July 2014
- Mr Brian Barry, Director of Specialist Hospitals and Women's Health
- Mrs Bernie Owens, Director of Unscheduled and Acute Care
- Ms Catherine McNicholl, Director of Adult, Social and Primary Care
- Mrs Jennifer Welsh, Director of Surgery and Specialist Services
- Mr Shane Devlin, Director of Planning, Performance and Informatics
- Mrs Maureen Edwards, acting Director of Finance – July–December 2014

A declaration of Board Members' interests has been completed and is available on request from the Chief Executive's office, Belfast Health and Social Care Trust headquarters, A Floor, Belfast City Hospital, 51 Lisburn Road, Belfast BT9 7AB. The executive and senior management of the Trust, along with the Director of Finance of the Trust have the responsibility for the preparation of the accounts and Annual Report. They have provided the auditors with the relevant information and documents required for the completion of the audit. The responsibility for the audit of the Trust rests with the Northern Ireland Audit Office.

The Chief Executive has confirmed there is no relevant audit information of which the Trust's auditors are unaware. A full Governance Statement is available from the Chief Executive's office.

The Directors confirm that they have taken steps to ensure they are aware of the relevant audit information, and have established that the Trust's auditors are aware of the information.

The notional cost of the audit for the year ending 31 March 2015 which pertained solely to the audit of the accounts is £74,700 made up as follows, public funds £69,500 and Charitable Trust Funds £5,200.

During the year the Trust purchased no non-audit services from its external auditor.

Managing attendance

Belfast Trust recognises that the health and well being of the workforce is critical to the effective functioning of the organisation. The health of employees directly affects the quality of patient and client care and with this in mind the Trust continues to view the management of attendance as a corporate priority. During the period the Trust continued to work towards meeting the target of reducing absence levels to 5% by March 2015.

It is recognised that Mental Health-related (25%) and Musculoskeletal (17.5%) conditions are key causes of absence and these have been specifically targeted in 2014/15 through a range of initiatives including Early Intervention Physiotherapy Service, Guidance and Support Leaflets on Mental Health in the workplace, Clinical Psychology Services, Condition Management Programme, the Here4U programme, training and support for managers in the implementation of the reviewed Prevention and Management of Stress Policy and a range of Health Improvement initiatives.

Best practice attendance management has been promoted including:

- Establishment of annual absence targets for each Directorate
- Delivery of monthly Mandatory Training for Managers in Attendance Management Protocol, in addition to ad-hoc, on-site, tailored training for managers and their teams regarding absence. 1,295 staff and managers were trained in Attendance Management between April 2014 and March 2015
- Design and launch of a new training course entitled "Managing Disability in the Workplace and Reasonable Adjustments"
- Case Management and Case Conference Meetings incorporating Occupational Health and Management
- Delivery of training for Managers using Human Resources Payroll and Travel System (HRPTS) to record sickness absence
- Completion of annual audit of compliance with the Attendance Protocol with findings showing an improvement in overall compliance rates
- Provision of Human Resources (HR) Drop-in clinics for managers and staff at a number of Trust facilities, providing advice on a range of HR issues including sickness absence.

Complaints management

We recognise that there are times when patients, clients and their families may feel unhappy with the service we have provided. We encourage any user of our services to provide us with both positive and negative feedback. We take complaints seriously as they offer the opportunity for the Trust to learn and improve the quality of our services. We aim to deal with complaints in an open,

independent and timely manner as early resolution is important to both complainants and the Trust. The Complaints Review Group meet quarterly to monitor complaints received, identify any trends and consider any learning which can be shared.

The complaints department continues to provide training for staff on the importance of providing excellence in care and when care isn't at the standard it should be, how to deal with complaints locally.

Information Governance

In Belfast Trust information governance is the framework of law and best practice that regulates the manner in which information is managed, obtained, handled, used and disclosed. We are an organisation that collects and processes vast quantities of information from our patients, clients and other users as well as from our staff. We use this information, for example, for efficient planning, proper maintenance of accounts, to provide assurance on the level of service provision and the monitoring of outcomes. Good quality information forms the basis of high quality care.

We are very aware of the need to ensure that all personal data is held in a secure and confidential manner and continually look at ways to improve how we handle paper and computer records. We endeavour at all times to treat this information with the utmost care and respect.

We have well defined information governance structures across the Trust. Information Asset Owners are senior managers who now have a clear responsibility for information governance within designated areas of the organisation.

Data loss or mismanagement does occasionally happen and while these breaches are relatively minor in nature, nevertheless the Trust continues to use the learning from such incidents to inform and develop good practice. A recent audit from the Information Commissioner's Office was welcomed as an opportunity to have independent scrutiny on how we manage personal information. The Trust views the outcome as a beneficial way to improve what we can do to protect and secure all personal data.

Infection prevention and control

In the lifespan of Belfast Trust we have achieved a year-on-year 60% reduction in our numbers of Clostridium difficile (C.diff) and MRSA bacteraemias. The reduction targets set for 2014/15 were extremely challenging. This year for the first time the outturn was above the target number for both C.diff and MRSA bacteraemias. The increasing workload and bed occupancy demands faced by the Trust over this year could have played some part in this increased incidence. The target for C.diff was 105 cases and the outturn was 140. The target for MRSA bacteraemias was 16 and the outturn was 28.

Director's report

Directorates with the greatest increase in numbers of these target organisms have developed an action plan to address this situation. These plans are reviewed monthly at the Healthcare Associated Infection Improvement Team (HCAIIT) meetings. The Trust continues to prioritise infection prevention and control at the highest level in the organisation from ward to board. Ward to board assurance on the HCAI reduction programme is delivered through review of balanced scorecards on a regular basis by Ward Sisters, Assistant Service Managers, Service Managers, Co-Directors and Directors. Action plans are produced where standards have not reached the accepted target level. Balanced scorecards for Directorates are reviewed at a monthly Safety Improvement Team (SIT) and HCAI Improvement Team (HCAIIT) meetings and at Directorate Accountability Review meetings with the Executive Team.

Specified infections (all MRSA bacteraemias, Clostridium difficile / MRSA infections which appear on Part 1 of a death certificate and Clostridium difficile clusters) are investigated by a Root Cause Analysis (RCA) process. The RCA investigations are undertaken by the clinical team supported by Consultant Medical Microbiologists and Infection Prevention and Control Nurses (IPCNs). The findings and related action plans are brought by Governance Managers to Directorate Governance meetings and learning is shared at HCAIIT meetings.

The Regulation and Quality Improvement Authority (RQIA) have made numerous visits to the Trust in the past year and have visited all critical care units. This is a comprehensive audit that in addition to scrutinising the governance structure, also includes clinical practices, decontamination of equipment and environmental cleanliness. All the critical care units have scored very well in these independent audits.

In this year independent scrutiny has also been undertaken through internal audit. The Infection Control, controls assurance standard was subject to verification in March 2015 and the score of 91% reflected substantive compliance.

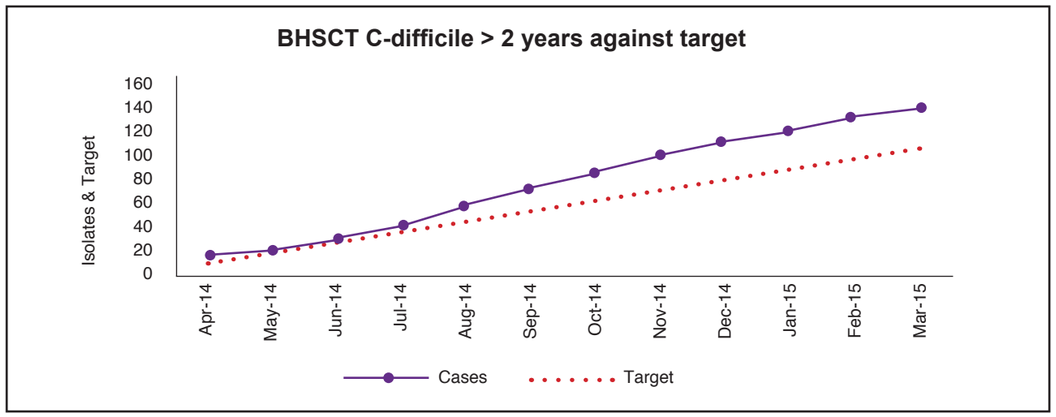
Surveillance of healthcare associated infections (HCAIs) is ongoing. The IPCNs scrutinise laboratory results for any microorganisms that can cause problems for our patients. In the last year we are seeing an increase in the number of Carbapenemase Producing Enterobacteriaceae (CPE) microorganisms which are very resistant to antibiotics. These microorganisms normally live harmlessly in the bowel and do not cause infection. They can cause infection in patients who are very ill, for example, when they need intensive care or while receiving chemotherapy. To ensure that patients who may be carrying these organisms are identified quickly a new risk assessment form has been introduced.

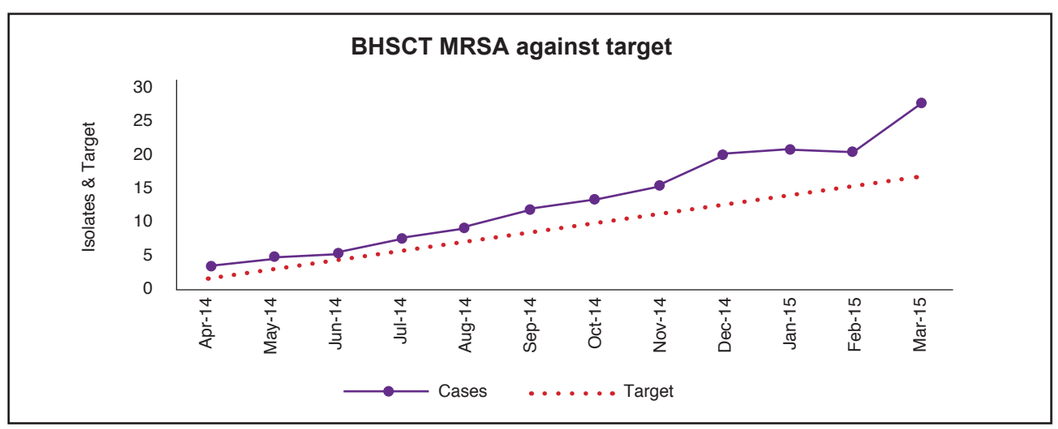
The prevention of HCAIs remains a high priority for the Trust and we believe that control of infection is everyone's business. Everyone must remember to carry out hand hygiene before and after visiting a patient, not to visit when we are ill and to observe visiting times so that we can provide a clean, safe environment for our patients.

Performance report

Performance: Health Care Acquired Infections

One of the key challenges of the Trust in 2014/15 was our success in meeting targets for reducing the levels of MRSA and C-diff contracted by our patients during their stays in our hospitals. Performance in this regard is best illustrated by the tables below. Although performance has been below target, the incidence of these infections remains on a downward trajectory. It is also noteworthy that the proportion of infections acquired in the community, ie. where the patient was infected before they were admitted and only diagnosed when in hospital, appears to be higher this year compared to 2013/14.





Performance: Inpatient and day cases

The Trust's aim was to have 80% of patients treated within 13 weeks and for no patient to wait longer than 26 weeks. Over the year as a whole 68% of patients were treated within 13 weeks. However, 8,630 patients were waiting over 26 weeks by year end.

The Trust continues to have a shortfall in capacity in a number of specialties, which impacted on the delivery of the 26 week maximum waiting time target, by March 2015. The Trust continues to work closely with the Health and Social Care Board (HSCB) to review those specialties facing particular difficulties. In addition it is the intention of the Trust to form a high level, medically-led elective care reform group to improve access to services.

Performance: Outpatients

The Trust's aim was to have 80% of patients treated within nine weeks. At the same time the Trust sought to ensure that no patient waited longer than 15 weeks by the end of the year – over the year as a whole 59% of patients were treated within nine weeks and 38,010 patients were waiting for longer than 15 weeks by year end. As with inpatient elective care, the Trust continues to have a shortfall in capacity in a number of specialties, which impacted on the delivery of the 15 week maximum waiting time target for the end of March 2015.

The Trust will continue to review opportunities for addressing current demand with the HSCB in the context of resources available. A detailed outpatient review is being completed and opportunities identified through this process will be taken forward. The Trust is also hoping to secure some funding from the DHSSPS Change Fund for 2015/16 to take forward modernisation initiatives within outpatient services in 2015/16.

Performance: Fractures

The Trust's aim was to ensure that 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. Due to increased pressures during the year, cumulative performance was 91% however the target was exceeded in the fourth quarter, traditionally the period of highest demand. The implementation of additional fracture theatre lists over weekends has contributed to this improvement.

Performance: Emergency Department

The Trust had two aims during the year; to ensure that 95% of patients attending Emergency Departments (EDs) in the Trust would be treated, admitted or discharged within four hours of their arrival and that no patient would wait for longer than 12 hours – our performance in relation to the four hour target was only 69% and more than1,700 patients were waiting for longer than 12 hours

in ED. Again the Trust has been working continuously with the HSCB to identify capacity issues resulting from an increase in ED attendances, increased emergency admissions and an increasing acuity of patients attending the Royal Victoria Hospital (RVH) in particular. Throughout the year ED pressures were the focus of a high level clinically led improvement group and the work of this group will continue into 2015/16.

Performance: Renal services

The Trust aimed to undertake a total of 80 kidney transplants during 2014/15 including transplants involving live donors. In fact a total of 98 transplants were delivered in year.

Performance: Cancer

During the year the Trust aimed to ensure that 98% of patients urgently referred with a suspected cancer began their treatment within 62 days.

Over the year 62% of patients had their cancer treatment commenced within 62 days. The Trust continues to focus on improving performance against the 62 day target with service areas working to reduce waits of suspected cancer patients for outpatient appointments, scopes and imaging. 588 patients did not have their treatment commenced within 62 days. Of these 362 began their journey in another Trust before being transferred to Belfast.

Actions currently being undertaken to improve performance:

- Additional breast clinics are being put in place to meet demand for urgent breast referrals and improve performance against the 14 day target
- Work underway to agree a straight to scope pathway for Upper GI patients
- Actions are being taken to address waiting times for 1st appointments for red flag, routine and urgent colorectal patients
- Weekly LAOP list being established in plastics to improve surgical capacity and work underway with South Eastern Trust to look at outpatient waiting times
- Work around referral process for red flag PET and EUS also underway
- Red flag analysis being carried out by HSCB with a view to identifying further areas for improvement work.

Performance: Children in care

The Trust is subject to a number of standards in relation to looking after the children under our care. The Trust meets these standards in most areas. This year we managed to ensure that 79%

of children leaving our care were in either training, education or employment – a 9% improvement from the 2013/14 position.

Performance: Mental health services

The Trust aimed this year to ensure that none of our patients waited for longer than nine weeks to access child and adolescent or adult mental health services, or longer than 13 weeks to access psychological therapies.

In March 2015, 36 patients waited for longer than nine weeks for access to mental health services; none of these longer waits were for CAMHS services. This was an improvement from earlier months. In relation to psychological services there were 164 breaches of the 13 week standard. The Trust continues to work with the HSCB to address capacity issues in mental health services, especially in relation to psychological therapies.

Performance: Community care carers assessments

The Trust had a target for the year to complete all assessments within five weeks and start all packages within eight weeks. At the end of March 2015 all assessments were completed within five weeks and of the 39 clients awaiting the start of their package, only two were waiting over the eight week target (5%).

Safety and Excellence

Annual Quality Report

In November 2014 Belfast Trust published its second Annual Quality Report. The aim of this report is to give an account of our plans and progress in quality and safety improvement in hospital, community and home settings.

The report included updates on quality improvement work highlighted in last year's Annual Quality Report and included performance against the standards agreed regionally as part of Quality 2020. It presents information comparing our Trust with other similar organisations in the National Health Service and against regional quality improvement targets, and includes a wide range of indicators covering five key themes in delivering quality:

Effective Health & Social Care
Standardised comparisons of mortality rates with United Kingdom (UK) peers and national audit data comparing specialty services with UK peers.

Delivering Best Practice
Our performance against best practice care including data on hospital falls, pressure ulcers, healthcare associated infections and individual carers assessments.

Protecting people from avoidable harm
Our performance in managing and learning from incidents which relate to the safety and quality of care we provide.

Ensuring people have a positive experience of service
We continually use patients and clients feedback to improve what we do, this section outlines some of the feedback we have received and how it has contributed to change and improvement.

Staff health and wellbeing
Acknowledging the importance of looking after our staff and highlighting key pieces of work underway around staff engagement and leadership. It highlights staff achievements and awards for the year.

This Annual Quality Report reflects the achievements we have made in the areas of quality and safety, however delivering a high quality service is a process, and only by continuously reviewing our performance can we continue on our journey of achievement. Work is underway to produce a 2014/15 report.

The full report can be accessed at:
www.belfasttrust.hscni.net/pdf/BT14-1019_Quality_Report_A_1314_sml.pdf

BCH Direct – acute care for frail elderly

The hustle and bustle of a busy Emergency Department can be a noisy and intimidating place for a frail elderly person in need of acute care.

BCH-Direct is a new service which facilitates direct access to comprehensive geriatrician assessment and treatment for frail elderly patients who would otherwise have to attend the RVH/Mater Emergency Departments. It opened in October 2014 and is based in the Belfast City Hospital. The service operates over seven days a week with the unit opening from 9am–9pm and with an assessment function available in Ward 7 South from 9pm until 9am.

We have established a referral process and protocol with the Northern Ireland Ambulance Service targeting patients over 75 years old who meet the agreed frail elderly criteria (patients who require a 999 response still attend the Emergency Department).

To date over 1,150 patients have attended the unit, reducing the number of transfers across the hospital sites, providing more timely and patient-centred care and ensuring that quality and safety are at the cornerstone of service delivery. Further developments for 2015/16 will see the establishment of a respiratory pathway and developing referral pathways with Acute Care at Home Model.

Being open – saying sorry when things go wrong

Harming a patient can have devastating emotional and physical consequences on the individual, their family and carers, and can be distressing for the professionals involved. Displaying openness and trust in such events is one of Belfast Trusts core values. Our 'Being open' policy expresses the commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers), when they have suffered harm as a result of their treatment.

It is based on published guidance by the National Patient Safety Agency (NPSA), and outlines the principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident. It also provides a supported process for engaging with patients and/or their carers in the investigation of the incident.

In December 2014, we launched a 'Being open – saying sorry when things go wrong' training module. This e-learning programme is aimed at all healthcare professionals, and provides guidance on how to communicate openly with patients and/or carers, giving guidance on the steps to take when things go wrong. The training is designed to support staff in displaying openness with our patients and clients.

Belfast Trust is committed to improving the safety and quality of the care we deliver to the public through learning from any incidents. 'Being open' is an integral part of our Adverse Incident Reporting and Management policy, and we have processes in place to ensure that all patients/ relatives/carers are informed of any incident where harm has occurred, and that there is a full and open investigation of the incident. From June to September 2014 all of our Serious Adverse Incidents since 2009 were reviewed to ensure that we had been open with the patients/carers/ relatives as appropriate and that any actions agreed following investigation of these incidents were being processed.

Datixweb development

Datix is a risk management software package used by Belfast Trust to record and manage information on incidents, claims, complaints, risks, safety alerts, requests for information and inquests. The system administration and operational management of the incidents, risks and safety alerts modules is carried out by the Datix team in the Corporate Governance department, while staff in other departments operate the remaining modules.

Datixweb is a web-based interface which allows staff and managers to access the system quickly and easily via the Intranet. The Trust currently has Datixweb for the incidents, risks, safety alerts and complaints modules.

Safety and Excellence

Incidents module – At the end of 2014, 95% of the Trust's reported incidents were being captured via Datixweb. This marks successful completion of a gradual roll-out across the Trust and replaces the duplicated effort of large A3 paper forms being completed by staff and then placed onto the system by a central team.

As well as access to their own incidents for local area managers, the system has been adapted over the years to assist specialist teams to be able to record, view and analyse relevant incident types, eg. tissue viability team for pressure ulcer incidents, Governance Pharmacists for medication incidents. This has been further developed in 2014/15, and a pilot is due to start in early 2015/16 of a specialist section for recording physical interventions for use by the management of aggression team. Work has also progressed on an enhanced incident investigation section which allows for the recording of contributory factors, learning themes and the sharing of learning. This is also due to be piloted in early 2015/16.

The Datix team continues to provide regular and ad hoc reports to managers throughout the Trust and in 2014/15 established a link with the Trust's mortality system to allow incident data to be reviewed at mortality meetings.

Complaints module – In partnership with the complaints team, work has begun on development of this module to allow managers local, real-time access to the complaints recorded against their service area. An initial pilot has been established to allow the manager to view their own complaints and there are plans to bring more pilot areas on board in early 2015/16. Over time, full access will be developed so that managers can add, amend and update their own complaint records.

Risks and safety alerts modules – These modules are well established in the Trust and the Datix team continues to make on-going enhancements and provide training for new users.

Ensuring safety in RICU

The Standardised Critical Care Resuscitation and Emergency Airway Management (SCREAM) course was developed in the Regional Intensive Care Unit for critical care nurses, to equip them with the necessary skills and knowledge to deal safely with emergency situations.

The rationale for the course arose from several safety indicators, which included learning from an incident in the unit concerning resuscitation, leadership, roles, responsibilities and team working in emergency scenarios. Also the new purpose-built Regional Intensive Care Unit (RICU) will see a change to the nursing role regarding emergency airway management and resuscitation. Critical care nurses were requesting specific skills to deal with these issues and it was hoped that addressing this would improve confidence and morale going forward into the new accommodation.

SCREAM is an intensive one day programme, which consists of three interactive skill stations, including airway management, breathing, emergency tracheostomy care and a circulatory care station including the massive haemorrhage protocol. Both medical and nursing staff from RICU are involved in teaching on the course.

The theory section was implemented through pre and post assessment testing using a condensed booklet which provided evidence of learning and a baseline knowledge. A target pass rate was set at 75%. Pre and post confidence level testing was also carried out with the nursing staff to ascertain the positive outcome on confidence levels after the course which was one of the key objectives.

To date 144 nursing staff have successfully completed the course. One of the outcomes has been an increased awareness of how the human factors influence how we work as a team and how this can impact upon clinical outcomes of care for the critically ill patient. The ability to provide confident and competent staff means the reduction in harm and promotion of safe standardised practice for the critically ill patient.

The course is now recognised as a standardised emergency course for the Belfast Trust critical care service and will be rolled out to the two remaining services within the Belfast City Hospital and Mater Hospital sites.

The development of SCREAM demonstrates the commitment of the RICU team to the values of Belfast Trust of openness, integrity and a commitment to change. Identifying issues within the culture of critical care and responding to patient safety needs by improving morale and confidence amongst staff to support and develop the service to provide a culture of safety for patients within the Belfast Trust Critical Care Service.

Safety in paediatric intensive care

At the beginning of 2014 we implemented a daily Paediatric Intensive Care Unit (PICU) Safety Brief.

A small multi disciplinary project group was set up aiming that within six months we would achieve the practice of having a PICU safety brief on 95% of mornings per month. We used the Institute of Healthcare Improvement (USA) model for improvement..

Key to our success was the team's engagement, ownership and celebration of success, not to mention the use of a cow mascot, Daisy – the patient safety and quality improvement cow.

The practice of a daily safety brief has now spread to other clinical areas in Royal Belfast Hospital for Sick Children (RBHSC), namely Allen Ward (Medical), Barbour Ward (Surgical) and the Emergency Department.

Since this success, Daisy has endorsed other safety and quality improvement initiatives in RBHSC – so beginning a patient safety and quality improvement movement in RBHSC.

We were delighted when PICU was awarded the NI IHM PS (Northern Ireland Institute of Healthcare Management, Patient Safety) Award 2014.

Take off and landing!

Take Off and Landing is a snapshot survey of interruptions and distractions at anaesthesia induction and wake-up.

Recognising the importance that human factors play in patient safety, a survey was carried out last year. Comparison with the aviation industry led to the concept of a "Sterile Cockpit" being introduced to the Royal Belfast Hospital for Sick Children (RBHSC) Theatre environment to reduce distractions and maximise focus.

Safety and Excellence

Dr Copeland was awarded 1st place for her oral presentation at the Royal College of Anaesthetists (UK) Safety Conference, 2014, and this survey has also been endorsed by Daisy, the patient safety and quality improvement cow!

Continuous improvement

Establishment of a 24/7 primary PCI service in Northern Ireland

The key to successful outcomes for treating ST segment Myocardial Infarction (STEMI) is short times to treatment. The longer the time to treatment, the more damage occurs to the heart muscle.

Previously in Northern Ireland the majority of clinically eligible patients with a diagnosis of STEMI received thrombolysis ('clot-busting' drugs) in their local hospital. More recently this treatment has also been carried out in the pre hospital setting where it is administered by ambulance paramedics and nursing teams.

There has been a growing body of evidence suggesting that primary Percutaneous Coronary Intervention (pPCI), whereby patients are taken directly to an interventional centre catheter lab, for coronary angiography +/- Percutaneous Coronary Intervention immediately following diagnosis of STEMI, delivers reduced mortality and better longer-term outcomes than thrombolysis, when delivered in an acceptable timeframe. The recommended national target is to begin the treatment in hospital within 150 minutes of the call for help. This is referred to as Call to Balloon time (CTB). Primary PCI as a first treatment for STEMI needs to be delivered by staff with an appropriate level of experience and training in settings with sophisticated diagnostic and monitoring facilities 24 hours a day, 7 days a week on an immediate access basis.

With this in mind the Health and Social Care Board commissioned a primary PCI service from the two interventional centres which give best coverage for the population of Northern Ireland, Belfast Trust and Altnagelvin. Belfast Trust 24/7 primary services started in September 2013, with very positive results. Waiting for an elective cath procedure has health, psychological and employment implications. Waiting times for both in-hospital and elective cardiac cath lab procedures have fallen substantially over the 2 year period. We are adhering to national performance indicators and have seen a reduction in the number of patients waiting more than 13 weeks.

Acute care at home – supporting elderly patients

The Trust is working collaboratively with Integrated Care Partnership in establishing a Belfast wide Acute Care at Home Team. Funding has been received to start a five day referral service.

This is a consultant led multidisciplinary team which will work closely with Primary Care colleagues to meet the growing needs of older people, carers and the Community. This dedicated team adds to existing services in providing comprehensive and rapid specialist assessment, advice and intervention to those elderly people in most need of help. Our aim is to provide an appropriate alternative to hospital attendance and admission.

Transforming breast cancer follow up

Belfast Trust breast cancer team as part of the regional Transforming Cancer Follow-Up (TCFU) Project has radically transformed breast cancer follow-up across the Trust by implementing a Self-Directed Aftercare (SDA) pathway. The TCFU programme was initiated in partnership with Macmillan, the Health and Social Care Board and the Public Health Agency, to introduce and test new models of cancer follow up across Northern Ireland. The project was driven by the growing number of cancer survivors, the increased pressure on the follow-up system and recognition that cancer follow-up was not meeting patient's needs. A new self-directed aftercare pathway tailored to patient need was implemented, supported by the recovery package; holistic needs assessment, health and wellbeing events, treatment summary record and GP cancer care review. It aimed to improve the quality of patients after treatment experience, promote their health and wellbeing, reduce inefficiencies in hospital follow-up and enhance service coordination and integration.

The adoption and roll out of a holistic self-directed aftercare pathway has now been applied to over 50% of patients in the Trust following breast cancer treatment. Patients entering into the SDA pathway are fully supported by the recovery package which involves a needs assessment by a clinical nurse specialist and a health and wellbeing event to provide education and support. They receive mammograms directly without having to see their consultant and to ensure that the system is robust, they have rapid access back into the system if they have concerns. A survivorship website has also been developed to signpost to local services such as physical exercise programmes or financial advice. All these improvements have created a foundation of greater patient empowerment and patient-centred care and led to increased patient satisfaction.

Patients are now only reviewed by a consultant when required which represents a more effective and efficient service. We are now seeing an 18% reduction in surgical breast review waiting lists, and a 5% reduction in breast oncology review waiting lists. 345 patients are on the SDA pathway who do not require review appointments, and patients now receive their mammograms on time. The TCFU principles and learning from the breast project have now been taken forward in other tumour sites, with pathway redesign work ongoing in prostate, colorectal, gynae and haematology services in the Trust to improve cancer follow-up and quality of care.

Day opportunities

In May 2014, following extensive public consultations held in partnership with Trusts, the Health and Social Care Board approved the regional model for day opportunities for adults with a learning disability. This model reflects the expectation of the Bamford Review “to enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships.” (Equal Lives).

In response to the publication of the Regional Post Consultation Report we have started a review of each service user’s plan, to ensure that future arrangements for day opportunities fully reflect the ethos and aspirations of Equal Lives. Full consultation with service users and their carers is central to this process. Alongside this the Trust has established a multi-agency project group with representation from a full range of stakeholders, to assist in the development of local strategies to enhance and develop day opportunities giving a greater range of choice and variety of opportunities for learning disabled adults within their local communities and also achieve greater social inclusion.

This represents a 3–5 year strategy built around the individual needs and views of each service user and their carers consistent with the requirements of Equal Lives.

Implementation of palliative and end of life service improvement programme

The Belfast Trust Implementation Group is on target to achieve the priorities set for 2014/15 by the Belfast Partnership Palliative and End of Life Care Steering Group. Task and finish groups have made significant progress in promoting identification of patients and appropriate communication; use of the End of Life Care Operational System (ELCOS) and electronic palliative and end of life care coordination system; advance care planning; education and development of multidisciplinary staff; and how we involve and engage with the public to support the on-going implementation of the programme.

Significant achievements in the last year include regional recognition of the Trust’s advance statement ‘A Record of My Wishes’ which, used in conjunction with ‘Your Life, Your Choice’, is being amended for HSC adoption; and the standard for nursing discharge of patients who have palliative or end of life care needs irrespective of diagnosis.

Transforming the Belfast glaucoma service

Glaucoma is the second leading cause of blindness in the United Kingdom (UK), with patients needing regular tests, treatment and monitoring throughout their lives.

An increasingly ageing population and the chronic nature of the disease, has meant that the service had become overwhelmed, and patients have experienced delays in their regular review appointments, which are crucial to the ongoing management of their condition. A further catalyst for change came from the 2009 NICE guidelines on glaucoma which set out suggested monitoring intervals for review. Change was crucial to ensure that patients would be reviewed regularly, helping reduce unnecessary blindness.

The Health and Social Care Board, Trust managers, glaucoma team and representatives from community optometry developed a business plan to modernise the service. The aim was to deliver a service which was efficient and effective in coping with the demand and to provide an optimum level of patient care.

In April 2013 in an innovative move, the Glaucoma Service was relocated to the Shankill Wellbeing and Treatment Centre, the first time a secondary care service has been located in a primary care setting. State of the art equipment and technology have made the service one of the most technologically advanced in the UK. We have also established a one-stop clinic enabling tests, consultation and results to be combined in one appointment. The referral system has also been changed, and a new glaucoma referral form allows optometrists to refer directly to the service reducing the administrative burden on General Practice. A multi-disciplinary team (MDT) of consultants, specialist nurses, optometrists, eye care liaison officers (ECLOs) has been established. The ECLOs see all newly diagnosed glaucoma patients to discuss diagnosis and glaucoma education. There is also a Glaucoma Support Group for users and carers.

Since relocating the service, clinic capacity has tripled and we have taken hundreds of review patients from other backlogged eye clinics in Belfast and beyond. Currently the service provides glaucoma care for over 4,500 review patients. The glaucoma review backlog has been cut by two-thirds and should be cleared completely by July 2015. In the last seven months the waiting time to first appointment for new glaucoma patients has decreased from 36 weeks to less than 12 weeks. Regular audit ensures continued improvement as does a strong multidisciplinary team which meets and discusses review cases regularly. We have a programme to actively up-skill optometrists, technicians and nurses within the service and there are now two trainees from the Northern Ireland deanery rotating through the service. Last but not least, we continue to support and empower our patients through multimedia learning, face-to-face education sessions and information leaflets.

Promoting accessibility through art and engagement

Belfast Trust is the largest Trust in Northern Ireland. We serve an increasingly diverse population of 340,000 people in Belfast, provide regional services across Northern Ireland, and we employ some 22,000 staff. We are committed to embracing diversity, promoting good relations and challenging sectarianism and racism to ensure service users and staff enjoy equality of opportunity and access to health and social care in a welcoming and safe environment

The Trust developed its good relations strategy Healthy Relations for a Healthy Future in partnership with a diverse range of stakeholders and engaged with service users to ensure that the Strategy was meaningful and would meet identified needs. The Trust carried out a consultation process with stakeholders to inform this Strategy and most importantly the actions contained within it.

A prime example of this was that while most people were comfortable using our services, they felt that that we could do more to promote good relations and equality of access to our Wellbeing and Treatment Centres.

The Trust's vision for Wellbeing and Treatment Centres is that they provide ease of access for everyone, located in well-established hubs of community activity where people go to shop and access other services.

To promote a greater sense of welcome in Wellbeing and Treatment Centres, we sought the views of service users and staff to help inform and influence the environment and ambience within these centres to make them more welcoming shared spaces for everyone regardless of race, religion, political opinion or where the centre was located. Focus groups were convened for each centre to give staff and service users an opportunity to articulate their views and experiences.

The Trust's Art Co-Ordinator discussed the benefits of art in health and how it can engender improved health and wellbeing, good relations, and improved experience.

Continuous improvement

As a result pieces of art are being produced by service users expressing their identities and cultures to be displayed in each of the Wellbeing and Treatment Centres.

The art workshop took place in February 2015 and welcomed representatives from across Belfast from different religions and cultures including, older people, people with disabilities, women's groups, men's groups, Ethnic Minority groups and young people's groups. The finished artwork will be formally unveiled in coming months and will be displayed in each Wellbeing and Treatment Centre.

Implementation of COPD discharge bundle

Belfast Trust is the first in Northern Ireland to introduce a Chronic Obstructive Pulmonary Disease (COPD) discharge bundle. The previous year we had 1,756 COPD admissions to hospital, with a 12% readmission rate.

A recent audit has shown very positive results including an 18% increase in smoking cessation rates and a 32% increase in the percentage of patients referred/attending pulmonary rehab and self-management. Patients are more involved in their care and there has been an improvement in the overall patient experience, with self-management plans given to 17% of patients on baseline audit compared to 90% of patients with the COPD discharge bundle.

Through the use of the COPD discharge bundle we are able to avoid inappropriate admission and readmission to hospital, and we are noticing fewer attendances by this group of patients at our Emergency Departments.

Just in time – improving neutropenic sepsis management

Neutropenic sepsis (NS) is a common, complication of cytotoxic chemotherapy. It remains a potentially fatal complication of chemotherapy and requires prompt intervention using IV antibiotics. The national target is to start treatment within 60 minutes of presentation.

Belfast Trust has developed an integrated care pathway (ICP) to improve the recognition and

management of neutropenic sepsis, which is now used by nursing and medical staff throughout the Trust, for patients with suspected NS.

A baseline audit carried out in June 2011 highlighted shortfalls in meeting the 60 minute standard, with only 18% of patients receiving first dose antibiotics within 60 minutes. Staff in Emergency Departments, acute oncology/haematology assessment areas and inpatient wards needed to be properly equipped to consistently recognise and promptly manage NS, so an ICP and associated care bundle was developed specifically for patients with suspected NS. To ensure a standardised response this information is on the Northern Ireland Cancer Network (NICaN).

The original ICP was launched in November 2011, with a more compact version introduced in January 2014. It guides nursing and medical staff through essential steps required within the first hour of care, incorporating a simple 'ABCD' checklist.

On-going education ensures staff familiarity with the ICP and regular audit monitors progress. A care bundle also ensures that NS remains a priority, and nursing staff immediately review all aspects of patients' management. Monthly outcomes are reported at chemotherapy and governance meetings and fed back to staff, with cases failing the 60 minute target reviewed to highlight areas for improvement.

The implementation of an ICP has resulted in significant improvements in all aspects of initial care outlined in the NS NICaN guidelines. Recent audits show significant and sustained improvements in all aspects of patient care, including delivery of first dose antibiotics, thus minimizing patients' risk of septic complications. Over the last year, consistently over 80% of patients receive first dose antibiotics within 60 minutes compared to 18% within 60 minutes at June 2011. The ICP and care bundle have improved patients' safety, experience and quality of care. They are used across Belfast Trust and are currently being introduced across the Northern Ireland Cancer Network. The ICP ensures NS is considered, and essential clinical care delivered systematically and quickly. High risk patients are speedily identified and septic complications can be avoided. The care bundle continually highlights the importance of NS, reviews progress and offers encouragement.

A sustained effort involving the whole multidisciplinary team has been fundamental in improving NS management. Regular education, review and dissemination of results and willingness to seek and act on feedback to make interventions more user friendly have all been essential. Encouragement and immediate feedback of positive results has enabled staff engagement and ownership of the ICP.

Continuous improvement

The Resettlement Team – supporting mental health patients

The Resettlement Team is a community mental health team which was created five years ago to support long stay hospital psychiatric patients from the Knockbracken Healthcare Park on their journey from hospital care to community settings. Rooted in the Bamford vision and guided by Transforming Your Care (TYC), it is a small and dedicated multidisciplinary service, to facilitate effective rehabilitation for patients whose needs are assessed as being best met with more intensive support than would be available through mainstream adult mental health services.

The team provides a service to around 116 patients with severe and enduring mental health problems. The core patient group has hospital admissions ranging from 10–60 years and the Resettlement Team was formed as a specialist service to assist these people in the transition from long stay hospital to community care. This has been achieved through a low volume, high intensity model and evidence of success is demonstrated through a low number of patients needing readmission (currently under 2%). The team works collaboratively with patients and their families, ensuring goals and aspirations are actively pursued through a recovery based approach, thus fostering a culture of hope, empowerment and the promotion of independence.

The overall experience and patient journey has been further supported by a dedicated and independent Peer Advocate. As part of the closure of a long stay ward the Advocate wrote a paper entitled 'A Return to Community', describing the patient journey from hospital to community capturing the reflections and hopes of patients:

'Is this all mine?'

'That's a fair bit different from the last place...'

'I can hear the traffic and see all the lights going by',

'Telling me that I am voluntary is like giving me a million pounds'

The poignancy of these quotes highlights how isolated from society hospital patients can feel and that we can never truly understand the importance of choices and experiences we take for granted. The learning from this work will continue to inform our services in the future.

As part of the resettlement process the artists in residence with Artscare and a local poet with a mental health background supported patients to express some of the thoughts and emotions of their journeys. This ongoing project has resulted in works of art and prose that have been used to decorate walls and bedrooms in their new environments.

Over the last 12 months, as the long stay hospital wards close and patients are resettled into the community, the Resettlement Team is using the skills and experience developed during the resettlement process to refocus their work into preventing the potential re-emergence of a new long stay population, working with patients who have long or repeated admissions into acute psychiatric care.

Self Directed Support – putting the person in control

Self Directed Support is a core element of Transforming Your Care (TYC), and it is being implemented across the region through the five Health and Social Care Trusts.

The term 'Self Directed Support' establishes the ways in which individuals and families can have informed choice about the way care is provided to them. Through a partnership approach to needs assessment individual outcomes are agreed.

Self Directed Support enables people to choose how their care is provided, and gives them as much control as they want over their personal budget. It includes a number of options for getting support.

The individual's personal budget can be:

- Taken as a direct payment (a cash payment)
- A managed budget (where the Trust holds the budget, but the person is in control of how it is spent)
- Or the Trust can arrange a service.

Individuals can choose a mixture of all three of the different types of Self Directed Support.
In law direct payments allow individuals, following assessment of need, to receive a direct payment and purchase their own care.

Direct payments have been in operation for a long time and are just one of the ways of getting Self Directed Support.

The main change with Self Directed Support is transparency about the budget and empowering

Continuous improvement

individuals to work in partnership focusing on their agreed outcomes following assessment. Self Directed Support represents major change in the way services are assessed, organised and delivered.

Self Directed Support enables people to take more control over decisions which affect their lives. It is intended to support independent living by giving people more choice, control and flexibility over their own care.

"What Matters to Me"

To ensure patient-centred care, the Institute for Healthcare Improvement (IHI) promotes the concept of "Flipping Healthcare". In addition to asking patients and their families "what's the matter with you", healthcare staff should also ask "what matters to you".

Last year staff in the Paediatric Intensive Care Unit (PICU) decided to pilot this concept, and laminated cards were designed for each child's bedside on which they or their parents would record and display "what matters" most to their child, eg. favourite toys, favourite song, cartoon, favourite position, etc. Feedback from patients, staff and parents has been very positive to date.

This pilot was endorsed by Daisy, the patients safety and quality improvement cow, and now has spread to other clinical areas in the Royal Belfast Hospital for Sick Children (RBHSC), namely Day Care Unit and Barbour Ward (surgical ward).

This example of patient centred care has been recognised in NI Paediatric Collaborative as a concept worthy of spreading to all Children's Wards in Northern Ireland.

In December 2014, at the IHI Annual Conference, Florida, USA, Maureen Bisognano, President and CEO of IHI, in her key-note address highlighted the work of PICU, RBHSC as exemplary work in improving quality of patient care.

Partnerships

A Smoke Free Site – update

Every year 2,300 deaths in Northern Ireland are attributable to smoking related illnesses, and almost one third of cancers are attributable to smoking.

Treating smoking related illness costs £164m each year in Northern Ireland, with 16,700 people believed to be admitted to hospital for smoking related illnesses per year. Behind all these statistics are individuals and families whose suffering is largely preventable, so as a healthcare provider and one of the largest Trusts in the United Kingdom (UK), we have an opportunity to positively impact on the health of all who engage with the Trust. Smoke Free status has already been achieved in 92% of acute hospital settings in Republic of Ireland, with plans for all facilities to achieve this by end 2015. Similarly a sizable proportion of UK Trusts are Smoke Free, with Scotland implementing a total ban on Smoking on any NHS site by end March 2015.

Since 2007 all Belfast Trust facilities have operated a Smoke Free Policy inside their buildings and while this is successful, during 2014/15 we have continued to work towards a Smoke Free status across all our sites including entrances and exits, Trust owned vehicles and grounds. The Smoke Free policy across all sites will be applicable to all employees, patients, visitors, clients, contractors, volunteers and members of the public. We aim to promote the health and wellbeing of all staff, patients, visitors, contractors and the public who visit out sites. We want to reduce the effects of second hand smoke to all Belfast Trust site users and promote a cleaner, healthier environment. We will provide a positive corporate example and promote a non-smoking culture in the catchment area of Belfast Trust, providing support to those who wish to quit smoking, and positively influence a reduction in rates of smoking related deaths.

A Smoke Free steering group has representation from all directorates and to date the main emphasis of the group has been policy development and communication of agenda including gauging support. An opinion survey was launched on both internet and intranet sites along with a snapshot physical survey on acute sites. The results of this survey are strongly supportive of Trust becoming smoke free across all sites with 74% of those surveyed agreeing to such a move. The smoke free agenda has also been endorsed at Trust Board, and it is planned that Belfast Trust will be smoke free across all sites by March 2016.

Community integration from Muckamore Abbey Hospital

The Trust has continued to successfully plan for the discharge from Muckamore Abbey Hospital of those patients who no longer need assessment or treatment, and to achieve the regional targets for successful reintegration to community settings.

Working closely with individual patients and their families, a person centred plan is completed for each patient. This requires the full involvement of multi-disciplinary teams in both the hospital and the community and assists in the identification of the most suitable community placement for each person. The overall process is quality assured by an independent advocate and “quality of life” questionnaires are completed, with each service user and their family at three monthly intervals following discharge from hospital.

There is a range of options including nursing, residential and supported living placements which are tailored to the needs of each patient. We work in partnership with a broad range of stakeholders including the Northern Ireland Housing Executive and private care providers, to develop accommodation and services customised to patients’ needs. Positive feedback has been received on this process of Community Integration with one provider commenting: “The depth of involvement and the detail of the process was excellent and it was always very clear the residents and their families wishes and needs were always at the fore. The resettlement team throughout was always available for advice, help and guidance, as were the ward staff”.

Belfast Trust has now developed and agreed individual plans for the remaining identified patients. This requires the new development of community alternatives and we are working with a range of providers and other stakeholders so that these are completed as quickly as possible to facilitate final hospital discharge.

Alongside these developments we have successfully strengthened our Community Care and Treatment services for learning disabled adults and their families through the additional recruitment of a range of staff to provide more effective and responsive services, designed to prevent any unnecessary hospital admissions and support service users and their carers within the community.

Community treatment and support services

Community Treatment and Support Services are in the midst of a development plan which will increase the capacity of community services to meet the needs of a growing and increasingly complex learning disabled population.

Community infrastructure funding to support resettlement from long stay hospitals is being used to

expand, and in some cases, reshape existing services to support resettlement patients, reducing future hospital admissions and providing comprehensive care and treatment services in the community.

The expanded service will be delivered by four multi–disciplinary community teams, a care management team, a psychological therapies service and an intensive support service which will also provide extended hours and on call provision.

Family support hubs and locality planning

The establishment of family support hubs across Belfast represents the implementation of one of the 'signature projects' outlined by The Office of First Minister and Deputy First Minister (OFMDFM) in keeping with the Early Intervention and 'Delivering Social Change' agenda.

The hubs form part of a regional network across Northern Ireland and reflect key elements of the Children and Young People's Strategic Partnership (CYPSP) service delivery model in achieving their six high level outcomes:

- Being healthy
- Living in economic and environmental wellbeing
- Enjoying learning and achieving
- Living in a society that respects their rights
- Contributing positively to community and society
- Living in safety and with stability.

Belfast Trust, acting on behalf of the Belfast Outcomes Group, and working closely with the four Belfast area Locality Planning Groups, has had direct involvement in the establishment of the family support hub network across Belfast.

To date five hubs have been established in Belfast and are based in inner East Belfast, the Upper Springfield/Whiterock area of West Belfast, South Belfast, Outer North Belfast and Shankill. Another four hubs are currently under development, in areas within West, North and South Belfast. These hubs are a network of local service providers from community, voluntary and statutory organisations, working in partnership to provide an early response to families who need support to help them to achieve good outcomes.

As well as having a support role to the family support hubs, Belfast Trust has responsibility for governance through the service level agreements which are in place with the family support hub lead body organisations.

The family support hubs also identify any unmet need within their area and use this information to contribute to future planning for service provision in conjunction with area Locality Planning Groups.

Locality Planning Groups are partnerships between statutory, voluntary and community organisations who are working with and for children, young people and families at a local level. Locality planning has been recognised, by the CYPSP, as the bedrock of structures that are engaged in the planning processes for children and families in Northern Ireland. Since locality groups provide an inclusive forum for local planning, they can adopt a more strategic view of service provision and the support needs of families in their geographical area. There are four such groups in Belfast; North, South, West and East Belfast, and Belfast Trust contributes to all of them.

The Trust's involvement in the work of both Locality Planning Groups and family support hubs represents its commitment to partnership working with both the community and voluntary sector in responding to the needs of local families.

HIV service user forum

Personal and Public Involvement (PPI) describes the way patients, clients, service users, carers and communities are involved in Health and Social Care. High quality engagement and involvement are central to the delivery of quality care and can lead to improvement in the experience of people using our services.

Within the context of PPI, the service manager of the Regional Centre for HIV care together with the Community Development Team assist service users to identify:

- Levels of user satisfaction
- The strengths of the service and what could be done better
- Reasons for DNAs and how they could be avoided
- How service users want the service to engage with them in the future
- Individuals who might be willing to participate in a workshop to explore the findings.

A questionnaire was distributed in HIV clinics during February and March 2014 to get a snapshot of service users. 94 questionnaires were completed, representing just over 10% of service users. While the findings confirmed some issues, such as dissatisfaction with the telephone appointment system, it was encouraging that there was overwhelmingly positive feedback about the staff and the quality of the service.

The next step was a workshop for service users and representatives of relevant support organisations (Positive Life and Rainbow Project) to discuss the issues identified and explore possible solutions. A lively discussion resulted in numerous suggestions for solutions to some of the issues identified, as well as strengthening relationships with support organisations. Following the workshop, the main findings of the questionnaire were prominently displayed in the clinics to provide feedback to all service users and an initial meeting of a service user forum was advertised in the clinic.

This was held in October 2014 and attended by ten service users, representatives of Rainbow Project and Positive Life and Belfast Trust staff. As a result of this first meeting a service user has worked with Trust staff on further improvements to the telephone and IT systems. Work is ongoing on improving systems further, but there has already been a significant decrease in complaints.

The Forum has met for a second time and a service user has agreed to chair the group. He is now working closely with the service manager and other Forum members in drawing up the agenda and shaping future meetings.

Supporting bereaved families

In spite of our best efforts, the reality is that we cannot always achieve the outcome we would wish for. The Regional Intensive Care Unit (RICU) provides a compassionate and dignified bereavement support follow-up service for relatives of patients who die while in RICU. It is maintained by a team of nurses and doctors within RICU and funded by REVIVE the Regional Intensive Care Unit's charity.

The service includes returning the patient's personal effects in a bespoke property bag; and sending a specially designed condolence card, four weeks after the death. This card carries an open invitation to telephone or meet with the critical care bereavement team to discuss any unresolved issues or unanswered questions about their loved one's care. Relatives who took part in an end-of-life research study in RICU, positively commented on receiving the card and appreciated that time had been taken to remember them and acknowledge the loss of their loved one.

Partnerships

RICU's bereavement follow-up support in relation to the property bag and condolence card has been adopted by the Trust's Bereavement Forum as a model of good practice for improving the family experience. Moreover, the adoption of this model offers an equitable support service to all bereaved families in the Trust.

People

Being a corporate parent – our responsibility to young people in our care

As a corporate parent, we have a responsibility and duty to support and assist any young people in our care in planning for the future including finding employment. Tanya McCallen, 21, was in the care of Belfast Trust from a young age and remains in contact with her former foster carers. She is currently employed as a nursing auxiliary in Royal Belfast Hospital for Sick Children. Her journey to employment has been challenging, requiring determination and commitment, fully supported by the Trust's Employability Scheme for young people in care.

Tanya met with the Belfast Trust Employability Service in 2009 when she was completing Year 12. At this point she was having difficulty with her GCSE Maths, so arrangements were made for her to have support from a maths tutor. In April 2012 Tanya successfully applied for a temporary post as a seasonal support service assistant, and worked for three months as a catering assistant in the Mater Hospital. This gave Tanya her first experience of paid employment and knowledge of what it would be like to work in Belfast Trust. In October 2012 Tanya applied for a position as a nursing auxiliary, however did not meet one of the entry criteria (GCSE Maths or equivalent), so unfortunately she failed to be shortlisted.

Understandably this knocked Tanya's confidence; however she was determined to get the job next time round. She recognised that she had some work to do to give her the best chance of securing employment. In December 2012 Tanya successfully completed a Level 2 Numeracy with Start360. In February 2013, to add to her experience, Tanya started a work placement two days a week as a care assistant with a Nursing Home. She also started the Aiming Higher programme with Include Youth in March 2013.

In November 2013 the nursing auxiliary position was advertised again, and Tanya felt in a much better position to apply, she now had the required numeracy qualification, relevant work experience and felt more confident following completion of the Aiming Higher programme. She was successful at interview for the nursing auxiliary post and started work in Allen Ward in September 2014.

Tanya feels receiving support from Employability Service increased her chances to gain employment and without this support may not be in the position she currently is today. She is one of nine young people who have started work in ring fenced posts during the last twelve months. Four are in nursing auxiliary posts and four are within the Patient Client Support Services (PCSS) department, with an additional one employed as a clerical officer. At a recent Employability Service celebration event, Tanya inspired other young people in the audience when she said: "My advice is to never give up and if you want to achieve something enough you will get there. My goal is to work as a children's nurse, which will require more study and more hard work."

Emotional wellbeing – supporting staff

People who are emotionally healthy are in control of their behaviour. They are able to handle life's challenges, build strong relationships and recover from setbacks.

Being emotionally healthy does not mean never going through bad times or experiencing emotional problems, we all go through loss and change. While these are normal parts of life, they can still cause sadness, anxiety and stress. The difference is that people with good emotional health can have an ability to bounce back from adversity, trauma, and stress. This ability is called resilience. The Health Improvement department has launched a new training programme aimed at promoting and protecting emotional wellbeing. 'Top Tips for Looking After Yourself' aims to build and strengthen resilience through developing confidence skills and self help strategies which will enable individuals to protect and promote their emotional wellbeing.

Recognition event

The Annual Recognition of Learning Ceremony took place in March 2015. Last year the Learning and Development Team supported 350 staff to complete an accredited qualification, with 130 learners attending the actual event. Chief Executive Dr Michael McBride congratulated all of the learners and spoke about the crucial importance of staff being recognised and valued for their commitment and contribution to the care of our patients and clients.

Learning and Development is one of our core values and it vital that staff continue to acquire and develop their skills so that they can deliver high quality care and support. Staff attended the Recognition Event from across all directorates and professional groups. The specific qualifications being recognised included: Institute of Leadership and Management (ILM) Level 5 in Coaching and Mentoring, ILM Level 3 & Level 5 in Leadership and Management, ProQual Certificate in Healthcare Support at Level 2 and 3, K101 Introduction to Health and Social Care, Level 2 Certificate Working in the Health Sector, Basic IT Skills and Essential Skills ICT, Communication and Application of Number.

This was the first time the Trust had included special awards into the ceremony. The award winners were nominated by the programmes' tutors for their outstanding efforts and achievements and three "Learner of the Year" awards were made for specific accredited programmes and one Manager's award for Supporting Learning.

Coaching

Coaching as a development initiative was first introduced in 2013 as another method of enhancing skills and performance. Since then, over 40 senior staff have completed a Coaching Qualification which has enabled them to provide coaching to approximately 200 staff in the Trust. Any grade or profession of staff can request coaching, and to-date staff from across a wide range of professions and grades have accessed this service. To further support coaching as a development initiative, we have also introduced coaching skills for Line Managers to support the day-to-day management of their staff.

The Trust has been recognised for the work that it has done to-date on bringing about a coaching culture. In 2014, the Irish Institute of Training & Development National Training Awards awarded the Trust with a Highly Commended Recognition for the work it has completed on coaching. This coaching initiative was also recognised internally as part of the Chairman's Awards in 2014, when it achieved second place under the People category. The Trust continues to look for opportunities to grow coaching as a development opportunity across the organisation, given the positive outcomes, and coaching is now offered as part of our manager development programmes.

HPMA – (Healthcare People Management Association) Learning & Development Team of the Year Award 2014

In 2014 the Human Resources Learning & Development Team was awarded the HPMA Northern Ireland team of the year.

This is the inaugural year that the awards have been introduced at a local branch level, and the team was recognised for its work and contribution towards health and social care in Northern Ireland. As part of the submission, the team had to demonstrate how it reached exceptional performance levels by embracing technical excellence and innovation. It also gave specific examples of how it has contributed to the overall performance of the Trust and how it measures and evaluates its performance.

Embedding Trust values

The Trust has launched an initiative to ensure that all staff are familiar with our Values and likewise that our behaviours reflect these values in all our interactions. There are multiple strands to this initiative but one which has had very positive feedback has been the provision of Team Values Workshops. The purpose of the workshops are:

- To explore how the values are reflected in the work and behaviours of the team
- To identify areas for improvement and create a team pledge for future supportive behaviours.

The demand for the workshops has been extremely high and to-date almost 40 teams have requested a workshop. Feedback has been extremely positive and the Trust continues to offer this training to all teams in the Trust.

Investors in People

The Trust continues to use the internationally recognised framework of Investors in People (IIP) to improve organisational performance through our people. The IIP Framework helps us to align processes, enable and engage with staff across a number of key people management initiatives such as Employee Engagement, Leadership/Management Development and Organisational Change, ultimately supporting a sustained culture of performance improvement.

As an accredited IIP organisation we have now committed for our next assessment in March 2016 to be assessed against additional evidence requirements to achieve a bronze level award. We believe this demonstrates our commitment to continuous performance improvement to improve care for our patients and clients.

As part of this process we will receive independent feedback against our identified organisational priorities and can benchmark against other high performing organisations. As part of this process we will be reviewing how we perform against the framework's requirements in such areas as:

- Effective strategic planning
- Developing people
- Leading and managing effectively
- Engaging and empowering employees
- Recognising and valuing continuous improvement.

Summer scheme

The seventh summer scheme has been successfully provided with 341 children and 199 families being accommodated.

During an evaluation of the scheme, 97% of parents rated the scheme as either excellent or very good, 93% of respondents said that they were able to use annual leave for holidays rather than childcare and 98% said that they were able to work their usual hours. 94% of parents said that the summer scheme ensured that they did not have to take any unpaid leave. Parents were asked if providing a summer scheme enabled them to balance their work and family more effectively to which 98% strongly agreed or agreed.

In addition Employers for Childcare Vouchers provides a beneficial method of paying for registered childcare for employees. There are currently 770 participating in the Scheme.

"I just wanted to say thanks for another great summer scheme. My son really enjoyed all the trips and activities. Please pass on our appreciation to all involved".

"My son thought the summer scheme was brilliant! All the staff at Fullerton House were very friendly and seemed to have a great rapport with the children".

"I just wanted to say thanks. My daughter loved her time at summer school. The service was terrific and enabled me to continue working full-time; much to the delight of my manager (no term time was needed)."

"This has been my first opportunity to say thanks a million for yet another amazing summer for the boys and me. Once again you and your team have done an amazing job and I can't thank you enough."

Work life balance flexible working policies

Belfast Trust is committed to promoting equality and to attracting and retaining highly skilled and experienced staff. The Trust reviewed the suite of Work Life Balance Policies and the Special Leave Policy in September 2014, which enable staff to balance both home and work commitments and improve their working lives. These are:

- Job Sharing
- Employment Break
- Part-Time Working
- Term-Time Working
- Flexi-Time Scheme
- Compressed Working
- Homeworking
- Flexible Retirement

Last year there were 982 applications received with a 95% approval rate.

Health and wellbeing

The Trust has successfully implemented its health and wellbeing action plan. This incorporates a collaborative approach to addressing both stress and employee wellness. In addition to specific stress management tools and interventions, we have started a number of initiatives under Occupational Health, Health Improvement, Here4U and Improving Working Lives.

Six health fairs have taken place in the Mater Hospital, Musgrave Park Hospital, Belfast City Hospital, Royal Jubilee, Grove Health and Wellbeing Centre and the Royal Victoria Hospital. The emphasis was on the range of support available to staff, and the importance of looking after your own wellbeing. On offer were blood pressure and cholesterol checks in addition to stands providing information on Staff Care, Smoking Cessation, Alcohol and Drug Awareness, Oral Health, Diet and Nutrition, Here4U, Cycle to Work Scheme and the Trust's Improving Working Lives initiatives.

We launched a new Health and Wellbeing at Work newsletter for staff in October, providing information on wellbeing initiatives for staff and managers. In January the Trust signed up for Business in the Community's £ for lb 12 week weight loss challenge, to help employees lose weight. 128 employees signed up for the challenge, with weekly support groups across four of our sites; Shankill Health and Wellbeing Centre, Arches Wellbeing and Treatment Centre, Knockbreda Centre and Musgrave Park Hospital.

The Early Intervention Physiotherapy Service for staff was launched in May 2014, providing staff with musculoskeletal injuries quicker access to the Occupational Health Physiotherapy Service.

The Trust was awarded distinction in the Annual Occupational Safety Awards 2014, and was a shortlisted finalist at the Irish News Workplace and Employment Awards for Employee Health and Wellbeing.

Employment Equality and Diversity Plan 2014-17

Recognising that equality in employment and the elimination of workplace discrimination and harassment are essential for developing a diverse workforce and maximising effectiveness, the Trust has developed its third Employment Equality and Diversity Plan for the period 2014-17. The plan provides structured and practical action plans to meet the following four key objectives designed to implement this commitment and to build on our work to date:

1. To promote and champion equality, good relations and diversity within the organisation
2. To develop and maintain corporate policies and procedures which support and underpin equal opportunities and diversity in the workplace
3. To foster an accessible and inclusive working environment for all staff and to continue to take steps to ensure our workforce is representative of the community we serve
4. To set in place appropriate systems to evaluate and measure the success of corporate Human Resources policies and the implementation of the Employment Equality and Diversity Plan.

Significant progress has been made in the first year of the new plan with developments particularly in the areas of training, monitoring and partnership working. In addition the Trust completed its second triennial report under the Fair Employment and Treatment (NI) Order 1998 during the year.

Resources


£20
Bank of England
I PROMISE TO PAY THE BEARER ON DEMAND THE SUM OF
TWENTY
Pounds
the BANK of ENGLAND
E II R

Financial resources

Size and scale

The Belfast Trust had an operating expenditure budget of £1.2 billion in 2014/15 which makes it one of the largest healthcare Trusts in the UK in budgetary terms. The Trust employs around 17,860 (whole time equivalent) staff, and manages an estate worth over £1 billion.

Financial environment

The increasingly difficult financial climate facing the public sector and the wider economy continued to be felt by the Belfast Trust and its staff in 2014/15.

In order to maintain safe and effective services with less income in real terms, the Trust set itself an efficiency target of £37m, equivalent to around 3% of its total 2013/14 expenditure. It is widely acknowledged that efficiency savings are becoming increasingly difficult to achieve without adversely impacting patients and clients. Nevertheless, at the end of the year the Trust had delivered almost 90% of its £37m target, mainly through staff productivity and service reform. The gap in our savings plan was addressed through in-year slippage resulting from delays in the implementation of a range of service developments.

The Trust also experienced a number of cost increases during 2014/15 including a growth in emergency department and unscheduled care demand and the implementation of a new bed contract which will enhance patient safety and experience in our hospitals.

During the year, the Trust implemented a number of service developments and improvements, including the establishment of a 24/7 PCI service, enhancement of spinal surgery, growth in mental health primary care hubs and the expansion of high cost drug and therapy treatments.

Despite the enormous challenges and increased demand for our services, the Trust achieved financial balance in 2014/15 while continuing to drive forward its quality and safety agenda. It should be noted however that this outcome was attributable in part to a significant level of one-off funding being made available in 2014/15.

Financial targets

Whilst operating within this very challenging financial environment, the Trust has continued to improve the safety and responsiveness of services for its patients and clients and was still able to achieve all of its statutory financial targets which are outlined below:

- Breakeven on income and expenditure
- Maintain capital expenditure within the agreed Capital Resource Limit.

The above achievements have been delivered through a combination of sound financial management, the concerted efforts of our staff and the continued implementation of the Trust's efficiency and reform programme.

Financial governance

The Trust has continued to maintain sound systems of internal control which are designed to safeguard public funds and assets. The same high degree of security is maintained over patients' and residents' monies, and charitable trust funds, administered by the Trust. Our internal control framework relies on a combination of robust internal governance structures, policies and procedures, control checks and balances, self-assessments and independent reviews. The Chief Executive's assurances in respect of this area are set out in the Governance Statement of the annual accounts for 2014/15.

In terms of financial management and control across the Trust, a detailed financial plan is prepared and approved by the Trust Board at the beginning of each financial year and budgets are allocated to directorates. Financial performance is monitored and reviewed through detailed financial reporting to directors on a monthly basis. An aggregate summary of the financial position to date and forecast yearend position is presented by the Director of Finance to Trust Board each month.

Off-Payroll expenditure

The Trust had the following number of off-payroll engagements in excess of £58,200 per annum in place as at 31 March 2015.

	Number of Staff
Off Payroll staff as at 1 April 2014	8
New engagements during the year	1
Number of engagements transferred to payroll	0
Number of engagements that have come to an end during the year	0
Number of engagements that fell below the £58.5k threshold	2
Off-Payroll staff as at 31 March 2015	7

MORE – Maximising Outcomes, Resources and Efficiencies

The Trust's MORE programme was established in 2007/08 to ensure continued delivery of safe and responsive services, against a backdrop of increasing demand, rising cost pressures and efficiency savings targets.

The programme's focus is on securing efficiencies through enhancing productivity, changing the way we deliver services, modernising and driving improvements in health and social care, eliminating waste and maximising value for money. The MORE programme links with the regional Quality Improvement & Cash Releasing (QICR) programme which is an integral part of the Transforming Your Care (TYC) programme.

The focus of the MORE programme is essentially about ensuring the right care is delivered by the right person, doing the right thing, in the right place.

The programme has been successful in delivering around 3% year-on-year cash releasing/ productivity efficiencies over the past seven years.

One area in which the Trust has made significant savings in recent years is management costs. In 2014/15 the total cost of management fell by almost 2%. The 2014/15 cost represents 2.95% of the Trust's income. This 2.95% compares favourably with 3.15%, 3.1% and 3.6% in the previous three years.

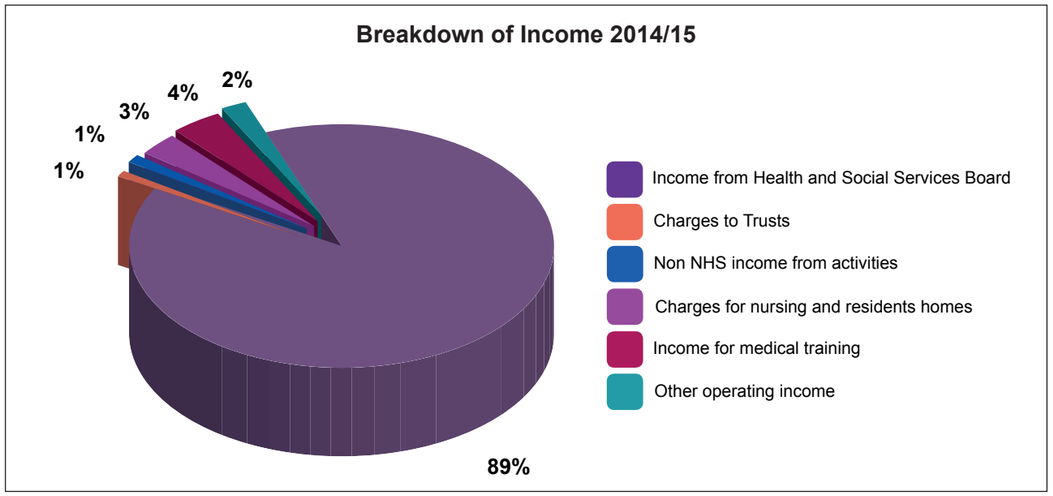
The nature and scale of changes which the health and social care sector will face over the next few years is significant and 2015/16 is expected to be the most challenging to date from a financial perspective. As always, the Trust will endeavour to ensure that the required changes are effectively managed through the continued successful operation of the MORE programme which reports through to the Trust Board and the regional Financial Stability Programme Board. The Trust will continue to ensure that the areas of discretionary spend, management costs and procurement efficiencies are specifically targeted, and initiatives involving service changes will be subject to equality screening and full public consultation, as appropriate. We will, of course, ensure that the highest standards of quality and safety are maintained across our services as our reform and efficiency programme progresses.

Resources

Income and expenditure

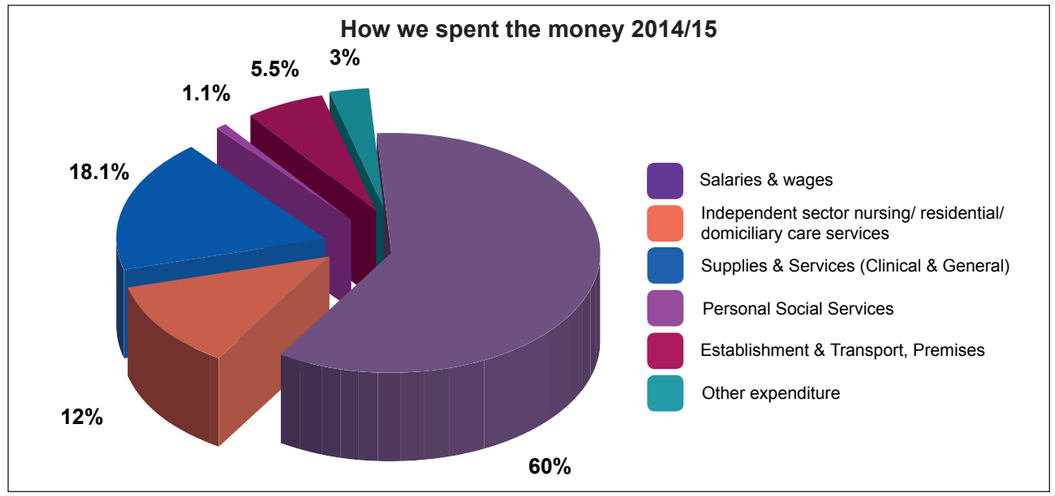
The information below provides an analysis of Trust's income and a breakdown of expenditure in 2014/15.

The majority of funding, almost 90%, comes from the Department of Health, Social Services and Public Safety, through the Health and Social Care Board and the Public Health Authority. The Trust also receives funding for medical education and commercial research, from private patients and from clients in residential and nursing homes. The chart below shows the breakdown of the different sources of income.



The money which the Trust receives is used to deliver health and social care services for the population of Belfast and a range of regional services such as cardiac surgery and neurosurgery for the population of Northern Ireland.

The second chart shows how the Trust spent this money in 2014/15. The largest cost incurred by the Trust is staff salaries, representing just over 60% of total expenditure. Within this pay total, the Trust spent £168 million on doctors and dentists, £245 million on nurses and midwives and £79 million on social work/social care and domiciliary/homecare staff. Significant non-pay costs include £226 million (18% of total expenditure) for clinical and general supplies such as drugs and medical equipment and £149 million (12% of expenditure) for residential, nursing and domiciliary care delivered by other organisations on the Trust's behalf. The chart below shows the breakdown of expenditure into its key components.



Investing in staff

The Trust spends around £749 million on staff salaries, employing circa 17,860 staff (whole time equivalents) across a diverse range of professional groups. The Trust endeavours to ensure that staff are effectively deployed to improve the safety and responsiveness of our services. In addition to a number of Human Resource employee related schemes, the Trust provides taxable benefits to staff through a number of salary sacrifice schemes, as follows:

- Childcare Vouchers
- Cycle to Work Scheme
- Translink Tax Smart Scheme
- Medic Care Staff Benefit Scheme
- Banking Employee Benefits Scheme.

In addition to providing direct financial benefits for staff through reduced taxation, these schemes aim to promote general overarching benefits in terms of enhancing the general health and well-being of staff.

Resources

Investing in facilities

Belfast HSC Trust has a fixed asset base of £1,085m. The Trust continues to maintain and develop this infrastructure to provide the facilities required to support patient and client care.

In 2014/15 the capital funding allocation for the Trust was £38.2m, of which £21.8m related to major specific capital projects and £16.4m was for various minor capital projects, net of land and building sales of £5.6m. Expenditure on larger schemes included:

Capital Scheme	Expenditure 2014/15 £m	Total Project Value £m
RGH Phase 2B	2.7	151.7
RGH Maternity New Build	2.7	46.2
Children's Hospital	2.3	219.4
Acute Mental Health In Patient Unit	3.0	32.2
RVH Cath Labs	1.2	3.5
ICT	7.4	7.4
Decontamination Schemes	2.1	4.9

The minor capital projects consisted of a range of minor works, equipment and ICT projects.

During 2014/15 a number of schemes were completed and preparations made to bring them into operation. In addition, work commenced on both the Acute Mental Health Unit on the BCH site and Children's Hospital on RVH, this included site clearance and enabling works.

The Trust ICT infrastructure was enhanced and maintained by an investment of £7.4m which included the development of clinical information systems, increased IT capacity and enhancement of the infrastructure.

Investment in Radiography equipment exceeded £2m which included the replacement of a CT scanner and mobile image intensifiers and also the replacement and enhancement of a number of other pieces of equipment.

General Capital expenditure included a number of minor building schemes to maintain and refurbish Trust buildings and improve the patients' experience and also the replacement of a range of medical equipment.

Research and development

Research to improve the care and management of patients is an important part of the Trust's overall activity, extending right across the health and social care spectrum. Care of patients is informed by results of recent research in order to ensure that patients receive the most up-to-date, evidence-based treatment possible.

Researchers within the Trust work closely with colleagues in partner organisations, including local universities, other Trusts, major charities and local and international companies to enable access to the most recent treatments in the context of clinical trials. The relationship with Queen's University Belfast is particularly important, and responsibility for oversight of many studies is shared by both organisations. Patients and clients of the Trust play an important role in suggesting research ideas and work closely with researchers to ensure that studies are completed effectively.

Belfast Trust hosts a number of important elements of the regional Northern Ireland research structure, including the Northern Ireland Clinical Research Network, the Northern Ireland Clinical Research Facility, a Clinical Trials Unit and the Northern Ireland Cancer Trials Network. These provide expertise and research leadership for all of Northern Ireland. Funding for research within the Trust comes from a variety of sources, including Government, the EU, Research Councils, Charities and commercial partners.

The Trust research office has oversight of research taking place within the Trust and ensures that it is conducted in line with proper ethical standards and all relevant legislation. Almost one thousand research projects take place in the Trust at any time, with up to two hundred new research projects being approved each year. These range from small studies designed to better understand aspects of patient experience through to large national and international clinical trials of new drugs or cutting-edge technology.

Our research continues to influence patient management and care in almost every part of the Trust. One area of interest is adverse outcomes in pregnancy. Trust researchers are developing new ways of predicting harmful pregnancy outcomes using blood tests, which will allow mothers at highest risk to be identified early in pregnancy and offered preventive treatments. In addition our research can make a difference on a global level - previous work into how to diagnose diabetes in pregnancy has led to change in pregnancy guidelines in many countries around the world, helping to prevent harmful outcomes for both mothers and babies.

Donations and fundraising

Charitable donations help us to improve the quality of care we provide to our patients and clients across the Trust. During 2014/15, in line with the previous financial year, the Trust received donations, income and legacies totalling just under £1.8m. This income is received mainly from former patients, clients and their relatives in recognition of the Trust's work. Individual donors are too numerous to mention, but examples of improvements we have made as a result of donations and legacies received during 2014/15 include:

- Funding of medical research in a number of areas including; Alzheimer's Disease, Acute Myeloid Leukaemia, Cardiology and Ovarian, Bowel and Breast cancer
- The provision of multisensory therapy equipment at Muckamore Abbey Hospital
- Upgrading of the Physiotherapy walking training room at Musgrave Park Hospital. This has provided an enhanced rehabilitation facility for patients, in particular amputees
- A selection of garden furniture to enhance patients experience and comforts
- Provision of toys, equipment and craft supplies, and visits from entertainers to the children's wards where play specialists interact with the children to help alleviate any anxieties and fears they may have and involve the children in rehabilitation activities
- The funding of the refurbishment of a training room for neurosciences nursing and medical staff
- Provision of a Robotic Liquid Handler to enable the Laboratory to deliver a high throughput of molecular testing at the RBHSC
- Updating of the swimming pool at Muckamore Abbey Hospital
- Provision of rehabilitation activities, entertainment, outings and small Christmas gifts for Hospital inpatients, Elderly Care Facilities, Day Centre and Training Resource Centre clients throughout Belfast Trust
- A residential activity weekend took place allowing physically disabled children to enjoy outdoor supervised activities with qualified staff in attendance.

If you would like to make a donation to the Trust to help us continue to enhance the experiences of patients and clients in our care, please contact:
The Charitable Funds Section
4th Floor, Glendinning House
6 Murray Street
Belfast BT1 6DP
Tel: 028 9504 5393
E-mail: charitabletrustfunds@belfasttrust.hscni.net

BSTP: Business Services Transformation Programme

This year has seen further significant changes for the Trust as the Business Services Transformation Project (BSTP) has been progressed. The Finance, Procurement and Logistics (FPL) and Human Resources, Payroll, Travel and Subsistence (HRPTS) systems have been successfully implemented and we continue to embed new processes. We have overcome many challenges, principally in the area of payroll processing and a Regional Benefits Realisation Project has now been initiated in the Business Services Organisation (BSO) to refine the systems and related processes to ensure optimal value from the systems is achieved.

Employee and Manager Self Service functionality allows staff and managers to electronically perform a number of tasks which were previously paper based. It gives employees immediate access to their personal information and offers opportunity for improved efficiency. This functionality within HRPTS has been deployed to almost 20,000 staff with a log on rate of 58% and a plan is in place to maximise staff access to the system by roll out of a team support role and by deploying additional ICT infrastructure where possible.

A regional decision to revise the timing of implementation of the E-Recruitment module within HRPTS has resulted in modifications to the Trust's original transition plan. We are due to deploy the E-Recruitment module and transition the Recruitment function to BSO Shared Services from April 2015 on a phased basis with Nurse Recruitment to be deployed at the end of the overall deployment period.

The functions of Accounts Payable and Accounts Receivable were transferred to BSO Shared Services in February 2014 and the Payroll function transferred in May 2014. The Payroll service was particularly problematic initially due to technical system issues affecting National Insurance calculations, HMRC issues affecting tax deductions and transitional difficulties with the communication links to the Trust. All of these issues were resolved speedily through collaborative working between the relevant parties and BSO Shared Services has made significant improvements in service in the last six months of the year.

We have already established strong links with BSO Shared Services and are committed to working closely with them and the rest of the HSC in Northern Ireland to ensure that the services provided are as efficient and effective as we need them to be.

Resources

Sustainability Report

Energy

Being 'leading edge' is one of our main values and innovation is encouraged throughout the organisation. In July 2014, the Trust identified a new renewable product which uses daylight energy instead of solar energy as a means to produce renewable heat. The system is an innovative, daylight photon-powered nanotechnology which uses the photonic energy to produce heat throughout the year. In total, 56 panels were mounted at Forest Lodge providing heating and hot water for those who use the building.

A significant proportion of the Trust's electricity costs can be attributed to lighting. Many of our buildings require lighting day and night and this is often provided by older inefficient lighting. Modern LED lights consume less than half the electricity of these older lights and often have a superior light output. To avail of these benefits, the Trust has installed these high efficiency LED lights in many buildings and sites over the past year.

New efficient boilers and combined heat and power plants were installed at Muckamore Abbey Hospital. This modern energy infrastructure included new heating pipework, ensures greater resilience, increased patient comfort and reduced carbon at the same time.

Water

Water is an essential and costly resource used across the Trust every day. The Royal Victoria Hospital, Belfast City Hospital, Mater Hospital and Musgrave Park Hospital use more than 750 million litres of water each year. To reduce dependence on the mains water network and save money, the Trust has three operational borewells which provide a private supply of water to both the Belfast City Hospital and Musgrave Park Hospital sites. The borewell at Musgrave Park Hospital supplies approximately 97% of the water used each month.

Transport

We are very conscious of the environmental impact of the transport activities of the fleet of over 200 passenger and freight vehicles, which support the provision of care for patients and clients. We

take every possible opportunity to reduce the size of the fleet through improved route planning and scheduling and all Trust drivers receive mandatory training in fuel efficient driving techniques. The environmental impact of travel by patients, visitors, staff, suppliers and contractors to Trust facilities is also significant. It has been estimated that one third of all travel in Belfast relates to Belfast Trust. More sustainable forms of travel are promoted through our webpage and on appointment letters. Translink have introduced a new Metro bus service through the Musgrave Park Hospital site offering the same level of public transport service to that site as was already available to the other Belfast hospitals.

Our Travel Plan provides opportunities for staff to travel more sustainably through its schemes to promote bus and train travel; cycling; walking; and lift sharing and participation in all these schemes has continued to increase. Additionally we are working in partnership with the Public Health Agency and Sustrans to deliver a workplace active travel programme at the Royal Hospitals to encourage healthier travel modes for staff, which have the consequence of being more sustainable. Effective initiatives from the scheme will be adopted by other Trust sites and learning will be shared with other organisations seeking to promote active travel.

Waste

Belfast Trust is pro-active in the reduction, recycling and reuse of its waste. We provide mandatory waste training to staff highlighting good practice and emphasising the importance of waste reduction and use of correct waste segregation practices. The Trust monitors waste tonnage produced to ensure reduction targets are achieved and continually looks for opportunities to achieve further reductions.

We have introduced a dry mixed recycling stream for domestic waste – separating recyclable items at source such as paper, cardboard, cans, plastic bottles etc. As a result the percentage of such waste going to landfill has reduced to just over 3%, with 58% of waste being recycled and 39% reused. 100% of our clinical waste continues to be used as a fuel supplement to generate electricity. All confidential paper waste removed from the Trust is 100% recycled by a licensed contractor.

The Trust has a furniture store for desks, chairs, ward furniture, catering equipment etc to reduce the requirement to purchase new items. Any undamaged furniture not suitable for reuse within the Trust is donated to charity.

Remuneration Report

Scope of the report

The Remuneration Report summarises the remuneration policy of Belfast Trust and particularly its application in connection with senior managers. The report also describes how the Trust applied the principles of good corporate governance in relation to senior managers' remuneration in accordance with HSS (SM) 3/2001 issued by the DHSSPS.

Remuneration committee

The Board of the Trust, as set out in its Standing Orders and Standing Financial Instructions, has delegated certain functions to the Remuneration Committee including the provision of advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy. The membership of this committee is:
Mr Peter McNaney: Chairman Mr Les Drew: Non-Executive Director
Dr Val McGarrell: Non-Executive Director.

Remuneration policy

The policy on remuneration of the Trust Senior Executives for current and future financial years is the application of terms and conditions of employment as provided and determined by the DHSSPS.

Performance of Senior Executives is assessed during a performance management system which comprises of individual appraisal and review. Their performance is then considered by the Remuneration Committee and judgements are made as to their banding in line with the Departmental contract against the achievement of regional organisation and personal objectives. The relevant importance of the appropriate proportions of remuneration is set by the DHSS&PS under the performance management arrangements for senior executives. The recommendations of the Remuneration Committee go to the full Board for formal approval.

Service contracts

All Senior Executives, except the Trust Medical Director, in the year 2014/15 were employed on the DHSSPS Senior Executive Contract. The contractual provisions applied are those detailed and contained within Circulars HSS (SM) 2/2001, for those Senior Executives appointed prior to December 2008, and HSS(SM) 3/2008 for those Senior Executives appointed in the Trust since December 2008.

The Trust Medical Director is employed under a contract issued in accordance with the HSC Medical Consultant Terms and Conditions of Service (Northern Ireland) 2004.

Notice period

A three-months notice is to be provided by either party except in the event of summary dismissal. There is nothing to prevent either party waiving the right to notice or from accepting payment in lieu of notice.

Retirement age

The Trust does not operate a general retirement age for its staff including Senior Executives. However, the Trust reserves the right to require an individual or group of employees to retire at a particular age where this can be objectively justified.

Retirement benefit costs

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Superannuation Scheme can be found in the HSC Superannuation Scheme Statement in the Department Resource Account for the DHSSPS.

The cost of early retirements are met by the Trust and charged to the Net Expenditure Account at the time the Trust commits itself to the retirement.

As per requirements of IAS 19, full actuarial valuations by a professional qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full validation for Resource Accounts purposes as at 31st March 2012 was certified in February 2015 and is used in the 2014/15 accounts.

Premature retirement costs

Section 16 of the Agenda for Change Terms and Conditions Handbook sets out the arrangements for early retirement on the grounds of redundancy and in the interest of efficiency of the service.

Under the terms of Section 16 of the Agenda for Change Terms and Conditions Handbook staff made redundant who are members of the HPSS Pension Scheme, have at least two years' continuous service and two years' qualifying membership and have reached the minimum pension age, currently 50 years, can opt to retire early without a reduction in their pension as an alternative to a lump sum redundancy payment of up to 24 months' pay. In this case the cost of the early payment of the pension is paid from the lump sum redundancy payment, however if the redundancy payment is not sufficient to meet the early payment of pension cost the employer is required to meet the additional cost.

Dr Michael McBride
Chief Executive
Belfast Health and Social Care Trust

Remuneration Report

Senior Employees' Remuneration (Audited)

The salary, pension entitlements and the value of any taxable benefits in kind of the most senior members of the Trust were as follows:

	2014-15				2013-14
Name	Salary £000s	Benefits in Kind (to nearest £100)	Pensions Benefit (to nearest £1000)	Total £000s	Salary £000s
Non-Executive Members					
P McNaney (appointed 3 March 2014) (1)	20-25	N/A	N/A	20-25	0-5
L Drew	5-10	N/A	N/A	5-10	5-10
C Jenkins	5-10	N/A	N/A	5-10	5-10
V McGarrell	5-10	N/A	N/A	5-10	5-10
T Hartley	5-10	N/A	N/A	5-10	5-10
J O'Kane	5-10	N/A	N/A	5-10	5-10
Executive Members					
C Donaghy (left 30 June 2014)	35-40	N/A	N/A	35-40	145-150
M McBride (appointed 8 December 2014) (2)	40-45	N/A	34,000	70-75	N/A
A Stevens (left 31 July 2014) (3)	60-65	N/A	N/A	60-65	180-185
C Jack (appointed 1 August 2014)	180-185	N/A	50,000	230-235	N/A
M Dillon (acted up as Chief Executive 01/07/14-08/12/14)	120-125	N/A	68,000	185-190	110-115
M Edwards (acted up as Director of Finance 01/07/14-08/12/14)	85-90	800	31,000	115-120	N/A
M Mallon (left 31 July 2014)	35-40	N/A	N/A	35-40	100-105
D McAlister (appointed 1 August 2014) (4)	60-65	N/A	100,000	160-165	N/A
J Welsh	85-90	2,400	10,000	95-100	80-85
B Creaney	120-125	N/A	33,000	155-160	70-75
C McNicholl	90-95	N/A	9,000	100-105	90-95
B Barry	90-95	N/A	9,000	100-105	90-95
J Devlin	70-75	800	16,000	90-95	70-75
C Worthington	85-90	N/A	N/A	85-90	85-90

(1) Mr P McNaney appointed as Chair of Belfast HSC on 3 March 2014
(2) Dr Michael McBride appointed 8th December 2014. Estimated full year equivalent salary £190-£195k. His Full Year CETV costs are disclosed by the Belfast Trust.
(3) Dr A Stevens left 31st July 2014. His Full Year CETV costs are disclosed in the Accounts of the Northern Trust
(4) Mr D McAlister was appointed on 1st August 2014 Estimated full year equivalent salary £90k-95k. His Full Year CETV costs are disclosed by the Belfast Trust.

The Benefits in Kind listed above relate to Leased Cars.

Senior Employees' Remuneration (Cont'd)

The salary, pension entitlements and the value of any taxable benefits in kind of the most senior members of the Trust were as follows:

	2013-14			2014-15				
	Benefits in kind (to nearest £100)	Pensions Benefit (to nearest £1000)	Total £000s	Real increase in pension and related lump sum at age 60 £000s	Total accrued pension at age 60 and related lump sum £000s	CETV at 31/03/14 £000s	CETV at 31/03/15 £000s	Real increase in CETV £000s
						*	*	
P McNaney (appointed 3 March 2014) (1)	N/A	N/A	0-5	N/A	N/A	N/A	N/A	N/A
L Drew	N/A	N/A	5-10	N/A	N/A	N/A	N/A	N/A
C Jenkins	N/A	N/A	5-10	N/A	N/A	N/A	N/A	N/A
V McGarrell	N/A	N/A	5-10	N/A	N/A	N/A	N/A	N/A
T Hartley	N/A	N/A	5-10	N/A	N/A	N/A	N/A	N/A
J O'Kane	N/A	N/A	5-10	N/A	N/A	N/A	N/A	N/A
C Donaghy (left 30 June 2014)	N/A	24,000	170-175	N/A	N/A	N/A	N/A	N/A
M McBride (appointed 8 December 2014) (2)	N/A	N/A	N/A	10-12.5	275-280	1,235	1,326	51
A Stevens (left 31 July 2014) (3)	N/A	12,000	190-195	N/A	N/A	N/A	N/A	N/A
C Jack (appointed 1 August 2014)	N/A	N/A	N/A	10-12.5	200-205	851	937	58
M Dillon (acted up as Chief Executive 01/07/14-08/12/14)	N/A	18,000	125-130	12.5-15	170-175	813	918	78
M Edwards (acted up as Director of Finance 01/07/14-08/12/14)	N/A	N/A	N/A	5-7.5	90-95	329	370	30
M Mallon (left 31 July 2014)	N/A	39,000	140-145	N/A	N/A	N/A	N/A	N/A
D McAlister (appointed 1 August 2014) (4)	N/A	N/A	N/A	17.5-20	125-130	410	494	70
J Welsh	2,600	20,000	105-110	2.5-5	75-80	288	313	16
B Creaney	N/A	12,000	85-90	7.5-10	100-105	402	454	38
C McNicholl	N/A	49,000	135-140	2.5-5	160-165	765	810	19
B Barry	N/A	(8,000)	80-85	2.5-5	155-160	894	894	21
J Devlin	N/A	15,000	85-90	0-2.5	10-15	94	107	11
C Worthington	N/A	81,000	165-170	N/A	N/A	N/A	N/A	N/A

Remuneration Report

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HPSS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

* CETV are at year end or date of retirement/resignation depending on which is earlier.

CETVs are calculated within the guidelines prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (Including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude the increases due to inflation or any decreases due to transfer of pension rights.

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The midpoint of the remuneration band of the highest paid director in the Belfast HSCT in financial year 2014-15 was £182,500 (2013-14, £182,500). This was 6.26 times (2013-14, 6.54) the median remuneration of the workforce, which was £29,137 (2013-14, £27,901).

Total remuneration includes salary, non-consolidated performance-related pay,benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The change in the ratio from 6.54 in 2013-14 to 6.26 in 2014-15 arises due to the fact that the highest paid director in 2014-15 has remained in the same Banding whereas there has been an increase in the median figure as a result of incremental drift, a 1% pay award to some staff and the additions of Homehelps who now have a Whole Time Equivalent applied to them when previously they did not.

The employees that receive remuneration above the highest paid director would fall into the catagory of medical staff whose earnings would have additional allowances for their specialised roles and whose gross earnings can vary from year to year.

The median calculation is based on 21,622 employees in 2014-15 and on 20,063 employees in 2013-14. Staff with no Gross Pay or negative Gross Pay were deleted from these totals. Staff whose Whole Time Equivalents were less than full time where made up to Full Time Equivalents. Although it was not feasible to extract cumulative Gross Pays the Weekly and Monthly Gross Pays were Annualised in both years and a consistent approach was kept in both years.

Accounts

BELFAST HEALTH AND SOCIAL CARE TRUST
ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

FOREWORD

These accounts for the year ended 31 March 2015 have been prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, in a form directed by the Department of Health, Social Services and Public Safety.

STATEMENT OF ACCOUNTING OFFICERS RESPONSIBILITIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health, Social Services and Public Safety has directed the Belfast Health and Social Care Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Belfast Health and Social Care Trust, of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FREM) and in particular to:

- Observe the accounts direction issued by the Department of Health, Social Services and Public Safety including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in FREM have been followed, and disclose and explain any material departures in the financial statements;
- Prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Belfast Health and Social Care Trust will continue in operation;
- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Belfast Health and Social Care Trust;
- Pursue and demonstrate value for money in the services the Belfast Care and Social Care Trust provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Accounting Officer for health and personal social services resources in Northern Ireland has designated Dr Michael McBride of the Belfast Health and Social Care Trust as the Accounting Officer for the Belfast Health and Social Care Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Belfast Health and Social Care Trust assets as set out in the Accountable Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

Accounts

BELFAST HEALTH AND SOCIAL CARE TRUST
ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

CERTIFICATES OF DIRECTOR OF FINANCE, CHAIRMAN AND CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 103 to 146) which I am required to prepare on behalf of the Belfast Health and Social Care Trust have been compiled from and are in accordance with the accounts and financial records maintained by the Trust and with the accounting standards and policies for HSC bodies approved by the DHSSPS.

Mcii Dillon — Director of Finance

4.6.15 — Date

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 103 to 146) as prepared in accordance with the above requirements have been submitted to and duly approved by the Trust Board.

[signature] — Chairman

4 June 2015. — Date

[signature] — Chief Executive

4/6/15 — Date

Governance statement 2014/15

Introduction / scope of responsibility

The Board of the Belfast Health and Social Care (HSC) Trust is accountable for internal control. As Accounting Officer and Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisations policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health, Social Services and Public Safety (DHSSPS).

Specifically, the Trust has the following key relationships through which it must demonstrate a required level of accountability:

- With HSC Board commissioners, through service level agreements, to deliver health and social services to agreed specifications. The Trust has established engagement processes with the HSC Board (which includes the Public Health Authority (PHA) for appropriate areas). For example regular meetings are held with Local Commissioning Group (LCG) representatives to discuss local services and a Specialist Services Liaison Group (with representatives from the Trust, HSC Board and PHA) meets to review issues associated with regional services. A range of other engagement processes are in place i.e. Transforming Your Care (TYC) Collaboration Board, to address specific areas of service with HSC Board and other appropriate agencies
- With colleague agencies in the HSC, through close and positive working arrangements
- With local communities, through holding public board meetings, and publishing an annual report and accounts
- With patients, through the management of standards of patient care; and
- With the DHSSPS, through the performance of functions and meeting statutory financial duties. These are monitored through formal reporting mechanisms and Accountability Review meetings which are held twice yearly and relevant Trust senior staff are in attendance.

Compliance with Corporate Governance Best Practice

The Trust applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Trust does this by undertaking continuous assessment of its compliance with Corporate Governance best practice for example by complying with relevant controls assurance standards, completing an annual ALB Board Governance self-assessment and action plan. The Trust's self-assessment for 2014/15 was presented to Trust Board for discussion and approval. The self-assessment covered a number of areas including Board composition and commitment; Board evaluation, development and learning; Board insight and foresight; and Board engagement and involvement. The self-assessment identified a number

of issues which included; appointment terms of Non-Executive Directors not staggered due to RPA process, inclusion of feedback from key stakeholders and adverse publicity in relation to service delivery within the past 12 months. No other Trust Board performance issues were identified through this review.

The Trust has sought independent verification of the annual ALB Board Governance self-assessment. The report has confirmed the ratings and flags applied as accurate and found no disparities. This information will be used to further inform the action plan from the self-assessment process. In addition the Trust receives assurance from external and internal auditors through the Report to those Charged with Governance and Internal Audit Reports.

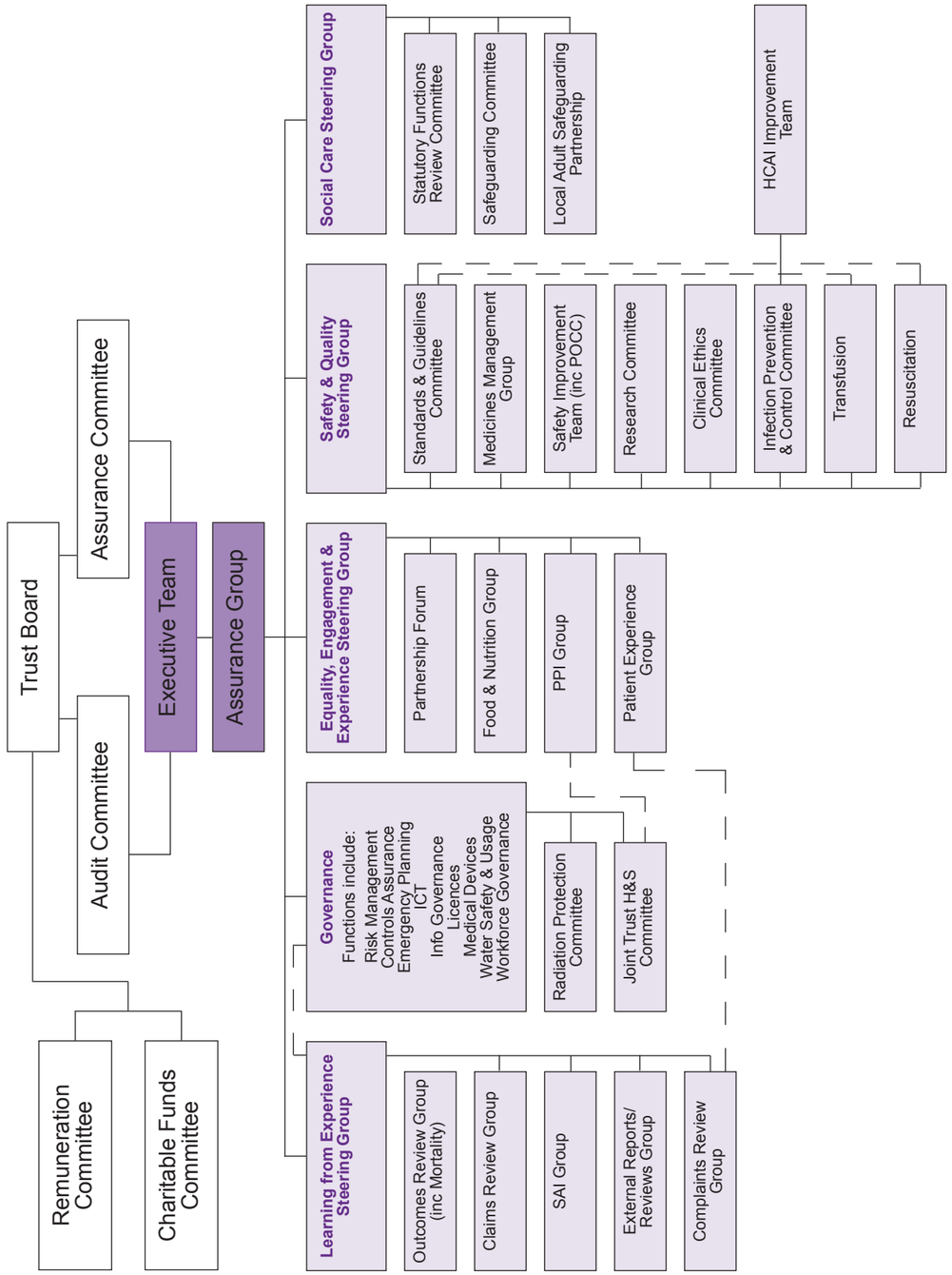
Governance framework

The Board of the Trust exercises strategic control over the operation of the organisation through a system of corporate governance which includes:

- A schedule of matters reserved for Board decisions
- A scheme of delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers
- Standing Orders and Standing Financial Instructions
- An Audit Committee
- An Assurance Committee
- A Remuneration Committee
- A Governance Steering Group
- A Safety & Quality Steering Group
- A Learning from Experience Steering Group
- A Social Care Steering Group
- An Equality, Engagement & Experience Steering Group
- A Complaints Review Group
- A Charitable Trust Fund Advisory Committee.

The following diagram demonstrates the Trust's assurance framework structure:

ASSURANCE SUB-COMMITTEE STRUCTURE



The role of the Trust Board is to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. Throughout the year the Trust Board has been briefed on control issues by the Chairs of the Audit Committee and Assurance Committee. The Trust held five public Trust Board meetings and six Trust Board workshops during 2014/15. Standing agenda items included reports from the Chief Executive, performance, quality, and financial performance reports.

Trust Board attendance records for 2014/15 ranged from 82% to 94% of attendees.

Performance is managed through a number of local, directorate and Trust wide performance and accountability structures where underperformance is identified and corrective action discussed. The Trust uses a series of Directorate scorecards and quarterly Chief Executive led performance meetings for all Directorates to provide further rigour to the performance management process.

At Trust Board meetings, the Board are provided with data on performance across all thirty two of the Ministerial Targets through the Trust Performance Report. In 2014/15 the Trust was working to deliver the 39 Ministerial Performance Targets as per the commissioning directions. The Trust did not fully deliver on eighteen of the reported performance targets within the following areas:

- Fractures
- Cancer
- ED waiting times (4 hour and 12 hour targets)
- Outpatient access waiting times (80% <9 weeks waiting / 15 week maximum waiting time)
- Diagnostic waiting times
- Inpatient and daycase access maximum waiting times (26 weeks)
- Psychological therapies waiting time.

The reasons for underperformance are different in each of the areas but the common thread includes increased demand, over and above expectations. Specific issues included:

- Fractures – A considerable growth in demand which resulted in fracture performance falling below the 95% standard in October and November 2014
- Cancer – a continued delay in transfers of patients from other Trusts so that the target to ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days, was not achieved
- ED waiting times – a 10% growth in unscheduled admissions, within a system of more complex patients, had a considerable impact on 4 and 12 hour performance
- Over delivery of review appointment activity in outpatients which resulted in a lack of capacity for new appointment activity resulting in underperformance against core new activity targets

- Considerable unfunded capacity issues in elective care which did not allow us to meet demand for example in the areas of orthopaedics, vascular surgery and urology.

The Board of Directors' review mortality data as part of the performance report and are appraised of performance against quality indicators, as set out in the Trust's Safety and Quality Improvement Plan. These indicators include HCAI, crash calls, patient falls, pressure ulcers where improvement in outcomes has been recorded.

The Audit Committee provides the Trust Board with an independent and objective review on its financial systems of internal control. The Chair of the Audit Committee provides the Board with an Annual Report each year. This committee met four times during the year. The Audit Committee completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness. The results are submitted to the DHSSPS and an action plan is drawn up for any areas that require improvement. No performance related issues were identified as part of this review. The work of the Internal Audit and External Audit functions is fundamental to providing assurances on the on-going effectiveness of the system of internal financial control. In addition, the controls assurance standards and the annual self-assessment against the standards provide an important assurance to the Assurance Committee.

The Assurance Committee met on four occasions during the year and is comprised of Non-Executive Directors only. The Head of Internal Audit is also in attendance and reports directly on any risk or governance related Internal Audit reports. The Assurance Committee's role is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for ensuring there is a robust system in place for identifying principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Remuneration Committee is responsible for advising the Board on the remuneration of the Chief Executive and Directors of the Trust, guided by DHSSPS policy and best practice. The Committee is chaired by the Trust Chairman and two other Non-Executive Directors and met twice during 2014/15.

No Assurance or Remuneration Committee performance related issues were raised by the Board Governance Self-Assessment.

Business Planning

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

The Trust's Corporate Plan sets out the vision and purpose, core values and long term objectives that will shape the strategic direction and priorities for a three year period. The Trust has five long

term corporate objectives. These are:

- To provide safe, high quality and effective care
- To modernise and reform our services
- To improve health and wellbeing through engagement with our users, communities and partners
- To show leadership and excellence through organisational and workforce development
- To make the best use of resources to improve performance and productivity.

The Corporate Plan and the Trust Delivery Plan set out annual targets to progressively deliver these corporate objectives.

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators and the Commissioning Plans of the Health and Social Care Board as set out in its Annual Commissioning Plan. While the Corporate Plan incorporates these Departmental/ commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets under each corporate objective. The Corporate Objectives and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Directorate Annual Performance Plans
- Service/Team annual plans
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework. Review and monitoring of progress against priorities and objectives (linked to DHSSPS/HSC Board priorities, the Trust Business/Management Plan (including the Trust Delivery Plan)) is carried out through:

- Trust Board Performance reports (monthly related to key performance indicators), to provide assurance at Board level
- Regular accountability/review meetings with Directorates to monitor progress against organisational and Directorate key priorities through Directorate scorecards
- Individual Personal Contribution Plans and Learning and Development Plans objectives to ensure learning and development supports the delivery of Directorate and organisational objectives.

Risk Management

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- Identify and prioritise the risks to the achievement of organisational policies, aims and objectives
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Trust is committed to providing high quality patient and client services in an environment that is both safe and secure. The Trust Board has approved an Assurance Framework and a Risk Management Strategy and has established an Assurance Committee whose membership includes all Non-Executive Directors. This Committee reports directly to the Trust Board. The Assurance Framework outlines the Chief Executive's overall responsibility and accountability for risk management. The Framework also sets out a system of delegation of responsibility at Trust Board, Executive Team and Directorate levels. While ensuring local ownership in managing and controlling all elements of risk to which the Trust may have been exposed, there is a clear line of accountability through to Trust Board.

The Risk Management Strategy was updated in June 2014 to incorporate further clarification regarding escalation of risk to the corporate risk register.

Risk management is at the core of the Trust's performance and assurance arrangements and the Assurance Committee, chaired by the Trust's Chairman, provides Board level oversight in this key area. This Committee, along with the Audit Committee, has scrutinised the effectiveness of the Risk Management Strategy.

The Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Trust may have to set priorities for the management of risk. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service. The Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Trust involves its service users, public representatives, contractors and other external stakeholders in the implementation of the Risk Management Strategy.

Risk management is integral to the training for all staff as relevant to their grade and situation, both at induction and in service. To support staff through the risk management process, expert guidance and facilitation has been available along with access to policies and procedures, outlining responsibilities and the means by which risks are identified and controlled. Actions taken to reduce risk have been regularly monitored and reported with trends being analysed at Directorate, Corporate and Board levels.

Dissemination of good practice has been facilitated by a range of mechanisms including systems for the implementation and monitoring of authorative guidance, clinical supervision and reflective practice, performance management, continuing professional development, management of adverse events and complaints, multiprofessional audit and the application of evidence based practice. The Trust seeks to ensure that its medical workforce is equipped to provide the best health care that can be achieved through investment in education, appraisal, appropriate job planning and where issues arise that are appropriate to maintaining high professional standards these are dealt with using the appropriate procedures, involvement of National Clinical Assessment Service where necessary and regulatory bodies such as the General Medical Council and General Dental Council.

Information risk

Information is a vital asset, both in terms of the management of service users and the efficient management of services and resources. It plays a key part in corporate governance, service planning and performance management. It is therefore of paramount importance to ensure that information is efficiently managed and that appropriate policies, procedures and management accountability provide a robust governance framework for information management. Within the Trust the Information Governance Board oversees all aspects of information governance including data protection, ICT security, corporate records, freedom of information and data quality throughout the Trust. It also has the responsibility to lead and foster a culture that values, protects and uses information for the public good. This body ensures participation from all Directorates and is chaired by the Director of Performance Planning and Informatics. This Director also acts as the Senior Information Risk Owner and has a key role in considering how organisation goals will be impacted by information risks and how those risks may be managed. Over 30 Information Asset Owners have been identified across the Trust who have responsibility for the identification and management of risk in their areas.

During 2014/15 the Trust has completed the Controls Assurance Standards in relation to Information Management and ICT increasing the score on the previous year. Internally the Trust undertakes Information Governance Visits to a number of Departments and provides feedback to Information Asset Owners as to the actions that can be taken to improve information handling processes. Data Protection Awareness training is mandatory and can be undertaken as e:learning or by attending one of the regular information governance sessions. Throughout the year the Information Governance Board continues to monitor the information governance incidents that occur and reported 7 incidents to the Information Commissioners Office. In May 2014 the Records and Information Governance Team were winners of National Information & Records Management Society Team of the Year Award.

Public stakeholder involvement

The Trust remains committed to ensuring that Personal and Public Involvement (PPI) is embedded into all aspects of its business.

PPI is included in the Trust Assurance Framework committee structure, reporting via the Equality, Experience and Engagement Committee. PPI has also been included in the Trust Accountability Framework, requiring all service areas to account for their PPI activity, and PPI is reflected in the Trust Corporate Plan. There continues to be a wide range of user engagement opportunities throughout the Trust, both corporately and within clinical Directorates, which allow people to become involved in the development, improvement and evaluation of Trust service. In addition there a number of Trust-wide User Forum and specific Service User groups facilitated by and linked to the Trust which can provide opportunities for service user and other stakeholders to engage in decision making, feedback processes and associated risk issues.

A draft Organisational Framework for the Management of PPI is currently being consulted on and it is envisaged that this will be published by summer 2015. The implementation of this framework should lead to the development of more opportunities for engagement with service users and other stakeholders across the organisation, on a range of issues, which could potentially include risk. A PPI Standing Forum will be established by summer 2015.

PPI training is delivered for Trust staff and four members of Trust staff participated in the PHA commissioned PPI training for trainers programme. This training programme will be cascaded throughout the organisation.

Assurance

The Assurance Framework describes the relationship between organisational objectives, identified potential risks to their achievement and the key controls through which these risks will be managed, as well as the sources of assurance surrounding the effectiveness of these controls. The Assurance Framework incorporates the Risk Management Policy and establishes the context in which the Trust Management Plan was developed, as well as determining the mechanism through which assurances were provided to the Trust Board. The Assurance Framework lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes. The Assurance Committee regularly challenges or seeks verification of the quality of evidence coming to it.

The Assurance Framework was reviewed and updated in 2014 to reflect minor changes in the document and on-going adjustment to the Sub Committee structure. The updated Assurance Framework was approved by the Assurance Committee of the Trust Board on the 16th June 2014. The Assurance Framework allows an integrated approach to performance, targets and standards

which include controls assurance standards and quality standards for health and social care.

The Assurance Committee agenda and schedule of annual reports takes account of the Sub Committees structure. These committees report through the Assurance Group to Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and provide the necessary scrutiny of practice. At each Assurance Committee meeting, through the relevant chair, the Committee receives assurance reports from the following governance committees: Social Care Steering Group; Governance Steering Group; Learning from Experience Steering Group; Outcome Review Group; Complaints Review Group; Safety and Quality Steering Group; Equality, Engagement and Experience Steering Group as well as a litigation report encompassing clinical negligence and other claims. It also receives an annual health and safety report.

In addition the Committee receives updates on the Safety and Quality Improvement Plan; SAI Reports, and summary reports of RQIA unannounced hygiene inspections, RQIA thematic reviews and RQIA inspections of regulated providers. This taken with other internal assurances and the external assurances detailed under Sources of Independent Assurance means that the Board is satisfied that this level of assurance is of sufficient quality and meets its requirements. The Risk Register Review Group continues to meet on a quarterly basis, to scrutinise the evaluation of all significant risks arising from Directorate and Controls Assurance Risk Registers. Each Directorate has maintained and further developed systems to identify risk, assess impact and likelihood of harm occurring, and to maintain control in line with the Assurance Framework and the revised Risk Management Strategy. These risks are used to populate Directorate risk registers, which are updated on an on-going basis and which feed into the Belfast Trust's Assurance Framework Principal Risks and Controls.

Controls Assurance Standards

The Trust assessed its compliance with the 22 Controls Assurance Standards which were defined by the Department and against which a degree of progress is expected in 2014/15. The Trust achieved the following levels of compliance for 2014/15.

Standard	DHSSPS Expected Level of Compliance	2013/14 Trust Level of Compliance	2014/15 Trust Level of Compliance	Verified by
Building, Land, Plant and Non-Medical Equipment	75% - 99% (Substantive)	82% Substantive	82% Substantive	Internal Audit
Decontamination of Medical Devices	75% - 99% (Substantive)	77% Substantive	78% Substantive	Self Assessment
Emergency Planning	75% - 99% (Substantive)	86% Substantive	85% Substantive	Self Assessment
Environmental Cleanliness	75% - 99% (Substantive)	87% Substantive	87% Substantive	Self Assessment
Environmental Management	75% - 99% (Substantive)	78% Substantive	82% Substantive	Self Assessment
Financial Management (core standard)	75% - 99% (Substantive)	88% Substantive	89% Substantive	Internal Audit
Fire Safety	75% - 99% (Substantive)	87% Substantive	88% Substantive	Self Assessment
Fleet and Transport Management	75% - 99% (Substantive)	85% Substantive	85% Substantive	Self Assessment
Food Hygiene	75% - 99% (Substantive)	89% Substantive	90% Substantive	Self Assessment
Governance (core standard)	75% - 99% (Substantive)	95% Substantive	95% Substantive	Internal Audit
Health & Safety	75% - 99% (Substantive)	86% Substantive	88% Substantive	Self Assessment
Human Resources	75% - 99% (Substantive)	98% Substantive	98% Substantive	Self Assessment
Infection Control	75% - 99% (Substantive)	93% Substantive	91% Substantive	Internal Audit
Information Communication & Technology	75% - 99% (Substantive)	86% Substantive	86% Substantive	Self Assessment
Information Management	75% - 99% (Substantive)	75% Substantive	78% Substantive	Self Assessment
Management of Purchasing	75% - 99% (Substantive)	78% Substantive	79% Substantive	Self Assessment
Medical Devices and Equipment Management	75% - 99% (Substantive)	79% Substantive	81% Substantive	Self Assessment
Medicines Management	75% - 99% (Substantive)	75% Substantive	76% Substantive	Self Assessment
Research Governance	75% - 99% (Substantive)	89% Substantive	92% Substantive	Internal Audit
Risk Management (core standard)	75% - 99% (Substantive)	84% Substantive	85% Substantive	Internal Audit
Security Management	75% - 99% (Substantive)	86% Substantive	87% Substantive	Self Assessment
Waste Management	75% - 99% (Substantive)	87% Substantive	87% Substantive	Self Assessment

All 22 standards maintained substantive compliance by achieving an overall score of 75% or above.
All standards maintained or improved their compliance scores with the exception of:

- Infection Control which had a slightly reduced score compared to 2013/14 as a result of bench-marking results from Internal Audit, and
- Emergency Planning which dropped by 1% primarily as a result of unexpected reduction in resources for training in year. Appropriate actions to resolve this are being progressed.

The Trust recognise the significant internal control issues identified in Internal Audit reports and have reflected these in the self-assessment scores for any individual criteria affected.

Action plans for all of these standards have been established to support improved compliance during the coming year.

Sources of Independent Assurance

The Trust obtains Independent Assurance from the following main sources:

- Head of Internal Audit's Annual Report including an overall opinion on the system of Internal Controls
- Chair of Audit Committee's Annual Report to Trust Board
- Internal Audit – through a programme of annual audits based on an analysis of risk
- Northern Ireland Audit Office; through audit of the annual accounts and subsequent report to those charged with governance alongside any value for money (VFM) studies and subsequent reports
- Regulation and Quality Improvement Authority (RQIA); through regular inspections and subsequent reports
- Social Services Inspectorate for older people and children's services
- Medicines and Healthcare products Regulatory Agency (MHRA) through regular inspections and reports
- General Medical Council (GMC), General Dental Council (GDC), NI Medical and Dental Training Agency (NIMDTA) and various Royal Colleges.

Clinical Pathology Accreditation (CPA) is part of the routine cycle of external quality assurance for Clinical Pathology Laboratories across the UK. All the laboratories which require CPA accreditation are accredited. The Trust has had a number of inspections from CPA throughout 2014/15 (the Haematology Laboratory in the Mater Hospital and Regional Immunology Laboratory) and the laboratories inspected remain CPA accredited following inspection. Action plans have been requested and provided to address any non-conformances identified by the inspectors and the Trust is awaiting indication that the CPA inspectors are satisfied with the Trust's responses.

CPA is being replaced with UKAS accreditation to ISO 15189 standards. All laboratories requiring UKAS accreditation are working towards this. Both the Regional Immunology Laboratory and the Haematology Laboratory on the Mater Hospital site have been inspected and further work is required before the inspectors will consider a formal inspection for UKAS accreditation.

The Trust Blood Bank service had been subject to regular MHRA inspections. The last inspection was in May 2014 and the Trust Blood bank was deemed complaint with the Blood Safety and Quality Regulations (2005).

The British Standards Institute (BSI) is the Notified Body who audits compliance of the Central Decontamination Units (CDU) and the Endoscopy Decontamination Unit (EDU) against the relevant Medical Devices Directives. The Trust is audited biannually. Following the most recent audit all units (RVH, MPH CDU's and BCH EDU) retained their accreditation.

The Trust engages proactively with all such reviews and the Board is assured that appropriate actions are taken, by the Assurance Committee.

The Trust can confirm that it has effective arrangements in place to ensure the timely and effective implementation of agreed National Institute for Health and Clinical Excellence (NICE) guidance where reasonably practical. Any risks associated with non or partial compliance are highlighted in the Corporate Risk Register/Principal Risk Document and are reported to the HSC Board as required.

Internal audit

The Trust utilises an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

In 2014/15 Internal Audit reviewed the following systems:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Use of HRPTS	Limited
Non Pay expenditure (FPL)	Limited
Bank and cash (FPL)	Satisfactory
Financial assessments (including Direct Payments)	Satisfactory - Financial sssessments Limited - Direct Payments
Cash handling in Social Services Facilities	Satisfactory – Overall Limited - Glandore Children's Home
Management of client monies in the independent sector	Satisfactory - majority of facilities visited Limited – 3 facilities
Adult supported living client monies (Trust and independent sector)	Satisfactory – Trust Facilities Limited – Independent Sector Facilities
Year end stock take review	Satisfactory
Performance management and reporting	Satisfactory
Management of waiting lists (diagnostics and scopes)	Satisfactory
Reporting on discharge of statutory functions by social workers	Limited
Management and recruitment of medical locum staff	Satisfactory
Management of ICT contracts	Satisfactory
Statutory and mandatory training	Limited
Efficiencies and service reform	Satisfactory
Risk management	Satisfactory
Management of GP out of hours services	Satisfactory
Claims management	Satisfactory
Victoria Pharmaceuticals regional manufacturing unit	Satisfactory

In their annual report, the Internal Auditor reported that there is a satisfactory system of internal control designed to meet the Trust's objectives for the year ended 31 March 2015.

However, limited assurance has been provided in respect of four audits:

- Use of Human Resources, Payroll, Travel & Subsistence System (HRPTS): Limited assurance due to significant issues in relation to the number of HR files missing, authorisation of payments, core user access to HRPTS, roles and responsibilities between BHSCT and BSO Shared Service Payroll not being clarified, inaccuracies in management information reports and inaccurate payments
- Non-Pay Expenditure (FPL): Limited assurance due to significant issues in relation to Trust Managers knowledge and use of the system, checking the validity of requests to change trader bank details, and clarification on the roles and responsibilities of the Trust and the BSO Shared Service Centre
- Reporting on Discharge of Statutory Functions by Social Workers: Limited assurance in respect of insufficient evidence to support the statutory functions report and issues around the quality assurance of data
- Statutory & Mandatory Training: Limited assurance due to multiple systems being used to record training records, clarification needed on what statutory and mandatory training is required for different groups of staff, no evidence of comprehensive reporting at corporate level and attendance rates at training courses.

The following four reports received overall satisfactory level of assurance, however limited assurance was provided in specific areas as follows:

- Financial Assessments including Direct Payments: Internal Audit reported satisfactory assurance in respect of Financial Assessments but limited assurance in respect of Direct Payments. This was primarily due to the lack of evidence in respect of monitoring of direct payments
- Cash Handling in Social Services facilities: satisfactory assurance overall but limited in respect of Glandore Children's Home. This was due to the level of monies held within the facility and an insufficient audit trail for all transactions
- Management of Client Monies in the Independent Sector: satisfactory assurance for 10 out of the 13 facilities visited but limited assurance in respect of three facilities where there were insufficient controls around residents' bank accounts and monies
- Adult Supported Living Client Monies (Trust and Independent Sector): satisfactory assurance for Trust services and limited assurance for Independent Sector services. Exceptions noted included use of business accounts for clients' monies and inadequate controls around the management of service users' bank accounts.

A total of 36 Priority One findings (weaknesses that could have a significant impact on the system under review) were identified during 2014/15. 28 of which are included in the limited assurance

reports detailed above. All Priority One findings have been considered when identifying possible internal control divergences. Recommendations to address these control weaknesses have been or are being implemented. The Audit Committee have reviewed management responses to Internal Audit recommendations and monitor progress with the implementation of recommendations. Internal Audit conduct formal follow-up reviews in respect of the implementation of the priority one and two internal audit recommendations agreed in the Internal Audit reports. Internal Audit presented a full report which showed that 97% of agreed actions have been fully or partially implemented.

Review of effectiveness of the system of internal governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance within the Belfast HSC Trust. My review of the effectiveness of the system of internal governance is informed by the work of the internal auditors and the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Assurance Committee and sub committees, and a plan to address weaknesses and ensure continuous improvement to the system is in place.

Follow up audits are carried out and the Trust will continue to implement the compliance regime during 2015/16.

Internal Control Divergences
Prior Year Control Issues – closed

Management of Maintenance Contracts

All Service and Maintenance contracts with an annual value in excess of £10,000 have had a Contract Review Meeting. The ESD Contracts Department is utilising eSourcingNI as a procurement method to advertise and tender Service and Maintenance Contracts. Internal Audit have confirmed that all recommendations within our control have been fully implemented.

Radiology Information System

The Trust continues to manage the Radiology Information System at RVH to ensure that all appropriate plain film x-rays are allocated to a reporting work list. RQIA has completed a review and the Trust is working through the recommendations with the significant recommendations

completed. The Trust is in discussion with HSCB regarding a longer term solution to the Radiology Information System. This area will continue to be monitored through normal working arrangements.

Radiology reporting in orthopaedics

The Trust has developed a policy (Plain Film Evaluation and Recording by Orthopaedic Medical Staff) which has been operational since October 2014. This policy was approved by Trust Standard and Guidelines Committee in July 2014 and is available on the Trust intranet Hub. Directorate audits are now taking place regularly to monitor compliance and results are discussed at Orthopaedic team meetings. Internal Audit have confirmed that all recommendations have been fully implemented.

Paediatric congenital cardiac surgery

Further to the “Safe and Sustainable” review and public consultation on the future provision of services, the Minister, in consultation with his counterpart in the Republic of Ireland, commissioned a further review to consider the most appropriate service provision model for children with congenital cardiac disease. Following these reviews the Health Minister announced on 14th October 2014 that having considered the reports he recommended the implementation of a new cross-border model of co-operation that would result in scheduled paediatric heart surgery moving from Belfast to Dublin. This service is now being transferred to Dublin and in the interim Evelina and Birmingham Children’s are providing on-going services until the capacity in Dublin is assured. An all island CHD Network Board with senior Trust representatives is now constituted and meetings are on-going to ensure safe and effective care.

Patent case

This legal case related to the application of patent law to the design and construction of specialist buildings, and in this case a datacentre. The Trust usually procures products from suppliers or constructs buildings to its own commissioned designs, so this is a highly unusual area for the Trust to operate. In the unlikely event that the Trust does wish to procure a datacentre in future, we shall ensure design team check for and comply with any applicable patents.

The information on the extent of the patent and its applicability has been brought to the attention of the professional staff in BSO.

The case has now been settled out of court.

Special measures

On 21 November 2012 the Minister announced that the Special Measures arrangements introduced in April 2012 were being relaxed in view of the progress which has been made by the Trust in addressing a number of specific areas of concern. The Trust continues to formally report

performance and financial information to the DHSSPS in accordance with the normal accountability arrangements which are part of the HSC regular monitoring regime.

Asbestos and Construction, Design and Management (CDM) Regulations

The report to the Trust following criminal proceedings in the crown court made one recommendation – introduction of an asbestos permit to work system. To successfully implement such a system would require dedicated staff whose sole role would involve managing asbestos and the associated permit-to-work system. Health Estates submitted a bid for regional funding for this resource which was declined. It is the Trust’s priority to ensure that any potential exposure risk is alleviated and we continue to manage remaining asbestos safely so as to not pose any risk to patients, staff or visitors using our buildings.

Progress on Prior Year Control Issues – on-going

Trust procurement processes

The Trust has implemented the recommendations within our control from the action plan which had been developed as a result of the DHSSPS Review of Procurement Report. The Trust will implement those actions currently outside our control along with any outstanding internal audit recommendations once regional agreement has been reached or regional guidance has been issued e.g. outcomes from the DHSSPS lead Regional Task & Finish Group. The DHSSPS are currently drafting an overall Procurement Strategy for the HSC.

Financial position

In its Trust Delivery Plan for 2014/15, the Trust identified a potential year-end deficit of £27m, comprising unfunded cost pressures of £12m and projected savings slippage of £15m. A number of risks and assumptions around income, cost pressures and achievement of substantial savings underpinned the financial plan. The financial forecast was amended during the year to financial breakeven to take account of additional non-recurrent income of £25.5m received from HSCB as a result of the June and October monitoring rounds and to reflect contingency proposals totalling £1.5m.

Despite the emergence of a number of new cost pressures during the year and considerable slippage on acute reform savings in particular, the Trust has been able to achieve financial balance in 2014/15. This is attributable to a combination of contingency measures, slippage on new service developments and the allocation of non-recurrent funding by HSCB.

Moving forward into 2015/16 financial year the Trust faces significant challenges within an even tighter funding environment to address clinical targets and capacity issues whilst achieving a balanced financial position.

Business Service Transformation Project

The Trust previously reported on the challenges experienced with the implementation of the Business Services Transformation Project (BSTP) within Northern Ireland. The Finance, Procurement and Logistics (FPL) and Human Resources, Payroll, Travel and Subsistence (HRPTS) systems have been successfully implemented and we continue to embed new processes. We have overcome many challenges, principally in the area of payroll processing and a Benefits Realisation Project (BRP) has now been initiated in BSO to refine the systems and related processes to ensure optimal value from the systems is achieved. The regional BRP is expected to complete its work by March 2016.

Employee and Manager Self Service functionality within HRPTS has been deployed to almost 20,000 staff with a log on rate of 58% and a plan is in place to maximise staff access to the system by roll out of a team support role and by deploying additional ICT infrastructure where possible.

The functions of Accounts Payable and Accounts Receivable were transferred to BSO Shared Services in February 2014 and the Payroll function transferred in May 2014. The Payroll service was particularly problematic initially due to technical system issues affecting National Insurance calculations, HMRC issues affecting tax deductions and transitional difficulties with the communication links to the Trust. All of these issues were resolved speedily through collaborative working between the relevant parties and BSO Shared Services has made significant improvements in the last six months of the year.

A number of forums, both local and regional, have been established over the last number of months to monitor performance of BSO Shared Service Centres and appropriate key performance indicators have been established for the year ahead. The Shared Service Centres for Accounts Payable and for Payroll received limited Internal Audit opinions during the year and progress with related recommendations is monitored through the customer forums. Additionally, from April 2015, BSO have agreed to provide us with a quarterly assurance report in respect of the Shared Services provided.

A regional decision to revise the timing of implementation of the E-Recruitment module within HRPTS has resulted in modifications to the Trust's original transition plan. We are due to deploy the E-Recruitment module and transition the Recruitment function to BSO Shared Services from April 2015 on a phased basis with Nurse Recruitment to be deployed at the end of the overall deployment period.

Unscheduled care

The consultation process in respect of the future provision of emergency services in Greater Belfast concluded in May 2013 and pending a final decision the Trust continues to manage Emergency Services through 2 adult Emergency Departments (at RVH and MIH) and a Paediatric

Emergency Department. The Trust continues to identify waiting times to be seen by a Doctor in the Emergency Department as a risk and at this time can only give a partial assurance that patients will be seen in the timeframe recommended by the Manchester Triage System. The Trust has implemented processes to mitigate against this risk and when waiting times are approaching a breach, contingency arrangements are activated. The Trust's ability to recruit sufficient middle grade doctors to the Emergency Department continues to be challenging. A recruitment drive for consultants in line with College of Emergency Medicine recommendations has been implemented alongside the introduction of annualised consultant job plans. The Trust has developed a focused action plan to address the continuing challenges faced in the adult emergency departments supported by an IPT.

A report of the RQIA inspection of the Emergency Department at RVH was published on the 8 April 2014. A follow-up inspection was carried out from 9 to 11 December 2014. The report of this inspection concluded that good progress had been made to address the recommendations of the previous inspection with 17 recommendations being assessed as addressed, 3 recommendations addressed in principle, and 5 partially addressed. RQIA reported a significant improvement in nurse and consultant medical staffing levels and acknowledged that staff training was on-going with staff receiving induction training, supervision and appraisals. RQIA reported that difficulties continue in respect of staffing at speciality doctor level and a further 12 recommendations were made. An action plan was subsequently submitted to RQIA. The Trust's current assessment is that all of the first 25 recommendations and 11 of the 12 additional recommendations have been addressed. The outstanding recommendation regarding appointment of sufficient speciality doctors remains challenging. The Trust has embarked on a marketing and advertising campaign to recruit and is exploring alternative new roles (physician associates) in conjunction with the DHSSPS. Given the pressures in Adult Unscheduled Care across NI the Chief Medical Officer and Chief Nursing Officer have set up a regional taskforce to support the necessary improvements. Belfast is a separate work stream on this taskforce.

The Trust took possession of the new critical care building at the Royal site on the 24 April 2015. Plans to commission services (beginning with the Emergency Department) continue at pace and it is envisaged that the existing ED will transition across to the new building before Winter 2015.

Critical care and theatres will not move across until early in the 2016/17 financial year so as to allow for the completion of a substantial programme of post contract works in 2015/16. It is envisaged that the occupation of the maternity floors by maternity services will be in line with the timetable for the new maternity hospital.

The Children's ED which is contained in the Royal Belfast Hospital for Sick Children continues to deliver an effective unscheduled care service.

Hyponatraemia inquiry

The Trust has contributed fully to the public inquiry into deaths caused by hyponatraemia. The Trust has not been formally advised of the timescale for the publication of this report.

Serious Adverse Incidents

In February 2014 the Trust identified that in a number of cases, patients and/or families had not been fully informed of the occurrence of an adverse event and had not necessarily received feedback following proper investigation. Immediate corrective action was taken and a formal investigation was initiated. All staff involved in the management of SAIs were reminded of the absolute obligation (as defined in extant Trust policy) to engage with patients/service users and if appropriate their families when harm has occurred during the delivery of care.

Subsequently the Trust completed their planned review of the Incident Policy and associated procedures in April 2014, which included further clarity in relation to such engagement and training packages were also reviewed and updated accordingly. Patient/client and family/carer engagement and communication with the HM Coroner is now routinely monitored via HSCB on an on-going basis. The Trust continues to work collaboratively with HSCB and other ALB's to refine how this data is collected regionally. In addition the Trust launched an eLearning package to support the 'Being Open' policy and continues to provide regularly sessions on Root Cause Analysis (RCA) methodology and Incident reporting. The Trust has also established a RCA Chairs forum to support staff who are required to lead investigations associated with SAIs. The forum met twice in 2014/15 and will meet three times a year going forward.

The series of Incident related procedures now includes a procedure for shared learning, underpinning processes within the organisations Assurance Framework and reinforcing all conduits for learning, not only from incidents but also claims, complaints and audit. The Trust remains committed to continual improvement in this area.

Sir Liam Donaldson's report has now been published and this concluded that Northern Ireland was as safe as any other health care system. There are a number of strategic recommendations which are currently out for consultation to the end of May 2015. The Trust fully participated in the Donaldson Review and is currently engaged in the process of developing a collaborative HSC response.

New Control Issues
Iveagh Centre

The Iveagh Centre is the Regional Learning Disability Children's Inpatient Unit providing assessment and treatment services.

During 2012 the Trust, in consultation with the HSCB, identified a number of shared concerns. These included issues, also highlighted through RQIA Inspections, pertaining to skill mix within the Unit, the incidents of restrictive practices, unplanned admissions and delayed discharges. In response to these circumstances the Trust and HSCB jointly commissioned an Independent Review of the service which commenced mid 2013 with the final report published during November/December 2013. This report made a number of recommendations including the improvement of staff support and development opportunities and the securing of additional resources to enhance the skill mix within the service, on site management arrangements and the availability of community based services.

Following an inspection of the service, undertaken by RQIA during March 2014, significant improvement was noted while also recognising that 9 previously noted recommendations required further attention. However subsequent unannounced inspections were undertaken by RQIA on 30th May and 4th June 2014 which resulted in 35 recommendations and 5 formal Improvement Notices being issued. These formal Improvement Notices primarily related to governance arrangements surrounding restrictive practices, behavioural interventions, care planning and associated staff training/ development. In response to these developments a comprehensive and robust action plan was immediately put in place to ensure that all outstanding issues were urgently addressed and significant additional resources were deployed to the service. This was reflected in the outcome of subsequent RQIA inspections undertaken on 15/16th July 2014 and on 13th August 2014 following which the Trust received formal confirmation from RQIA that the service was fully compliant with all outstanding recommendations reviewed and that the 5 Improvement Notices had been fully addressed and would be withdrawn with immediate effect. Detailed and comprehensive arrangements are in place to ensure that full compliance is maintained and these issues remain the subject of continuous review. Since the mid-year Assurance Statement a further inspection has confirmed that full compliance has been maintained.

Radiation waste

During the year the NI Environment Agency issued a radioactive enforcement waste notice to the Trust. This was as a result of the Trust releasing one of our radioactive waste tanks one month earlier than required by the Radioactive Substances Act 1993. The Trust has completed a full investigation and has implemented an action plan to comply with the regulations. A follow-up visit was conducted on 14 November 2014 and an action plan agreed regarding repairs to be completed by June 2015. Following this the NI Environment Agency has accepted this as a satisfactory response to the enforcement notice.

Prompt payment performance

The Trust achieved 80.4% compliance in relation to the DHSSPS prompt payment target of paying 95% of invoices within 30 days. A change in measurement of the target from contracted terms to 30 days resulted in a reduced compliance rate for 2013/14 compared to previous years. Following

a move in February 2014 to BSO Accounts Payable Shared Service, the achievement of the target is now dependent both on procedures within BSO Accounts Payable Shared Service and appropriate actions by the Trust's nominated approvers. We witnessed a further fall in compliance during this first year of Shared Services and the cumulative prompt payment compliance for 2014/15 was 80.4%. The last two months of the year saw a much improved rate of over 87% and the Trust continues to work closely with BSO to ensure that all efforts to improve prompt payment compliance continue.

Marshall Inquiry/Safeguarding Board NI (SBNI) Thematic Review

There have recently been a number of reviews around the area of child sexual exploitation. The Trust has been fully engaged with the processes related to the Marshall Inquiry and subsequent report. At a regional level, the Trust is participating in the implementation of the Regional Action Plan to address the report's recommendations.

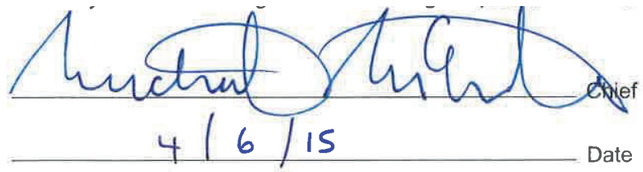
The Trust has also been fully engaged with the SBNI Thematic Review process. The Trust is awaiting the publication of the final Report in late June 2015.

In the interim the Trust has proactively sought to assimilate and disseminate learning from both processes as it emerges. The Trust has established arrangements to distil the emerging learning to inform practice development and service delivery arrangements and has incorporated this into a Trust Action Plan.

Conclusion

The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI.

Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the Trust has operated a sound system of internal governance during the period 2014/15.



Chief Executive

4/6/15

Date

BELFAST HEALTH AND SOCIAL CARE TRUST

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited the financial statements of the Belfast Health and Social Care Trust and its group for the year ended 31 March 2015 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise the Consolidated Statements of Comprehensive Net Expenditure, Financial Position, Changes in Taxpayers' Equity, Cash Flows, and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the group's and Belfast Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Belfast Health and Social Care Trust; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of Belfast Health and Social Care Trust's affairs as at 31 March 2015 and of the net expenditure, cash flows and changes in taxpayers' equity for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health, Social Services and Public Safety directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Department of Health, Social Services and Public Safety directions made under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance and Personnel's guidance.

Report

I have no observations to make on these financial statements.

KJ Donnelly

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU

Date 25 June 2015

BELFAST HEALTH AND SOCIAL CARE TRUST

CONSOLIDATED STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE YEAR ENDED 31 MARCH 2015

	NOTE	2015 £000s		2014 £000s	
		Trust	Consolidated	Trust	Consolidated
Expenditure					
Staff costs	3.1	(748,531)	(748,197)	(734,156)	(733,887)
Depreciation	4	(50,698)	(50,698)	(47,568)	(47,568)
Other expenditures	4	(536,753)	(537,956)	(486,929)	(488,024)
		(1,335,982)	(1,336,851)	(1,268,653)	(1,269,479)
Income					
Income from activities	5.1	43,039	43,039	42,120	42,120
Other operating income	5.2	44,454	45,524	49,889	51,127
Deferred income	5.3	0	0	0	0
		87,493	88,563	92,009	93,247
Net Expenditure		**(1,248,489)**	**(1,248,288)**	**(1,176,644)**	**(1,176,232)**
Revenue Resource Limit (RRL)	25.1	1,248,551	1,248,551	1,176,756	1,176,756
Add back charitable trust fund net expenditure		[redacted]	(201)	[redacted]	(412)
Surplus / (Deficit) against RRL		**62**	**62**	**112**	**112**

OTHER COMPREHENSIVE EXPENDITURE

	NOTE	2015 £000s		2014 £000s	
Items that will not be reclassified to net operating costs:		Trust	Consolidated	Trust	Consolidated
Net gain/(loss) on revaluation of property, plant and equipment	6.1/10/ 6.2/10	37,429	37,429	31,430	31,430
Net gain/(loss) on revaluation of intangibles	7.1/10/ 7.2/10	0	0	0	0
Net gain/(loss) on revaluation of charitable assets	8	0	2,780	0	1,602
Items that may be reclassified to net operating costs:					
Net gain/(loss) on revaluation of available for sales financial assets		0	0	0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2015		**(1,211,060)**	**(1,208,079)**	**(1,145,214)**	**(1,143,200)**

The notes on pages 107 to 146 form part of these accounts.

It is important to note however the distinction between public funding and the other monies donated by private individuals still exists.

"All funds have been used by the Belfast Health and Social Care Trust as intended by the benefactor. It is for the Charitable Trust Fund Advisory Committee within the Trust to manage the internal disbursements. The committee ensures that charitable donations received by the Trust are appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

All such funds are allocated to the area specified by the benefactor and are not used for any other purpose than that intended by the benefactor".

BELFAST HEALTH AND SOCIAL CARE TRUST

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

	NOTE	2015 Trust £000s	2015 Consolidated £000s	2014 Trust £000s	2014 Consolidated £000s
Non Current Assets					
Property, plant and equipment	6.1/6.2	1,077,815	1,077,815	1,059,688	1,059,688
Intangible assets	7.1/7.2	13,029	13,029	9,010	9,010
Financial assets	8.0	0	45,381	0	41,253
Trade and other receivables	12.0	0	0	0	0
Other current assets	12.0	0	0	0	0
Total Non Current Assets		**1,090,844**	**1,136,225**	**1,068,698**	**1,109,951**
Current Assets					
Assets classified as held for sale	9.0	983	983	6,352	6,352
Inventories	11.0	14,162	14,162	13,430	13,430
Trade and other receivables	12.0	36,908	36,914	33,228	33,342
Other current assets	12.0	465	465	593	593
Intangible current assets	12.0	0	0	105	105
Financial assets	8.1	0	0	0	0
Cash and cash equivalents	13.0	14,005	14,526	21,393	23,024
Total Current Assets		66,523	67,050	75,101	76,846
Total Assets		**1,157,367**	**1,203,275**	**1,143,799**	**1,186,797**
Current Liabilities					
Trade and other payables	14.0	(174,151)	(174,189)	(190,051)	(190,160)
Other liabilities	14.0	(1,218)	(1,218)	(666)	(666)
Intangible current liabilities	14.0	0	0	0	0
Provisions	16.0	(28,911)	(28,911)	(28,660)	(28,660)
Total Current Liabilities		(204,280)	(204,318)	(219,377)	(219,486)
Non Current Assets plus/less Net Current Assets / Liabilities		**953,087**	**998,957**	**924,422**	**967,311**
Non Current Liabilities					
Provisions	16.0	(40,704)	(40,704)	(37,185)	(37,185)
Other payables > 1 yr	14.0	(12,251)	(12,251)	(9,110)	(9,110)
Financial liabilities	8.0	0	0	0	0
Total Non Current Liabilities		(52,955)	(52,955)	(46,295)	(46,295)
Assets less Liabilities		**900,132**	**946,002**	**878,127**	**921,016**
Taxpayers' Equity					
Revaluation reserve		144,390	144,390	108,101	108,101
SoCNE reserve		755,742	755,742	770,026	770,026
Other reserves - charitable fund		0	45,870	0	42,889
		900,132	**946,002**	**878,127**	**921,016**

The notes on pages 107 to 146 form part of these accounts.

Signed ..... (Chairman) Date 4th June 2015

Signed ..... (Chief Executive) Date 4/6/15

BELFAST HEALTH AND SOCIAL CARE TRUST

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015

	NOTE	SoCNE Reserve £000s	Revaluation Reserve £000s	Charitable Fund £000s	Total £000s
Balance at 31 March 2013		**763,388**	**76,899**	**40,875**	**881,162**
Changes in Taxpayers' Equity 2013/14					
Grant from DHSSPS		1,183,000			1,183,000
Transfers between reserves		257	(257)	0	0
(Comprehensive expenditure for the year)		(1,176,644)	31,430	2,014	(1,143,200)
Transfer of asset ownership		(51)	29	0	(22)
Non cash charges - auditors remuneration	4	76			76
Movement - other		0			0
Balance at 31 March 2014		**770,026**	**108,101**	**42,889**	**921,016**
Changes in Taxpayers' Equity 2014/15					
Grant from DHSSPS		1,233,000			1,233,000
Transfers between reserves		1,140	(1,140)	0	0
(Comprehensive expenditure for the year)		(1,248,489)	37,429	2,981	(1,208,079)
Transfer of asset ownership		(5)	0	0	(5)
Non cash charges - auditors remuneration	4	70			70
Balance at 31 March 2015		**755,742**	**144,390**	**45,870**	**946,002**

BELFAST HEALTH AND SOCIAL CARE TRUST

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

	NOTE	2015 £000s	2014 £000s
Cash flows from operating activities			
Net expenditure after interest		(1,248,288)	(1,176,232)
Adjustments for non cash costs		85,267	36,744
(Increase)/decrease in trade and other receivables		(3,339)	1,317
Less movements in receivables relating to items not passing through the NEA			
Movements in receivables relating to the sale of property, plant and equipment		0	0
Movements in receivables relating to the sale of intangibles		0	0
Movements in receivables relating to finance leases		0	0
Movements in receivables relating to PFI and other service concession arrangement contracts		0	0
(Increase)/decrease in inventories		(732)	(1,173)
Increase/(decrease) in trade payables		(12,278)	23,289
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property plant and equipment		2,737	(549)
Movements in payables relating to the purchase of intangibles		0	0
Movements in payables relating to finance leases		0	0
Movements in payables relating to PFI and other service concession arrangement contracts		3,694	5,812
Use of provisions	16	(14,362)	(18,330)
Net cash outflow from operating activities		(1,187,301)	(1,129,122)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	6	(48,152)	(64,002)
(Purchase of intangible assets)	7	(6,570)	(4,273)
Proceeds of disposal of property, plant & equipment		15	0
Proceeds on disposal of intangibles		0	0
Proceeds on disposal of assets held for resale		5,551	1,044
Drawdown from investment fund		(1,098)	(1,053)
Share of income reinvested		(250)	350
Net cash outflow from investing activities		(50,504)	(67,934)
Cash flows from financing activities			
Grant in aid		1,233,000	1,183,000
Cap element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		(3,693)	(5,812)
Net financing		1,229,307	1,177,188
Net increase (decrease) in cash & cash equivalents in the period		(8,498)	(19,868)
Cash & cash equivalents at the beginning of the period	13	23,024	42,892
Cash & cash equivalents at the end of the period	13	14,526	23,024

The notes on pages 107 to 146 form part of these accounts.

BELFAST HEALTH & SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

1 Authority

These accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

The accounting policies follow IFRS to the extent that it is meaningful and appropriate to HSC Trusts. Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The Trust's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts, unless otherwise stated.

The PFI liability comparative figures shown within note 14 and 19 have been reclassified within the categories for less than and greater than 1 year, a smoothing effect to show a contained average figure for each year has been used to give a true and fairer view.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Currency and Rounding

These accounts are presented in UK Pounds sterling. The figures in the accounts are shown to the nearest £1,000.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Land, Buildings, Dwellings, Transport Equipment, Plant & Machinery, Information Technology, Furniture & Fittings, and Assets under construction.

Recognition
Property, plant and equipment must be capitalised if:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably, and
- The item has cost of at least £5,000, or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £1,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control, or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as "under construction" are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation of Land and Buildings
Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors (Statement of Asset Valuation Practice) Appraisal and Valuation Standards in so far as these are consistent with the specific needs of HSC.

The last valuation was carried out on 31 January 2015 by Land and Property Services (LPS) which is an independent executive within the Department of Finance and Personnel. The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard. The valuation at 31 January 2015 was considered by LPS to be not materially different to 31 March 2015 and there has therefore been no change to the values used.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Land and non-specialised buildings - open market value for existing use
- Specialised buildings - depreciated replacement cost
- Properties surplus to requirements - the lower of open market value less any material directly attributable selling costs or book value at date of moving to non - current assets.

Modern Equivalent Asset
DFP has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Land and Property Services have included this requirement within the latest valuation.

Assets Under Construction (AUC)
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use. The Trust has no borrowing costs and as such, no interest is capitalised in this respect.

Short Life Assets
Short life assets are not indexed. Short life is defined as a useful life of up to and including 5 years. Short life assets are carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Where the estimated life of fixtures and equipment exceeds 5 years, suitable indices will be applied each year and depreciation will be based on indexed amount.

Revaluation Reserve
An increase arising on revaluation is taken to the Revaluation Reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of "non - current assets held for sale" are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. The following asset lives have been used:

Asset Type	Asset Life
Freehold Buildings	25 - 60 years
Leasehold property	Remaining period of lease
IT Assets	3 - 10 years
Intangible assets	3 - 10 years
Other Equipment	3 - 15 years

1.5 Impairment loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits, the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the impairment in the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying

amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the Revaluation Reserve.

1.6 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the Trust's buildings takes account of the fact that different components of those buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

1.7 Intangible assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and intangible Assets under Construction. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for us
- The intention to complete the intangible asset and use it
- The ability to sell or use the intangible asset
- How the intangible asset will generate probable future economic benefits or service potential
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Donated assets

With effect from 1 April 2011, DFP guidance changed the policy on donated asset reserves. The donation reserve no longer exists. What used to be contained in the donated asset reserve has moved to the Statement of Comprehensive Net Expenditure Reserve (previously known as General Reserve) and to the Revaluation Reserve. Income for donated assets is now recognised when received.

1.9 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. In order to meet this definition IFRS 5 requires that the asset must be immediately available for sale in its current condition and that the sale is highly probable. A sale is regarded as highly probable where an active plan is in place to find a buyer for the asset and the sale is considered likely to be concluded within one year. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less any material directly attributable selling costs. Fair value is open market value, where one is available, including alternative uses.

Assets classified as held for sale are not depreciated.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount. The profit from sale of land which is a non depreciating asset is recognised within income. The profit from sale of a depreciating asset is shown as a reduced expense. The loss from sale of land or from any depreciating assets is shown within operating expenses. On disposal, the balance for the asset on the revaluation reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve.

Property, plant or equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.11 Income

Operating Income relates directly to the operating activities of the Trust and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Grant in aid
Funding received from other entities, including the Department and the Health and Social Care Board are accounted for as grant in aid and are reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.12 Investments

The Trust does not have any investments.

1.13 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Private Finance Initiative (PFI) transactions

DFP has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure, and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received
b) Payment for the PFI asset, including replacement of components
c) Payment for finance (interest costs).

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Assets
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the

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construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Off Statement of Financial Position PFI
The Trust has one off Statement of Financial Position PFI agreement where the asset has been determined under IFRS to belong to the contractor. The Trust does not have the asset on its Statement of Financial Position, no payments to the contractor are made therefore no financial impact to the Trust is reflected in the Statement of Comprehensive Net Expenditure.

1.17 Financial instruments

Financial Assets
Financial assets are recognised in the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial liabilities
Financial liabilities are recognised in the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial risk management
IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Liquidity risk
Since the Trust receives the majority of its funding through its principal Commissioner which is voted through the Assembly, it is therefore not exposed to significant liquidity risks.

1.18 Provisions

In accordance with IAS 37, provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using DFP's discount rate of -1.5% (negative real rate) for 0 up to and including 5 years, -1.05% (negative real rate) after year 5 up to 10 years and +2.2% in real terms for 10 years or more (+1.30% for employee early departure obligations for all periods).

The Trust has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount arising from the passage of time and the effect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Contingencies

Under IAS 37, the Trust discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.20 Employee benefits

Short-term employee benefits
Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been estimated using average staff numbers and costs applied to the average untaken leave balance determined from the results of a survey to ascertain leave balances as at 31 March 2014. It is not anticipated that the level of untaken leave will vary significantly from year to year.

Retirement benefit costs
The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Superannuation Scheme can be found in the HSC Superannuation Scheme Statement in the Departmental Resource Account for the Department of Health, Social Services and Public Safety.

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2014/15 accounts.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve
Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve
The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

1.22 Value Added Tax

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 24 to the accounts.

1.24 Government Grants

Government assistance for capital projects whether from UK, or Europe, were treated as a Government grant even where there were no conditions specifically relating to the operating activities of the entity other than the requirement to operate in certain regions or industry sectors. Such grants (does not include grant-in-aid) were previously credited to a government grant reserve and were released to income over the useful life of the asset.

DFP issued new guidance effective from 1 April 2011. Government grant reserves are no longer permitted. Income is generally recognised when it is received. In exceptional cases where there are conditions attached to the use of the grant, which, if not met, would mean the grant is repayable, the income should be deferred and released when obligations are met. The note to the financial statements distinguishes between grants from UK government entities and grants from European Union.

1.25 Losses and Special Payments

Losses and special payments are items that the Northern Ireland Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had HSC Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.26 Charitable Trust Account Consolidation

In 2012-13, HM Treasury/DFP agreed a one year extension to the exemption granted by HM Treasury from the FReM consolidation accounting policy which otherwise would have required the HSC Trusts and ALBs financial statements to consolidate the accounts of controlled charitable organisations and funds held on trust. This exemption no longer applies and as a result the financial performance and funds have been consolidated. The HSC Trusts and ALBs has accounted for these transfers using merger accounting as required by the FReM.

It is important to note however the distinction between public funding and the other monies donated by private individuals still exists.

“All funds have been used by Health and Social Care Trust as intended by the benefactor. It is for the Gifts and Endowments/Charitable Trust Fund Committee within Trusts to manage the internal disbursements. The committee ensures that charitable donations received by the Trust are appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust’s Standing Financial Instructions, Departmental guidance and legislation.

All such funds are allocated to the area specified by the benefactor and are not used for any other purpose than that intended by the benefactor”.

1.27 Accounting standards that have been issued but have not yet been adopted

Under IAS 8 there is a requirement to disclose those standards issued but not yet adopted.

The IASB have issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards have an effective date of 1st January 2013, and EU adoption is due from 1 January 2014.

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on ONS control criteria, as designated by Treasury. A review of the NI financial process is currently under discussion with the Executive, which will bring NI departments under the same adaption. Should this go ahead, the impact on DHSSPS and its Arms length bodies is expected to focus around the disclosure requirements under IFRS 12. 'Disclosure of Interests in other entities'.

The impact on the consolidation boundary of NDPB's and trading funds will be subject to review, in particular, where control could be determined to exist due to exposure to variable returns (IFRS 10), and where joint arrangements need reassessing

Management consider that any other new accounting policies issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 2 ANALYSIS OF NET EXPENDITURE BY SEGMENT

The Trust is managed by way of a Directorate structure, each led by a Director, providing an integrated healthcare service both for the resident population, and in the case of specialist services for the Northern Ireland population. The Directors along with Non Executive Directors, Chairman and Chief Executive form the Trust Board which coordinates the activities of the Trust and is considered to be the Chief Operating Decision Maker. The information disclosed in this statement does not reflect budgetary performance and is based solely on expenditure information provided from the accounting system used to prepare the accounts.

	2015			2014		
Directorate	Staff Costs £000s	Other Expenditure £000s	Total Expenditure £000s	Staff Costs £000s	Other Expenditure £000s	Total Expenditure £000s
Surgery and Specialist Services	138,172	110,671	248,843	133,879	106,800	240,679
Adult Social and Primary Care	151,931	141,624	293,555	151,778	135,988	287,766
Childrens Community Services	37,588	24,654	62,242	37,862	23,452	61,314
Unscheduled & Acute Care	194,789	86,380	281,169	189,989	79,332	269,321
Specialist Hospitals and Women's Health	116,293	61,111	177,404	111,084	68,166	179,250
Patient and Client Support Services	45,605	16,248	61,853	45,848	14,853	60,701
Other Trust Service/Corporate Group	64,153	66,461	130,614	63,749	74,662	138,411
Expenditure for Reportable Segments net of Non Cash Expenditure	**748,531**	**507,149**	**1,255,680**	**734,189**	**503,253**	**1,237,442**
Non Cash Expenditure			**80,302**			**31,211**
Total Expenditure per Net Expenditure Account			**1,335,982**			**1,268,653**
Income Note 5			**87,493**			**92,009**
Net Expenditure			**1,248,489**			**1,176,644**
Revenue Resource Limit			**1,248,551**			**1,176,756**
Surplus / (Deficit) against RRL			**62**			**112**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 3 STAFF NUMBERS AND RELATED COSTS

3.1 Staff Costs

Staff costs comprise:	2015 Permanently employed staff £000s	2015 Others £000s	2015 Total £000s	2014 Total £000s
Wages and salaries	601,429	35,951	637,380	626,697
Social security costs	49,144	693	49,837	46,595
Other pension costs	61,472	462	61,934	61,599
Sub-Total	712,045	37,106	749,151	734,891
Capitalised staff costs	620	0	620	735
Total staff costs reported in Statement of Comprehensive Expenditure	711,425	37,106	748,531	734,156
Less recoveries in respect of outward secondments			(7,883)	(6,383)
Total net costs			**740,648**	**727,773**

Total Net costs of which:	£000s	£000s
Belfast Health & Social Care Trust	748,531	734,156
Charitable Trust Fund	0	0
Consolidation Adjustments	(334)	(269)
Total	748,197	733,887

Staff Costs exclude £620k charged to capital projects during the year (2014 £735k)

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.
As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2014/15 accounts.

3.2 Average number of persons employed

The average number of whole time equivalent persons employed during the year was as follows;

	2015 Permanently employed staff No.	2015 Others No.	2015 Total No.	2014 Total No.
Medical and dental	1,551	174	1,725	1,706
Nursing and midwifery	6,141	199	6,340	6,216
Professions allied to medicine	2,626	69	2,695	2,642
Ancillaries	1,639	65	1,704	1,706
Administrative & clerical	2,931	271	3,202	3,234
Works	231	0	231	224
Social services	2,005	69	2,074	1,912
Total average number of persons employed	17,124	847	17,971	17,640
Less average staff number relating to capitalised staff costs	13	0	13	21
Less average staff number in respect of outward secondments	97	0	97	118
Total net average number of persons employed	**17,014**	**847**	**17,861**	**17,501**

Belfast Health & Social Care Trust	17,861
Charitable Trust Fund	0
Consolidation Adjustments	0
	17,861

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 3 STAFF NUMBERS AND RELATED COSTS

3.3 Reporting of early retirement and other compensation scheme - exit packages

The Belfast Health & Social Care Trust made no payments in respect of early retirement or other compensation scheme exit packages in the year ended 31 March 2015 or in the year ended 31 March 2014.

3.4 Staff Benefits

The Belfast Health & Social Care Trust has no staff benefits

3.5 Trust Management Costs

	2015 £000s	2014 £000s
Trust management costs	38,967	39,690
Income:		
RRL	1,248,551	1,176,756
Income per Note 5	87,493	92,009
Non cash RRL for movement in clinical negligence provision	(17,180)	(8,743)
Less interest receivable	0	0
Total Income	1,318,864	1,260,022
% of total income	**3.0%**	**3.1%**

The above information is based on the Audit Commission's definition “M2” Trust management costs, as detailed in HSS (THR) 2/99.

3.6 Retirements due to ill-health

During 2014/15 there were 47 early retirements from the Trust, agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £261k. These costs are borne by the HSC Pension Scheme.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 4 OPERATING EXPENSES

	2015 £000s		2014 £000s	
Operating Expenses are as follows:-	**Trust**	**Consolidated**	**Trust**	**Consolidated**
Purchase of care from non-HPSS bodies	149,112	149,112	157,072	157,072
Revenue grants to voluntary organisations	11,387	11,387	11,734	11,734
Personal social services	13,994	13,994	11,836	11,836
Recharges from other HSC organisations	2,586	2,586	3,154	3,154
Supplies and services - Clinical	212,579	212,540	198,858	198,822
Supplies and services - General	13,093	13,092	13,202	13,200
Establishment	13,052	13,052	13,016	13,016
Transport	3,518	3,518	3,017	3,017
Premises	52,141	51,961	52,635	52,635
Bad debts	3	3	549	549
Rentals under operating leases	932	932	979	979
Interest charges	1,621	1,621	1,410	1,410
PFI and other service concession arrangements service charges	9,059	9,059	9,079	9,079
BSO services	8,101	8,101	5,992	5,992
Training	1,973	1,972	1,747	1,747
Patients travelling expenses	807	807	747	747
Other charitable expenditure	0	1,424	0	1,146
Miscellaneous expenditure	8,226	8,226	12,536	12,523
Non cash items				
Depreciation	50,698	50,698	47,568	47,568
Amortisation	2,523	2,523	1,799	1,799
Impairments	13,811	13,811	(23,385)	(23,385)
Loss on disposal of property, plant & equipment (including land)	33	33	0	0
Provisions provided for in year	18,283	18,283	11,578	11,578
Cost of borrowing of provisions (unwinding of discount on provisions)	(151)	(151)	(702)	(702)
Auditors remuneration	70	75	76	83
Add back of notional charitable expenditure	0	(5)	0	(7)
Total	**587,451**	**588,654**	**534,497**	**535,592**

During the year the Trust purchased no non audit services from its external auditor (NIAO).

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 5 INCOME

5.1 Income from Activities

	2015 £000s		2014 £000s	
	Trust	**Consolidated**	**Trust**	**Consolidated**
GB/Republic of Ireland Health Authorities	570	570	416	416
HSC Trusts	343	343	1,087	1,087
Non-HSC:- Private patients	3,199	3,199	3,158	3,158
Non-HSC:- Other	4,226	4,226	4,847	4,847
Clients contributions	34,701	34,701	32,612	32,612
Total	**43,039**	**43,039**	**42,120**	**42,120**

5.2 Other Operating Income

	2015 £000s		2014 £000s	
	Trust	**Consolidated**	**Trust**	**Consolidated**
Other income from non-patient services	32,496	32,309	37,809	37,774
Seconded staff	7,883	7,723	6,383	6,138
Charitable and other contributions to expenditure by core trust	3,757	3,549	3,777	3,737
Donations / Government grant / Lottery funding for non current assets	318	144	1,730	1,376
Charitable income received by charitable trust fund	0	699	0	852
Investment income	0	1,100	0	1,060
Profit on disposal of land	0	0	190	190
Total	**44,454**	**45,524**	**49,889**	**51,127**

5.3 Deferred income

	2015 £000s		2014 £000s	
	Trust	**Consolidated**	**Trust**	**Consolidated**
Income released from conditional grants	0	0	0	0
Total	**0**	**0**	**0**	**0**
TOTAL INCOME	**87,493**	**88,563**	**92,009**	**93,247**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 6.1 Consolidated Property, plant & equipment - year ended 31 March 2015

	Land	Buildings (excluding dwellings)	Dwellings	Assets under Construction	Plant and Machinery Equipment	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or Valuation									
At 1 April 2014	99,247	771,129	28,375	167,792	183,505	8,605	40,051	8,024	1,306,728
Indexation	0	0	0	0	3,157	0	0	0	3,157
Additions	0	13,476	648	9,237	18,308	479	2,848	131	45,127
Donations / Government grant / Lottery funding	0	81	0	0	180	0	27	0	288
Reclassifications	0	0	0	0	0	0	0	0	0
Transfers	(387)	489	5,821	(6,254)	(14)	0	28	0	(317)
Revaluation exercise accumulated depreciation adjustment	0	(111,761)	(4,567)	0	0	0	0	0	(116,328)
Revaluation	1,363	46,698	2,528	33	0	0	0	0	50,622
Impairment charged to the SoCNE	(13,453)	(17,132)	(476)	0	0	0	0	0	(31,061)
Impairment charged to the revaluation reserve	(1,366)	(12,272)	(622)	0	0	0	0	0	(14,260)
Reversal of impairments	9,426	7,730	214	0	0	0	0	0	17,370
Disposals	0	(6,115)	(1,055)	0	(10,320)	(239)	(107)	0	(17,836)
At 31 March 2015	**94,830**	**692,323**	**30,866**	**170,808**	**194,816**	**8,845**	**42,847**	**8,155**	**1,243,490**
Depreciation									
At 1 April 2014	0	97,473	4,148	0	119,184	3,996	17,159	5,080	247,040
Indexation	0	0	0	0	2,090	0	0	0	2,090
Reclassifications	0	0	0	0	0	0	0	0	0
Transfers	0	(4)	4	0	(8)	0	0	0	(8)
Revaluation exercise accumulated depreciation adjustment	0	(111,761)	(4,567)	0	0	0	0	0	(116,328)
Revaluation	0	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments (indexn)	0	(6,115)	(1,055)	0	(10,302)	(238)	(107)	0	(17,817)
Disposals	0	24,778	1,629	0	15,827	956	6,922	586	50,698
Provided during the year	**0**	**4,371**	**159**	**0**	**126,791**	**4,714**	**23,974**	**5,666**	**165,675**
At 31 March 2015									
Carrying Amount									
At 31 March 2015	**94,830**	**687,952**	**30,707**	**170,808**	**68,025**	**4,131**	**18,873**	**2,489**	**1,077,815**
At 31 March 2014	**99,247**	**673,656**	**24,227**	**167,792**	**64,321**	**4,609**	**22,892**	**2,944**	**1,059,688**
Asset financing									
Owned	94,830	687,952	30,707	170,808	42,743	4,131	18,873	2,489	1,052,533
Finance leased	0	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	25,282	0	0	0	25,282
Carrying Amount									
At 31 March 2015	**94,830**	**687,952**	**30,707**	**170,808**	**68,025**	**4,131**	**18,873**	**2,489**	**1,077,815**
Of which:									
Trust	94,830	687,952	30,707	170,808	68,025	4,131	18,873	2,489	1,077,815
Charitable trust fund	0	0	0	0	0	0	0	0	0

Any fall in value through negative indexation or revaluation is shown as an impairment
The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure in respect of assets held under finance leases and hire purchase contracts is £0 (2014 £0).

The fair value of assets funded from the following sources during the year was:

	2015 £000s	2014 £000s
Donations	288	1,623
Government grant	0	0
Lottery funding	0	0

Professional revaluations of land and buildings are undertaken by Land and Property Services (LPS) at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS. See Accounting Policy Note 1, Section 1.3 for more details of valuation of Property, Plant and Equipment. The Trust's Land, Buildings and Dwellings were all revalued at 31 January 2015 by Land and Property Services. The valuations were carried out by the following valuers;

Mr. Neil McCall MRICS ; Mr Desy Monaghan MRICS; Mr Paul Beardmore MRICS

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 6.2 Consolidated Property, plant & equipment - year ended 31 March 2014

	Land	Buildings (excluding dwellings)	Dwellings	Assets under Construction	Plant and Machinery Equipment	Transport Equipment	Information Technology (IT)	Furniture and Fittings	Total
Cost or Valuation	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2013	99,715	693,345	26,142	159,783	163,797	8,884	29,875	7,878	1,189,419
Indexation	0	32,950	1,509	0	4,115	0	0	123	38,697
Additions	0	16,555	1,218	9,787	23,136	1,221	10,909	60	62,886
Donations / Government grant / Lottery funding	0	90	0	0	1,477	0	56	0	1,623
Reclassifications	0	0	0	0	0	0	0	0	0
Transfers	(406)	929	0	(1,778)	(78)	684	2	2	(645)
Revaluation	0	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	(62)	(241)	(1,189)	0	(9)	0	0	0	(1,501)
Impairment charged to the revaluation reserve	0	(249)	0	0	0	0	0	0	(249)
Reversal of impairments (indexn)	0	27,750	695	0	0	0	0	0	28,445
Disposals	0	0	0	0	(8,933)	(2,184)	(791)	(39)	(11,947)
At 31 March 2014	**99,247**	**771,129**	**28,375**	**167,792**	**183,505**	**8,605**	**40,051**	**8,024**	**1,306,728**
Depreciation									
At 1 April 2013	0	65,803	2,807	0	111,143	5,117	11,843	4,463	201,176
Indexation	0	3,969	201	0	2,788	0	0	76	7,034
Reclassifications	0	0	0	0	0	0	0	0	0
Transfers	0	(16)	0	0	(37)	0	2	0	(51)
Revaluation	0	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	(30)	(168)	0	(6)	0	0	0	(204)
Impairment charged to the revaluation reserve	0	(16)	0	0	0	0	0	0	(16)
Reversal of impairments (indexn)	0	3,335	93	0	0	0	0	0	3,428
Disposals	0	0	0	0	(8,932)	(2,137)	(791)	(35)	(11,895)
Provided during the year	0	24,428	1,215	0	14,228	1,016	6,105	576	47,568
At 31 March 2014	**0**	**97,473**	**4,148**	**0**	**119,184**	**3,996**	**17,159**	**5,080**	**247,040**
Carrying Amount									
At 31 March 2014	**99,247**	**673,656**	**24,227**	**167,792**	**64,321**	**4,609**	**22,892**	**2,944**	**1,059,688**
At 1 April 2013	**99,715**	**627,542**	**23,335**	**159,783**	**52,654**	**3,767**	**18,032**	**3,415**	**988,243**
Asset financing									
Owned	99,247	673,656	24,227	167,792	42,456	4,609	22,892	2,944	1,037,823
Finance leased	0	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	21,865	0	0	0	21,865
Carrying Amount									
At 31 March 2014	**99,247**	**673,656**	**24,227**	**167,792**	**64,321**	**4,609**	**22,892**	**2,944**	**1,059,688**
Asset financing									
Owned	99,715	625,345	23,335	159,783	36,276	3,767	18,032	3,415	969,668
Finance leased	0	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	2,197	0	0	16,378	0	0	0	18,575
Carrying Amount									
At 1 April 2013	**99,715**	**627,542**	**23,335**	**159,783**	**52,654**	**3,767**	**18,032**	**3,415**	**988,243**
Carrying amount comprises:									
Trust at 31 March 2015	94,830	687,952	30,707	170,808	68,025	4,131	18,873	2,489	1,077,815
Charitable trust fund at 31 March 2015	0	0	0	0	0	0	0	0	0
	94,830	687,952	30,707	170,808	68,025	4,131	18,873	2,489	1,077,815
Trust at 31 March 2014	99,247	673,656	24,227	167,792	64,321	4,609	22,892	2,944	1,059,688
Charitable trust fund at 31 March 2014	0	0	0	0	0	0	0	0	0
	99,247	673,656	24,227	167,792	64,321	4,609	22,892	2,944	1,059,688
Trust at 1 April 2013	99,715	627,542	23,335	159,783	52,654	3,767	18,032	3,415	988,243
Charitable trust fund at 1 April 2013	0	0	0	0	0	0	0	0	0
	99,715	627,542	23,335	159,783	52,654	3,767	18,032	3,415	988,243

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 7.1 Consolidated Intangible assets - year ended 31 March 2015

	Software Licenses £000s	Information Technology £000s	Total £000s
Cost or Valuation			
At 1 April 2014	14,181	0	14,181
Indexation	0	0	0
Additions	6,540	0	6,540
Donations / Government grant / Lottery funding	30	0	30
Reclassifications	0	0	0
Transfers	(28)	0	(28)
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Impairment charged to the revaluation reserve	0	0	0
Disposals	0	0	0
At 31 March 2015	**20,723**	**0**	**20,723**
Amortisation			
At 1 April 2014	5,171	0	5,171
Indexation	0	0	0
Reclassifications	0	0	0
Transfers	0	0	0
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Impairment charged to the revaluation reserve	0	0	0
Disposals	0	0	0
Provided during the year	2,523	0	2,523
At 31 March 2015	**7,694**	**0**	**7,694**
Carrying Amount			
At 31 March 2015	**13,029**	**0**	**13,029**
At 31 March 2014	**9,010**	**0**	**9,010**
Asset financing			
Owned	13,029	0	13,029
Finance leased	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0
Carrying Amount			
At 31 March 2015	**13,029**	**0**	**13,029**

Any fall in value through negative indexation or revaluation is shown as an impairment
The fair value of assets funded from the following sources during the year was:

	2015 £000s	2014 £000s
Donations	30	100
Government grant	0	0
Lottery funding	0	0

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 7.2 Consolidated Intangible assets - year ended 31 March 2014

	Software Licenses £000s	Information Technology £000s	Total £000s
Cost or Valuation			
At 1 April 2013	9,878	0	9,878
Indexation	0	0	0
Additions	4,173	0	4,173
Donations / Government grant / Lottery funding	100	0	100
Reclassifications	0	0	0
Transfers	30	0	30
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Impairment charged to the revaluation reserve	0	0	0
Disposals	0	0	0
At 31 March 2014	**14,181**	**0**	**14,181**
Amortisation			
At 1 April 2013	3,372	0	3,372
Indexation	0	0	0
Reclassifications	0	0	0
Transfers	0	0	0
Revaluation	0	0	0
Impairment charged to the SoCNE	0	0	0
Impairment charged to the revaluation reserve	0	0	0
Disposals	0	0	0
Provided during the year	1,799	0	1,799
At 31 March 2014	**5,171**	**0**	**5,171**
Carrying Amount			
At 31 March 2014	**9,010**	**0**	**9,010**
At 1 April 2013	**6,506**	**0**	**6,506**
Asset financing			
Owned	9,010	0	9,010
Finance leased	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0
Carrying Amount			
At 31 March 2014	**9,010**	**0**	**9,010**
Asset financing			
Owned	6,506	0	6,506
Finance leased	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0
Carrying Amount			
At 1 April 2013	**6,506**	**0**	**6,506**
Carrying amount comprises:			
Trust at 31 March 2015	13,029	0	13,029
Charitable trust fund at 31 March 2015	0	0	0
	13,029	0	13,029
Trust at 31 March 2014	9,010	0	9,010
Charitable trust fund at 31 March 2014	0	0	0
	9,010	0	9,010
Trust at 1 April 2013	6,506	0	6,506
Charitable trust fund at 1 April 2013	0	0	0
	6,506	0	6,506

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 8 FINANCIAL INSTRUMENTS

	2015			2014		
	Investments £000s	Assets £000s	Liabilities £000s	Investments £000s	Assets £000s	Liabilities £000s
Balance at 1 April	41,253	0	0	38,948	0	0
Additions	1,348	0	0	1,053	0	0
Disposals	0	0	0	(350)	0	0
Revaluations	2,780	0	0	1,602	0	0
Balance at 31 March	45,381	0	0	41,253	0	0
Trust	0	0	0	0	0	0
Charitable trust fund	45,381	0	0	41,253	0	0
	45,381	0	0	41,253	0	0

NOTE 8.1 Market value of investments as at 31 March 2015

	Held in UK £000s	Held outside UK £000s	2015 Total £000s	2014 Total £000s
Investment properties	0	0	0	0
Investments listed on Stock Exchange	0	0	0	0
Investments in CIF	45,381	0	45,381	41,253
Investments in a Common Deposit Fund or Investment Fund	0	0	0	0
Unlisted securities	0	0	0	0
Cash held as part of the investment portfolio	0	0	0	0
Investments in connected bodies	0	0	0	0
Other investments	0	0	0	0
Total market value of fixed asset investments	45,381	0	45,381	41,253

The only financial instruments held directly by the Trust as at 31 March 2015 are trade and other receivables, cash and trade and other liabilities. Details of these can be seen at Notes 12, 13 and 14 respectively.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 9 ASSETS CLASSIFIED AS HELD FOR SALE

	Land		Buildings		Total	
	2015 £000s	2014 £000s	2015 £000s	2014 £000s	2015 £000s	2014 £000s
Cost						
At 1 April	5,762	6,059	662	874	6,424	6,933
Transfers in	386	360	0	268	386	628
Transfers out	0	0	(52)	0	(52)	0
Impairment	(120)	(60)	0	(275)	(120)	(335)
(Disposals)	(5,210)	(597)	(398)	(205)	(5,608)	(802)
At 31 March	**818**	**5,762**	**212**	**662**	**1,030**	**6,424**
Depreciation						
At 1 April	0	0	72	28	72	28
Transfers in	0	0	3	44	3	44
Transfers out	0	0	0	0	0	0
Impairment	0	0	0	0	0	0
(Disposals)	0	0	(28)	0	(28)	0
At 31 March	**0**	**0**	**47**	**72**	**47**	**72**
Carrying amount at 31 March	**818**	**5,762**	**165**	**590**	**983**	**6,352**

Non current assets held for sale comprise non current assets that are held for resale rather than continuing use with the business.

During the year ended 31 March 2015, the following properties were sold. Fair value at disposal date is also shown below;

· 89 Durham Street	£275,000
· 16 Cupar Street	£160,000
· 414 Ormeau Road	£280,000
· Unit 5, 25 Tamar Street (Victoria DC)	£117,000
· 116-120 Great Victoria Street, (Shaftesbury Square Hospital)	£295,000
· 3 Hospital Road, (Belvoir Park Hospital)	£4,550,000

At 31 March 2015 non current assets held for resale comprise ;

· 53-57 Davaar Avenue
· 195 Templemore Avenue
· 14 Lower Crescent
· 106 Cullingtree Road (Grovetree House)
· 37 Glantane Drive
· Millar Lane DC
· Land for Supported Housing Muckamore

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 10 IMPAIRMENTS

	2015		
	Property, plant & equipment £000s	Intangibles £000s	Total £000s
Total value of impairments for the year	28,071	0	28,071
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	14,260	0	14,260
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	**13,811**	**0**	**13,811**

	2014		
	Property, plant & equipment £000s	Intangibles £000s	Total £000s
Total value of impairments for the year	(23,152)	0	(23,152)
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	233	0	233
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	**(23,385)**	**0**	**(23,385)**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 11 INVENTORIES

	2015 £000s		2014 £000s	
Classification	**Trust**	**Consolidated**	**Trust**	**Consolidated**
X-ray	227	227	314	314
Pharmacy supplies	6,072	6,072	5,243	5,243
Theatre equipment	4,627	4,627	4,383	4,383
Community care appliances	1,417	1,417	1,433	1,433
Laboratory materials	634	634	535	535
Fuel	548	548	760	760
Building & engineering supplies	632	632	674	674
Other	5	5	88	88
Total	**14,162**	**14,162**	**13,430**	**13,430**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 12 TRADE RECEIVABLES AND OTHER CURRENT ASSETS

12.1 Trade receivables and other current assets

	2015 £000s		2014 £000s	
Amounts falling due within one year	**Trust**	**Consolidated**	**Trust**	**Consolidated**
Trade receivables	8,344	8,344	5,152	5,152
Deposits and advances	0	0	0	0
VAT receivable	12,883	12,883	9,435	9,435
Other receivables - not relating to fixed assets	15,681	15,687	18,641	18,755
Other receivables - relating to property plant and equipment	0	0	0	0
Other receivables - relating to intangibles	0	0	0	0
Trade and other receivables	36,908	36,914	33,228	33,342
Prepayments and accrued income	465	465	593	593
Other current assets	465	465	593	593
Carbon reduction commitment	0	0	105	105
Intangible current assets	0	0	105	105
Amounts falling due after more than one year				
Trade receivables	0	0	0	0
Other receivables	0	0	0	0
Trade and other receivables	0	0	0	0
Prepayments and accrued income	0	0	0	0
Other current assets falling due after more than one year	0	0	0	0
TOTAL TRADE AND OTHER RECEIVABLES	36,908	36,914	33,228	33,342
TOTAL OTHER CURRENT ASSETS	465	465	593	593
TOTAL INTANGIBLE CURRENT ASSETS	0	0	105	105
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**37,373**	**37,379**	**33,926**	**34,040**

The balances are net of a provision for bad debts of £4,978k (2014 £5,671k)

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 12 TRADE RECEIVABLES AND OTHER CURRENT ASSETS

12.2 Trade receivables and other current assets: Intra-Government balances

	Amounts falling due within 1 year 2014/15 £000s	Amounts falling due within 1 year 2013/14 £000s	Amounts falling due after more than 1 year 2014/15 £000s	Amounts falling due after more than 1 year 2013/14 £000s
Balances with other central government bodies	20,382	17,213	0	0
Balances with local authorities	11	13	0	0
Balances with NHS /HSC Trusts	7,920	5,153	0	0
Balances with public corporations and trading funds	0	0	0	0
Intra-government balances	28,313	22,379	0	0
Balances with bodies external to government	9,066	11,661	0	0
Total receivables and other current assets at 31 March	**37,379**	**34,040**	**0**	**0**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 13 CASH AND CASH EQUIVALENTS

	2015 £000s		2014 £000s	
	Trust	**Consolidated**	**Trust**	**Consolidated**
Balance at 1st April	21,393	23,024	40,966	42,892
Net change in cash and cash equivalents	(7,388)	(8,498)	(19,573)	(19,868)
Balance at 31st March	**14,005**	**14,526**	**21,393**	**23,024**

The following balances at 31 March were held at	2015 £000s		2014 £000s	
	Trust	**Consolidated**	**Trust**	**Consolidated**
Commercial banks and cash in hand	14,005	14,526	21,393	23,024
Balance at 31st March	**14,005**	**14,526**	**21,393**	**23,024**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 14 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

14.1 Trade payables and other current liabilities

	2015 £000s		2014 £000s	
	Trust	**Consolidated**	**Trust**	**Consolidated**
Amounts falling due within one year				
Other taxation and social security	26,297	26,297	23,158	23,158
Trade capital payables - property, plant and equipment	22,222	22,222	24,959	24,959
Trade capital payables - intangibles	0	0	0	0
Trade revenue payables	75,465	75,465	93,765	93,765
Payroll payables	42,814	42,814	39,125	39,125
BSO payables	2,917	2,917	2,528	2,528
Other payables	4,436	4,474	4,266	4,375
Accruals and deferred income	0	0	2,250	2,250
Trade and other payables	174,151	174,189	190,051	190,160
Current part of imputed finance lease element of on balance sheet (SoFP) PFI and other service concession arrangements contracts	1,218	1,218	666	666
Other current liabilities	1,218	1,218	666	666
Carbon reduction commitment	0	0	0	0
Intangible current liabilities	0	0	0	0
Total payables falling due within one year	175,369	175,407	190,717	190,826
Amounts falling due after more than one year				
Other payables, accruals and deferred income	0	0	0	0
Trade and other payables	0	0	0	0
Clinical negligence payables	0	0	0	0
Finance leases	0	0	0	0
Imputed finance lease element of on balance sheet (SoFP) PFI and other service concession arrangements contracts	12,251	12,251	9,110	9,110
Long term loans	0	0	0	0
Total non current other payables	12,251	12,251	9,110	9,110
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**187,620**	**187,658**	**199,827**	**199,936**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 14 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

14.2 Trade payables and other current liabilities - Intra-government balances

	Amounts falling due within 1 year 2014/15	Amounts falling due within 1 year 2013/14	Amounts falling due after more than 1 year 2014/15	Amounts falling due after more than 1 year 2013/14
	£000s	£000s	£000s	£000s
Balances with other central government bodies	27,950	24,523	0	0
Balances with local authorities	11	22	0	0
Balances with NHS /HSC Trusts	7,436	10,466	0	0
Balances with public corporations and trading funds	0	0	0	0
Intra-government balances	**35,397**	**35,011**	**0**	**0**
Balances with bodies external to government	140,010	155,815	12,251	9,110
Total payables and other liabilities at 31 March	**175,407**	**190,826**	**12,251**	**9,110**

NOTE 14.3 LOANS

Loans

The Belfast Health & Social Care Trust did not have any loans payable at either 31 March 2015 or 31 March 2014.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 15 PROMPT PAYMENT POLICY

15.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that Trusts pay their non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The Trust's payment policy is consistent with the Better Payments Practice code and Government Accounting rules and its measure of compliance is:

	2015 Number	2015 Value £000s	2014 Number	2014 Value £000s
Total bills paid	382,186	472,431	369,119	506,482
Total bills paid within 30 days of receipt of an undisputed invoice	307,216	386,474	310,092	441,437
% of bills paid within 30 days of receipt of an undisputed invoice	**80.4%**	**81.8%**	**84.0%**	**87.2%**
Total bills paid within 10 day target	225,777	283,523	230,046	354,006
% of bills paid within 10 day target	**59.1%**	**60.0%**	**62.3%**	**69.9%**

New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

15.2 The Late Payment of Commercial Debts Regulations 2002

	2015 £
Amount of compensation paid for payment(s) being late	596
Amount of interest paid for payment(s) being late	128
Total	724

This is also reflected as a fruitless payment in note 26

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 16 PROVISIONS FOR LIABILITIES AND CHARGES - 2015

	Pensions relating to other staff £000s	Clinical negligence £000s	CSR restructuring £000s	Other £000s	2015 £000s
Balance at 1 April 2014	10,015	43,875	0	11,955	65,845
Provided in year	92	24,595		2,199	26,886
(Provisions not required written back)	(554)	(7,092)	0	(957)	(8,603)
(Provisions utilised in the year)	(502)	(12,475)	0	(1,385)	(14,362)
Cost of borrowing (unwinding of discount)	126	(323)	0	46	(151)
At 31 March 2015	**9,177**	**48,580**	**0**	**11,858**	**69,615**

	CSR £000s
CSR utilised costs include the following;	
Pension costs for early retirement reflecting the single lump sum to buy over the full liability	0
Redundancy costs	0
	0

Comprehensive Net Expenditure Account charges	2015 £000s	2014 £'000
Arising during the year	26,886	27,256
Reversed unused	(8,603)	(15,678)
Cost of borrowing (unwinding of discount)	(151)	(702)
Total charge within Operating expenses	**18,132**	**10,876**

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	CSR restructuring £000s	Other £000s	2015 £000s
Not later than one year	500	24,313	0	4,098	28,911
Later than one year and not later than five years	1,998	9,890	0	1,414	13,302
Later than five years	6,679	14,377	0	6,346	27,402
At 31 March 2015	**9,177**	**48,580**	**0**	**11,858**	**69,615**

Pensions relating to other staff is in relation to early retirement costs.

The provision for pensions is determined on the basis of information on current annual pension rates payable over average life expectancy derived from government actuarial tables and on payments made to HSC Superannuation Branch. The provisions for Clinical Negligence, Employers and Public Liability have been determined by assigning probabilities to expected settlement values.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

16.1 PROVISIONS FOR LIABILITIES AND CHARGES - 2014

	Pensions relating to other staff £000s	Clinical negligence £000s	CSR restructuring £000s	Other £000s	2014 £000s
Balance at 1 April 2013	10,127	51,459	0	11,713	73,299
Provided in year	210	24,271	0	2,775	27,256
(Provisions not required written back)	0	(14,580)	0	(1,098)	(15,678)
(Provisions utilised in the year)	(498)	(16,327)	0	(1,505)	(18,330)
Cost of borrowing (unwinding of discount)	176	(948)	0	70	(702)
At 31 March 2014	**10,015**	**43,875**	**0**	**11,955**	**65,845**

Provisions have been made for 6 types of potential liability: Clinical negligence, Employers Liability and Occupiers Liability, Early Retirement, Injury Benefit, Employment Law and Restructuring. The provision for Early Retirement and Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Superannuation Branch. For Clinical Negligence, Employer's and Occupier's claims and Employment Law the Trust has estimated an appropriate level of provision based on professional legal advice.

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	CSR restructuring £000s	Other £000s	2014 £000s
Not later than one year	495	24,419	0	3,746	28,660
Later than one year and not later than five years	1,981	16,883	0	1,541	20,405
Later than five years	7,539	2,573	0	6,668	16,780
At 31 March 2014	**10,015**	**43,875**	**0**	**11,955**	**65,845**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 17 CAPITAL COMMITMENTS

	2015 £000s	2014 £000s
Contracted capital commitments at 31 March not otherwise included in these financial statements		
Property, plant & equipment	17,370	13,880
Intangible assets	0	0
	17,370	13,880

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 18 COMMITMENTS UNDER LEASES

18.1 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods:

Obligations under operating leases comprise	2015 £000s	2014 £000s
Land		
Not later than 1 year	0	0
Later than 1 year and not later than 5 years	0	0
Later than 5 years	0	0
	0	**0**
Buildings		
Not later than 1 year	422	502
Later than 1 year and not later than 5 years	665	849
Later than 5 years	504	1,008
	1,591	**2,359**
Other		
Not later than 1 year	237	262
Later than 1 year and not later than 5 years	258	365
Later than 5 years	0	14
	495	**641**

18.2 Finance Leases

The Trust has included within its fixed assets a number of land and buildings held under leasehold arrangements. Under accounting standard IAS 17 'Accounting for leases', the Trust have assessed these land and buildings to be finance leases in nature. However, the associated financial obligations of these finance leases are deemed insignificant and therefore no finance lease creditor has been recorded in the accounts in this respect.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 18 COMMITMENTS UNDER LEASES

18.3 Operating Leases

Total future minimum lease income under operating leases are given in the table below for each of the following periods.

Obligations under operating leases issued by the Trust comprise	2015 £000s	2014 £000s
Land & Buildings		
Not later than 1 year	706	689
Later than 1 year and not later than 5 years	1,347	1,328
Later than 5 years	1,639	1,473
	3,692	**3,490**
Other		
Not later than 1 year	0	0
Later than 1 year and not later than 5 years	0	0
Later than 5 years	0	0
	0	**0**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 19 COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS

19.1 Off balance sheet PFI and other service concession arrangements schemes

	2015 £000s	2014 £000s
Estimated capital value of the PFI schemes		
Carparks	3,200	3,200
	3,200	**3,200**

Contract start date : 01/04/1997

Contract end date : 30/03/2017

The Trust has a PFI arrangement for the provision of a carpark at the Royal Group of Hospitals site. The carpark is not an asset of Belfast HSC Trust. The carpark is owned and operated by Carpark Services .

19.2 On balance sheet (SoFP) PFI Schemes

The Trust is committed to make the following payments during the next year

Details of the imputed finance lease charges are given in the table below for each of the following periods:

	2015 £000s	2014 £000s
Rentals due within one year	3,155	2,799
Rentals due later than one year and not later than five years	12,783	10,372
Rentals due later than five years	18,044	19,249
	33,982	32,420
Less interest element	16,776	18,396
Present value of obligations	**17,206**	**14,024**

Details of the minimum service charge are given in the table below for each of the following periods:

	2015 £000s	2014 £000s
Service charge due within one year	1,733	1,179
Service charge due later than one year and not later than five years	7,128	4,794
Service charge due later than five years	8,345	8,051
Total	**17,206**	**14,024**

19.3 Charge to the Statement of Comprehensive Net Expenditure account and future commitments

	2015 £000s	2014 £000s
Amounts included within operating expenses in respect of off balance sheet (SoFP) PFI and other service concession arrangement transactions	0	0
Amounts included within operating expenses in respect of the service element of on balance sheet (SoFP) PFI and other service concession arrangement transactions	9,059	9,079
	9,059	**9,079**

The payments to which the Trust is committed is as follows:	2015 £000s	2014 £000s
Not later than one year	6,110	6,210
Later than one year and not later than five years	25,975	25,304
Later than five years	31,816	38,598
	63,901	**70,112**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 20 OTHER FINANCIAL COMMITMENTS

The Belfast Health & Social Care Trust has not entered into any non cancellable contracts (which are not leases, PFI or other service concession arrangement contracts) in the current or previous financial year.

NOTE 21 FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities. Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

The Belfast Health & Social Care Trust did not have any financial instruments at either 31 March 2015 or 31 March 2014.

NOTE 22 CONTINGENT LIABILITIES

Material contingent liabilities are noted in the table below, where there is a 50% or less probability that a payment will be required to settle any possible obligations. The amounts or timing of any outflow will depend on the merits of each case.

	2015	2014
	£000s	£000s
Clinical negligence	3,890	3,366
Public liability	0	0
Employers' liability	0	0
Accrued leave	0	0
Injury benefit	0	0
Other	0	0
Total	**3,890**	**3,366**

The Belfast Health & Social Care Trust did not have any unquantifiable contingent liabilities as at the 31 March 2015 or 31 March 2014.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 23 RELATED PARTY TRANSACTIONS

The Trust is required to disclose details of transactions with individuals who are regarded as related parties consistent with the requirements of IAS 24 – Related Party Transactions. This disclosure is recorded in the Trust's Register of Interests which is maintained by the Office of the Chief Executive and is available for inspection by members of the public.

During the year the Belfast Health & Social Care Trust entered into the following material transactions with the following related parties.

HSC Bodies

The Belfast Health & Social Care Trust is an arms length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party and the ultimate controlling parent with which the Trust has had various material transactions during the year. During the year the Belfast Health and Social Care Trust has had a number of material transactions with other entities for which the Department is regarded as the ultimate controlling parent. These entities include the Health and Social Care Board, the five HSC Trusts and the Business Services Organisation.

Non Executive Directors

Some of the Trust's Non Executive Directors have disclosed interests with organisations from which the Trust purchased services from or supplied services to during 2014/15. Set out below are details of the amount paid to these organisations during 2014/15. In none of these cases listed did the Non Executive Directors have any involvement in the decisions to procure the services from the organisations concerned.

	Service Provided by Organisation	Payments to Related Party	Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
2014/15		£000s	£000s	£000s	£000s
Queen's University Belfast	Joint Appointments, premises and associated costs	5,761	3,997	635	940
Belfast City Council	Building Inspections, premises and associated costs, salary recharges	274	48	55	9
Prima Linea Training Associates	Training Course	1	0	0	0
Maurice Stevenson Ltd	Building & Engineering Services	618	0	136	0
2013/14					
Queen's University Belfast	Joint Appointments, premises and associated costs	6,011	3,258	85	845
Belfast City Council	Building Inspections, premises and associated costs, salary recharges	205	99	14	9

Interests in the above organisations were declared by the following Board members:-

Mr JPJ O'Kane (Non Executive Director) holds the position of Registrar and Chief Operating Officer for Queen's University Belfast

Mr P McNaney (Chairman) held the position of Chief Executive for Belfast City Council until 31 March 2014.

Dr V McGarrell (Non Executive Director) is the owner of Prima Linea Training Associates

Mr C Jenkins (Non Executive Director) is a Consultant for Maurice Stevenson Ltd

Transactions with these related parties are conducted on an arm's length basis. The purchase of goods and services are subject to the normal tendering processes under Northern Ireland Public Procurement Policy, Trust Standing Orders and Standing Financial Instructions. There are no provisions for doubtful debts against the related party balances owed. In addition, the Trust has not provided or received any financial guarantees in respect of any related parties identified.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 23 RELATED PARTY TRANSACTIONS (Cont'd)

Other Board Members and Senior Managers

In a similar way, some other Trust Board members and Senior Managers have disclosed interests in organisations from which the Trust purchased services in 2014/15. The details are set out below. Again, the officers listed had no involvement in the decisions to procure the services from the organisations concerned.

	Service Provided by Organisation	Payments to Related Party	Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000s	£000s	£000s	£000s
Relate NI	Counselling Services	18	0	0	0

Interests in the above organisations were declared by the following Board members:-

Mr B Barry holds the position of Board member for Relate NI

NOTE 24 THIRD PARTY ASSETS

The Trust held £695,217 Cash at bank and in hand and £4,550,182 short term investments at 31 March 2015 which relates to monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts. A separate audited account of these monies is maintained by the Trust.

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 25 FINANCIAL PERFORMANCE TARGETS

25.1 Revenue Resource Limit

The Trust is given a Revenue Resource Limit which it is not permitted to overspend

The Revenue Resource Limit (RRL) for the Trust is calculated as follows:

	2015 Total £000s	2014 Total £000s
HSCB	1,137,664	1,117,045
PHA	11,924	11,375
SUMDE & NIMDTA	18,767	18,473
DHSSPS (excludes non cash)	0	0
Other Government Departments	0	0
Non cash RRL (from DHSSPS)	80,302	31,211
Total agreed RRL	1,248,657	1,178,104
Adjustment for income received re Donations / Government grant / Lottery funding for non current assets	(318)	(1,730)
Adjustment for PFI and other service concession arrangements/IFRIC 12	212	382
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	1,248,551	1,176,756

25.2 Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2015 Total £000s	2014 Total £000s
Gross capital expenditure	51,667	67,101
Less charitable trust fund capital expenditure		
Less IFRIC 12/PFI and other service concession arrangements spend	(7,935)	(10,449)
(Receipts from sales of fixed assets)	(5,580)	(802)
Net capital expenditure	38,152	55,850
Capital Resource Limit	38,160	55,925
Overspend/(Underspend) against CRL	(8)	(75)

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

25.3 Financial Performance Targets

The Trust is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of RRL limits

	2014/15 £000s	2013/14 £000s
Net Expenditure	(1,248,489)	(1,176,644)
RRL	1,248,551	1,176,756
Surplus / (Deficit) against RRL	62	112
Break Even cumulative position(opening)	434	322
Break Even cumulative position (closing)	496	434

Materiality Test:

	2014/15 %	2013/14 %
Break Even in year position as % of RRL	0.00%	0.01%
Break Even cumulative position as % of RRL	0.04%	0.04%

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 26 LOSSES AND SPECIAL PAYMENTS

Type of loss and special payment	2014/15 Number of Cases	2014/15 £	2013/14 £
Cash losses			
Cash Losses - Theft, fraud etc	0	0	1,127
Cash Losses - Overpayments of salaries, wages and allowances	0	0	0
Cash Losses - Other causes	0	0	0
	0	**0**	**1,127**
Claims abandoned			
Waived or abandoned claims	0	0	0
	0	**0**	**0**
Administrative write-offs			
Bad debts	262	162,851	563,646
Other	0	0	0
	262	**162,851**	**563,646**
Fruitless payments			
Late Payment of Commercial Debt	6	724	5,483
Other fruitless payments and constructive losses			0
	6	**724**	**5,483**
Stores losses			
Losses of accountable stores through any deliberate act			0
Other stores losses	9	127,657	153,407
	9	**127,657**	**153,407**
Special Payments			
Compensation payments			
- Clinical Negligence	211	12,474,503	16,326,920
- Public Liability	19	210,620	106,121
- Employers Liability	103	717,838	1,020,991
- Other	8	109,914	36,258
	341	**13,512,875**	**17,490,290**
Ex-gratia payments	**63**	**52,716**	**28,886**
Extra contractual	**0**	**0**	**0**
Special severance payments	**0**	**0**	**0**
TOTAL	**681**	**13,856,823**	**18,242,840**

BELFAST HEALTH AND SOCIAL CARE TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 26 LOSSES AND SPECIAL PAYMENTS

26.1 Special Payments

The Belfast Health & Social Care Trust did not make any special payments or gifts during the financial year.

26.2 Other Payments

The Belfast Health & Social Care Trust did not make any other payments or gifts during the financial year.

26.3 Losses and Special Payments over £250,000

Losses and Special Payments over £250,000	Number of Cases	2014/15 £	2013/14 £
Cash losses	0	0	0
Claims abandoned	0	0	0
Administrative write-offs	0	0	0
Fruitless payments	0	0	0
Stores losses	0	0	0
Special Payments			
Compensation payments Clinical negligence (these cases are included in the total value of clinical negligence payments on note 26)	5	5,724,427	12,264,718
TOTAL	**5**	**5,724,427**	**12,264,718**

NOTE 27 POST BALANCE SHEET EVENTS

There are no post balance sheet events having a material effect on the accounts.

NOTE 28 DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 4th June 2015

Belfast Health & Social Care Trust

Account of monies held on behalf of Patients/Residents

for the year ended 31 March 2015

BELFAST HEALTH & SOCIAL CARE TRUST

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

STATEMENT OF TRUSTS RESPONSIBILITIES IN RELATION TO PATIENTS/RESIDENTS MONIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003, the Trust is required to prepare and submit accounts in such form as the Department may direct.

The Trust is also required to maintain proper and distinct accounting records and is responsible for safeguarding the monies held on behalf of patients/residents and for taking reasonable steps to prevent and detect fraud and other irregularities.

BELFAST HEALTH & SOCIAL CARE TRUST

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

ACCOUNT OF MONIES HELD ON BEHALF OF PATIENTS/RESIDENTS

Previous Year	RECEIPTS		
£		£	£
	Balance at 1 April 2014		
1,673,239	1. Investments (at cost)	1,675,121	
3,586,498	2. Cash at Bank	3,453,811	
14,530	3. Cash in Hand	9,410	5,138,342
2,689,431	Amounts Received in the Year		2,836,840
4,895	Interest Received		33,588
7,968,593	**TOTAL**		**8,008,770**
	PAYMENTS		
2,830,251	Amounts Paid to or on behalf of Patients/Residents		2,763,371
	Balance at 31 March 2015		
1,675,121	1. Investments (at cost)	4,550,182	
3,453,811	2. Cash at Bank	677,779	
9,410	3. Cash in Hand	17,438	5,245,399
7,968,593	**TOTAL**		**8,008,770**

Schedule of investments held at 31 March 2015

Cost Price	Investment	Nominal Value	Cost Price
£		£	£
58,528	GPK Patients Property Account First Trust Deposit Account		0
1,616,593	Bank of Ireland		4,550,182

I certify that the above account has been compiled from and is in accordance with the accounts and financial records maintained by the Trust.

Director of Finance _____

Date 4.6.15

I certify that the above account has been submitted to and duly approved by the Board

Chief Executive _____

Date 4/6/15

BELFAST HEALTH AND SOCIAL CARE TRUST- PATIENTS AND RESIDENTS MONIES

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited Belfast Health and Social Care Trust's account of Monies held on behalf of Patients/ Residents for the year ended 31 March 2015 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

Respective responsibilities of the Trust and auditor

As explained more fully in the Statement of Trust Responsibilities in relation to Patients' and Residents' Monies, the Trust is responsible for the preparation of the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health, Social Services and Public Safety's directions made thereunder. My responsibility is to audit, certify and report on the account in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the account

An audit involves obtaining evidence about the amounts and disclosures in the account sufficient to give reasonable assurance that the account is free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Belfast Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Belfast Health and Social Care Trust; and the overall presentation of the account. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited Patients' and Residents' Monies account and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the financial transactions recorded in the account conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the financial transactions recorded in the account conform to the authorities which govern them.

Opinion on account

In my opinion:

- the account properly presents the receipts and payments of the monies held on behalf of the patients and residents of the Belfast Health and Social Care Trust for the year ended 31 March 2015 and balances held at that date; and

- the account has been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health, Social Services and Public Safety directions issued thereunder.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the account is not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance and Personnel's guidance.

Report

I have no observations to make on this account.

K J Donnelly

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU
5 June 2015

MAHI - STM - 300 - 2803

Belfast Health and Social Care Trust

Charitable Trust Funds

Annual Accounts

for the year ended 31 March 2015

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972, (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health, Social Services and Public Safety has directed the Belfast Health & Social Care Trust to prepare for each financial year a statement of accounts in respect of endowments and other property held on trust by it in a form determined by the Department of Health, Social Services and Public Safety. The financial statements are prepared on an accrual basis and must provide a true and fair view.

In preparing the financial statements the Accounting Officer is required to;

- observe the accounts direction issued by the Department of Health, Social Services and Public Safety including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in Charities SORP 2005 have been followed, and disclose and explain any material departures in the financial statements;
- keep proper accounting records;
- ensure an effective governance framework and establishing arrangements for the prevention and detection of fraud and corruption.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Accounting Officer for health and personal social services resources in Northern Ireland has designated Dr Michael McBride of the Belfast Health & Social Care Trust as the Accounting Officer for the Belfast Health and Social Care Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Belfast Health and Social Care Trust assets are set out in the Accounting Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

Charitable Trust Funds

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

CERTIFICATES OF DIRECTOR OF FINANCE, CHAIRMAN AND CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 167 to 178) which I am required to prepare on behalf of the Belfast Health & Social Care Trust have been compiled from and are in accordance with the accounts and financial records maintained by the Belfast Health & Social Care Trust and in accordance with the accounting policies for HSC Charitable Trust Funds as approved by the Department of Health, Social Services and Public Safety.

Director of Finance

4.6.15

Date

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 167 to 178) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Chairman

4 June 2015

Date

Chief Executive

4/6/15

Date

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

GOVERNANCE STATEMENT

Introduction/Scope of Responsibility

The Board of the Belfast Health and Social Care (HSC) Trust is accountable for internal control. As Accounting Officer and Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisations policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health, Social Services and Public Safety (DHSSPS).

Specifically, the Trust has the following key relationships through which it must demonstrate a required level of accountability:-

- with HSC Board commissioners, through service level agreements, to deliver health and social services to agreed specifications. The Trust has established engagement processes with the HSC Board (which includes the Public Health Authority (PHA) for appropriate areas). For example regular meetings are held with Local Commissioning Group (LCG) representatives to discuss local services and a Specialist Services Liaison Group (with representatives from the Trust, HSC Board and PHA) meets to review issues associated with regional services. A range of other engagement processes are in place i.e. Transforming Your Care (TYC) Collaboration Board, to address specific areas of service with HSC Board and other appropriate agencies;
- with colleague agencies in the HSC, through close and positive working arrangements;
- with local communities, through holding public board meetings, and publishing an annual report and accounts;
- with patients, through the management of standards of patient care; and
- with the DHSSPS, through the performance of functions and meeting statutory financial duties. These are monitored through formal reporting mechanisms and Accountability Review meetings which are held twice yearly and relevant Trust senior staff are in attendance.

Compliance with Corporate Governance Best Practice

The Trust applies the principles of good practice in Corporate Governance and continues to strengthen its governance arrangements. The Trust does this by undertaking continuous assessment of its compliance with Corporate Governance best practice for example by complying with relevant controls assurance standards, completing an annual ALB Board Governance self-assessment and action plan. The Trust's self-assessment for 2014/15 was presented to Trust Board for discussion and approval. The self-assessment covered a number of areas including Board composition and commitment; Board evaluation, development and learning; Board insight and foresight; and Board engagement and involvement. The self-assessment identified a number of issues which included; appointment terms of Non-Executive Directors not staggered due to RPA process, inclusion of feedback from key stakeholders and adverse publicity in relation to service delivery within the past 12 months.

The Trust has sought independent verification of the annual ALB Board Governance self-assessment. The report has confirmed the ratings and flags applied as accurate and found no

disparities .This information will be used to further inform the action plan from the self-assessment process. In addition the Trust receives assurance from external and internal auditors through the Report to those Charged with Governance and Internal Audit Reports.

Governance Framework

The Board of the Trust exercises strategic control over the operation of the organisation through a system of corporate governance which includes:-

- a schedule of matters reserved for Board decisions;
- a scheme of delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers;
- Standing Orders and Standing Financial Instructions;
- An Audit Committee;
- An Assurance Committee;
- A Remuneration Committee;
- A Governance Steering Group;
- A Safety & Quality Steering Group;
- A Learning from Experience Steering Group;
- A Social Care Steering Group;
- An Equality, Engagement & Experience Steering Group;
- A Complaints Review Group;
- A Charitable Trust Fund Advisory Committee.

The role of the Trust Board is to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. Throughout the year the Trust Board has been briefed on control issues by the Chairs of the Audit Committee and Assurance Committee. The Trust held five public Trust Board meetings and six Trust Board workshops during 2014/15. Standing agenda items included report from the Chief Executive, performance, quality and financial performance reports.

The Trust Board acts as "Corporate Trustee" for the Charitable Trust Funds and is responsible for ensuring that these funds are held and managed separately from public funds.

The Trust Board has a Charitable Funds Advisory Committee, which is authorised by the Board to undertake any activity within its Term of Reference. It is authorised to seek advice from whatever source it deems to be appropriate in order to fulfil its function.

The roles and responsibilities of the Charitable Funds Advisory Committee in relation to the management and governance of the Trust Fund are as follows:-

- Oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation;
- Ratify the creation of new funds by the Director of Finance where funds and/or other assets are received from donors in circumstances where the wishes of the donor cannot be accommodated within the scope of an existing fund;
- Make recommendations on the potential for rationalisation of funds within statutory guidelines;
- Ensure that assets in ownership of, or used by, the Charitable Fund will be maintained with the Trust's general estate and inventory of assets;

- Ensure that funds are not unduly or unnecessarily accumulated;
- Ensure that expenditure from charitable funds is subject to appropriate value for money considerations including proper procurement procedures where applicable;
- Ensure that Annual accounts are prepared in accordance with DHSSPS guidelines and submitted to the Trust Board within agreed timescales; and
- On behalf of the Trust Board, and on the advice of the Senior Management Team, the Committee will authorise appropriate policies and procedures in relation to charitable funds.

The Trustees have delegated the authority for expenditure decisions to the Charitable Funds Advisory Committee. The Trustees have also delegated expenditure decisions to specific individuals within the Trust to recommend expenditure from restricted funds. These recommendations were approved by a designated Director of the Trust.

In the Belfast HSC Trust, the delegated authorities are contained in the Terms of Reference for the Charitable Funds Advisory Committee.

The Trust operates under a scheme of delegation approved by the Trust Board in June 2007. This authorised the extant local arrangements for approval to Trust Fund expenditure requests. These arrangements are regularly reviewed and updated by the Charitable Funds Advisory Committee. From 1st December 2008, the following arrangements for approval apply:

Expenditure Range	Approval Level
£0 to £1,000	Co-Director of Accounting and Financial Services
£1,001 to £4,999	Director of Finance
£5,000 to £24,999	Chief Executive
£25,000 to £99,999	Charitable Funds Advisory Committee
£100,000 and above	Trust Board

All Trust Fund expenditure requests are checked by the Charitable Trust Funds team to ensure:-

1. The proposed expenditure meets the objectives of the fund in question;
2. There are sufficient funds to cover the expenditure proposed in full;
3. Any revenue consequential are clearly identified and have a recurring funding source.

The Belfast Trust has responsibility for the administration of the Common Investment Fund.

The Audit Committee provides the Trust Board with an independent and objective review on its financial systems of internal control. The Chair of the Audit Committee provides the Board with an Annual Report each year. This committee met four times during the year. The Audit Committee completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness. The results are submitted to the DHSSPS and an action plan is drawn up for any areas that require improvement. No performance related issues were identified as part of this review. The work of the Internal Audit and External Audit functions is fundamental to providing assurances on the on-going effectiveness of the system of internal financial control. In addition, the controls assurance standards and the annual self-assessment against the standards provide an important assurance to the Assurance Committee.

The Assurance Committee met on four occasions during the year and is comprised of Non-Executive Directors only. The Head of Internal Audit is also in attendance and reports directly on any risk or governance related Internal Audit reports. The Assurance Committee's role is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for ensuring there is a robust system in place for identifying principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Remuneration Committee is responsible for advising the Board on the remuneration of the Chief Executive and Directors of the Trust, guided by DHSSPS policy and best practice. The Committee is chaired by the Trust Chairman and two other Non-Executive Directors and met twice during 2014/15.

Attendance records of key committees, including the Charitable Funds Advisory Committee, are maintained and have been reviewed to ensure that the Trust routinely meets its requirements for a full quorum.

Business Planning

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

The Trust's Corporate Plan sets out the vision and purpose, core values and long term objectives that will shape the strategic direction and priorities for a 3 year period. The Corporate Plan and the Trust Delivery Plan set out annual targets to progressively deliver the corporate objectives.

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators and the Commissioning Plans of Health and Social Care Board as set out in its Annual Commissioning Plan. While the Corporate Plan incorporates these Departmental/commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets under each corporate objective. The Corporate Objectives and associated annual targets (regional and local) are cascaded throughout the Trust by;

- Directorate Annual Performance Plans;
- Service/Team annual plans;
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework. Review and monitoring of progress against priorities and objectives (linked to DHSSPS/HSC Board priorities, the Trust Business/Management Plan (including the Trust Delivery Plan)) is carried out through;

- Trust Board Performance reports (monthly related to key performance indicators), to provide assurance at Board level;
- Regular accountability/review meetings with Directorates to monitor progress against organisational and Directorate key priorities through Directorate scorecards;
- Individual Personal Contribution Plans and Learning and Development Plans objectives to ensure learning and development supports the delivery of Directorate and organisational objectives.

Risk Management

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:-

- identify and prioritise the risks to the achievement of organisational policies, aims and objectives;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Trust is committed to providing high quality patient and client services in an environment that is both safe and secure. The Trust Board has approved an Assurance Framework and a Risk Management Strategy and has established an Assurance Committee whose membership includes all Non-Executive Directors. This Committee reports directly to the Trust Board. The Assurance Framework outlines the Chief Executive's overall responsibility and accountability for risk management. The Framework also sets out a system of delegation of responsibility at Trust Board, Executive Team and Directorate levels. While ensuring local ownership in managing and controlling all elements of risk to which the Trust may have been exposed, there is a clear line of accountability through to Trust Board.

Risk management is at the core of the Trust's performance and assurance arrangements and the Assurance Committee, chaired by the Trust's Chairman, provides Board level oversight in this key area. This Committee, along with the Audit Committee, has scrutinised the effectiveness of the Risk Management Strategy.

The Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Trust may have to set priorities for the management of risk. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service. The Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Trust involves its service users, public representatives, contractors and other external stakeholders in the implementation of the Risk Management Strategy.

Risk management is integral to the training for all staff as relevant to their grade and situation, both at induction and in service. To support staff through the risk management process, expert guidance and facilitation has been available along with access to policies and procedures, outlining responsibilities and the means by which risks are identified and controlled. Actions taken to reduce risk have been regularly monitored and reported with trends being analysed at Directorate, Corporate and Board levels.

Dissemination of good practice has been facilitated by a range of mechanisms including systems for the implementation and monitoring of authorative guidance, clinical supervision and reflective practice, performance management, continuing professional development, management of adverse events and complaints, multiprofessional audit and the application of evidence based practice. The Trust seeks to ensure that its medical workforce is equipped to provide the best health care that can be achieved through investment in education, appraisal, appropriate job planning and where issues arise that are appropriate to maintaining high professional standards these are dealt with using the

Charitable Trust Funds

appropriate procedures, involvement of National Clinical Assessment Service where necessary and regulatory bodies such as the General Medical Council and General Dental Council.

Information Risk

Information is a vital asset, both in terms of the management of service users and the efficient management of services and resources. It plays a key part in corporate governance, service planning and performance management. It is therefore of paramount importance to ensure that information is efficiently managed and that appropriate policies, procedures and management accountability provide a robust governance framework for information management. Within the Trust the Information Governance Board oversees all aspects of information governance including data protection, ICT security, corporate records, freedom of information and data quality throughout the Trust. It also has the responsibility to lead and foster a culture that values, protects and uses information for the public good. This body ensures participation from all Directorates and is chaired by the Director of Performance Planning and Informatics. This Director also acts as the Senior Information Risk Owner and has a key role in considering how organisation goals will be impacted by information risks and how those risks may be managed. Over 30 Information Asset Owners have been identified across the Trust who have responsibility for the identification and management of risk in their areas.

During 2014/15 the Trust has completed the Controls Assurance Standards in relation to Information Management and ICT increasing the score on the previous year. Internally the Trust undertakes Information Governance Visits to a number of Departments and provides feedback to Information Asset Owners as to the actions that can be taken to improve information handling processes. Data Protection Awareness training is mandatory and can be undertaken as e:learning or by attending one of the regular information governance sessions. Throughout the year the Information Governance Board continues to monitor the information governance incidents that occur and reported 7 incidents to the Information Commissioners Office. In May 2014 the Records and Information Governance Team were winners of National Information & Records Management Society Team of the Year Award.

Public Stakeholder Involvement

The Trust remains committed to ensuring that Personal and Public Involvement (PPI) is embedded into all aspects of its business.

PPI is included in the Trust Assurance Framework committee structure, reporting via the Equality, Experience and Engagement Committee. PPI has also been included in the Trust Accountability Framework, requiring all service areas to account for their PPI activity, and PPI is reflected in the Trust Corporate Plan. There continues to be a wide range of user engagement opportunities throughout the Trust, both corporately and within clinical Directorates, which allow people to become involved in the development, improvement and evaluation of Trust service. In addition there a number of Trust-wide User Forum and specific Service User groups facilitated by and linked to the Trust which can provide opportunities for service user and carers to engage in decision making, feedback processes and associated risk issues.

A draft Organisational Framework for the Management of PPI is currently being consulted on and it is envisaged that this will be published by summer 2015. The implementation of this framework

should lead to the development of more opportunities for engagement with service users and carers across the organisation, on a range of issues, which could potentially include risk. A PPI Standing Forum will be established by summer 2015.

PPI training is delivered for Trust staff and four members of Trust staff participated in the PHA commissioned PPI training for trainers programme. This training programme will be cascaded throughout the organisation.

Assurance

The Assurance Framework describes the relationship between organisational objectives, identified potential risks to their achievement and the key controls through which these risks will be managed, as well as the sources of assurance surrounding the effectiveness of these controls. The Assurance Framework incorporates the Risk Management Policy and establishes the context in which the Trust Management Plan was developed, as well as determining the mechanism through which assurances were provided to the Trust Board. The Assurance Framework lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes. The Assurance Committee regularly challenges or seeks verification of the quality of evidence coming to it.

The Assurance Framework was reviewed and updated in 2014 to reflect minor changes in the document and on-going adjustment to the Sub Committee structure. The updated Assurance Framework was approved by the Assurance Committee of the Trust Board on the 16th June 2014. The Assurance Framework allows an integrated approach to performance, targets and standards which include controls assurance standards and quality standards for health and social care.

The Assurance Committee agenda and schedule of annual reports takes account of the Sub Committees structure. These committees report through the Assurance Group to Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and provide the necessary scrutiny of practice. At each Assurance Committee meeting, through the relevant chair, the Committee receives assurance reports from the following governance committees: Social Care Steering Group; Governance Steering Group; Learning from Experience Steering Group; Outcome Review Group; Complaints Review Group; Safety and Quality Steering Group; Equality, Engagement and Experience Steering Group as well as a litigation report encompassing clinical negligence and other claims. It also receives an annual health and safety report.

In addition the Committee receives updates on the Safety and Quality Improvement Plan; SAI Reports, and summary reports of RQIA unannounced hygiene inspections, RQIA thematic reviews and RQIA inspections of regulated providers. This taken with other internal assurances and the external assurances detailed under Sources of Independent Assurance means that the Board is satisfied that this level of assurance is of sufficient quality and meets its requirements. The Risk Register Review Group continues to meet on a quarterly basis, to scrutinise the evaluation of all significant risks arising from Directorate and Controls Assurance Risk Registers. Each Directorate has maintained and further developed systems to identify risk, assess impact and likelihood of harm occurring, and to maintain control in line with the Assurance Framework and the Risk Management Strategy. These risks are used to populate Directorate risk registers, which are updated on an on-going basis and which feed into the Belfast Trust's Assurance Framework Principal Risks and Controls document.

The Trust assessed its compliance with the 22 Controls Assurance Standards which were defined by the Department. All standards achieved substantive compliance in 2014/15.

Sources of Independent Assurance

The Trust obtains Independent Assurance from the following main sources:

- Head of Internal Audit's Annual Report including an overall opinion on the system of Internal Controls
- Chair of Audit Committee's Annual Report to Trust Board;
- Internal Audit - through a programme of annual audits based on an analysis of risk;
- Northern Ireland Audit Office; through audit of the annual accounts and subsequent report to those charged with governance alongside any value for money (VFM) studies and subsequent reports;
- Regulation and Quality Improvement Authority (RQIA); through regular inspections and subsequent reports;
- Social Services Inspectorate for older people and children's services;
- Medicines and Healthcare products Regulatory Agency (MHRA) through regular inspections and reports;
- General Medical Council (GMC), General Dental Council (GDC), NI Medical and Dental Training Agency (NIMDTA) and various Royal Colleges.

The Trust engages proactively with all such reviews and the Board is assured that appropriate actions are taken, by the Assurance Committee.

Internal Audit

The Trust utilises an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis. Internal Audit last reviewed the Charitable Funds system and procedures in 2013/14 and a satisfactory level of assurance was provided. Internal Audit reviewed the following systems in 2014/15 of which elements were relevant to the Charitable Trust Funds:-

- Bank & Cash (Satisfactory Assurance)
- Cash Handling in Social Services facilities (Satisfactory Assurance)

In their annual report, the Internal Auditor reported that the Belfast Trust had a satisfactory system of internal control designed to meet the Trust's objectives for the year ended 31 March 2015.

Certain weaknesses and issues were identified by audit and recommendations to address these control weaknesses have been or are being implemented. The Audit Committee have reviewed management responses to Internal Audit recommendations and monitor progress with the implementation of recommendations.

Internal Audit conduct formal follow-up reviews in respect of the implementation of the priority one and two internal audit recommendations agreed in the Internal Audit reports. Internal Audit presented a full report which showed that 97% of agreed actions have been fully or partially implemented.

Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance within the Belfast HSC Trust. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Assurance Committee and sub committees, and a plan to address weaknesses and ensure continuous improvement to the system is in place.

Follow up audits are carried out and the Trust will continue to implement the compliance regime during 2015/16.

The Charitable Trust Fund Advisory Committee of the Belfast HSC Trust was in place for 2014/15.

The Charitable Trust Fund Advisory Committee recognise the current and ongoing economic conditions in investment markets and its impact on the Charitable Trust Fund's investments. The Charitable Trust Fund Advisory Committee will ensure that there is:

- Continued representation on behalf of the Belfast Charitable Trust Funds on the Common Investment Fund Committee;
- Continued discussion and review of Investment Management performance reports and forecasts.

The Charitable Trust Fund Advisory Committee will continue to meet on a regular basis in 2015/16 to discharge its duties and responsibilities, including the monitoring and oversight of new procedures as they continue to be embedded with the organisation.

There were no internal control divergences identified during the year in relation to Charitable Trust Funds.

Conclusion

The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of Charitable Trust Funds, as detailed in Manage Public Money NI.

Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the Trust has operated a sound system of internal governance during the period 2014/15.

4/6/15

Dr Michael McBride **Date**

Accounting Officer

Charitable Trust Funds

BELFAST HEALTH AND SOCIAL CARE TRUST - CHARITABLE TRUST FUNDS

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited the financial statements of the Belfast Health and Social Care Trust's Charitable Trust Funds for the year ended 31 March 2015 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. These comprise the Statement of Financial Activities, the Balance Sheet and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of the Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Belfast Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the trustees; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the incoming and outgoing resources recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the incoming resources and application of outgoing resources recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

- the financial statements give a true and fair view of the state of Belfast Health and Social Care Trust's Charitable Trust Funds' affairs as at 31 March 2015 and of its incoming and outgoing resources for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health, Social Services & Public Safety directions issued thereunder.

Opinion on other matters

In my opinion the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance and Personnel's guidance.

Report

I have no observations to make on these financial statements.

K J Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU

5 June 2015

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

STATEMENT OF FINANCIAL ACTIVITIES

	Note	Unrestricted Funds £000s	Restricted Funds £000s	Endowment Funds £000s	2015 Total Funds £000s	2014 Total Funds £000s
INCOMING RESOURCES						
Incoming resources from generating funds						
Voluntary income	2	78	621	0	699	852
Activities for generating funds		0	0	0	0	0
Investment income	3	342	758	0	1,100	1,060
Incoming resources from charitable activities	4	0	0	0	0	0
Other Incoming Resources		0	0	0	0	0
Total Incoming Resources		**420**	**1,379**	**0**	**1,799**	**1,912**
RESOURCES EXPENDED						
Costs of generating funds						
Costs of generating voluntary income		0	0	0	0	0
Fundraising trading: Costs of goods sold and other costs		0	0	0	0	0
Investment management costs		0	0	0	0	0
Charitable activities	6	(382)	(1,087)	0	(1,469)	(1,342)
Governance Costs	5	(39)	(95)	0	(134)	(165)
Other resources expended		0	0	0	0	0
Total Resources Expended		**(421)**	**(1,182)**	**0**	**(1,603)**	**(1,507)**
Net incoming/(outgoing) resources before transfers		**(1)**	**197**	**0**	**196**	**405**
TRANSFERS						
Gross transfer between funds	8	0	0	0	0	0
Net Incoming/(Outgoing) Resources before other recognised gains and losses		**(1)**	**197**	**0**	**196**	**405**
OTHER RECOGNISED GAINS/LOSSES						
Gains/(losses) on revaluation of fixed assets for charity's own use		0	0	0	0	0
Gains/(losses) on investment assets	12	866	1,914	0	2,780	1,602
Net Movement in Funds		**865**	**2,111**	**0**	**2,976**	**2,007**
Adjustment to add back: Notional Audit Fee	10	2	3	0	5	7
Net Movement in Funds excluding Notional Audit Fee		**867**	**2,114**	**0**	**2,981**	**2,014**
RECONCILIATION OF FUNDS						
Fund balances brought forward at 1 April 2014		**12,945**	**28,389**	**1,555**	**42,889**	**40,875**
Fund balances carried forward at 31 March 2015		**13,812**	**30,503**	**1,555**	**45,870**	**42,889**

The notes at pages 169 to 178 form part of this account

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

BALANCE SHEET

	Notes	31 March 2015 £000s	31 March 2014 £000s
Fixed Assets			
Intangible assets		0	0
Tangible assets	11	0	0
Heritage assets		0	0
Investments:			
Investments	12	45,381	41,253
Programme related investments		0	0
Total Fixed Assets		45,381	41,253
Current Assets			
Stocks		0	0
Debtors	13	29	114
Short term investments and deposits		0	972
Cash at bank and in hand		521	659
Total Current Assets		550	1,745
Creditors : Amounts falling due within one year	14	(61)	(109)
Net Current Assets/(Liabilities)		489	1,636
Total Assets less Current Liabilities		45,870	42,889
Creditors : Amounts falling due after more than one year	14	0	0
Provisions for liabilities and charges		0	0
Net Assets		**45,870**	**42,889**
Funds of the Charity			
Restricted Income Funds	15	30,503	28,389
Endowment Funds	15	1,555	1,555
Unrestricted Income Funds			
Unrestricted Income Funds	15	13,812	12,945
Revaluation reserve		0	0
Total unrestricted funds		13,812	12,945
Total charity funds		**45,870**	**42,889**

The notes at pages 169 to 178 form part of this account

Chairman: ..... **Date:** 4 June 2015

Chief Executive : ..... **Date:** 4/6/15

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

1. Accounting policies

1(a) Basis of preparation

The financial statements have been prepared in accordance with 'Accounting and Reporting by Charities' The Statement of Recommended Practice issued in March 2005, and with relevant guidance issued by the DHSSPS.

1(b) Incoming resources

All incoming resources are included in full in the statement of financial activities as soon as the following three factors can be met:

i. entitlement – arises when a particular resource is receivable or the charity's right becomes legally enforceable;

ii. certainty – where there is reasonable certainty that the incoming resource will be received;

iii. measurement – when the monetary value of the incoming resources can be measured with sufficient reliability.

1(c) Incoming resources from legacies

All incoming resources are recognised once the charity has entitlement to the resources, it is certain that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

1(d) Gifts in kind

i. Assets given for distribution by the charity are included in the Statement of Financial Activities only when distributed.

ii. Assets given for use by the charity (e.g. property for its own occupation) are included in the Statement of Financial Activities as incoming resources when receivable.

iii. Gifts made in kind but on trust for conversion into cash and subsequent application by the charity are included in the accounting period in which the gift is sold.

In all cases the amount at which the gifts in kind are brought into account is either a reasonable estimate of their value to the charity or the amount actually realised. The basis of the valuation is disclosed in the Trustees Report.

1(e) Intangible income

Intangible income (e.g. the provision of free accommodation) is included in the accounts with an equivalent amount in outgoing resources, if there is a financial cost borne by another party. The value placed on such income is the financial cost of the third party providing the resources.

1(f) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category. All expenditure is recognised once there is a legal or constructive obligation committing the charity to the expenditure. Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

1(g) Allocation of support costs and overheads

Support costs and overheads have been allocated between Governance Costs and Charitable Activities. Costs which are not wholly attributable to an expenditure category have been apportioned. The analysis of support costs and the bases of apportionment applied are shown in note 5. Where costs are shared by two or more charitable activities, support costs have been apportioned between categories and this is analysed in note 6.

1(h) Costs of generating funds

The costs of generating funds are the cost of Investment management fees.

1(i) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs comprise direct costs and an apportionment of overhead and support costs as shown in note 5.

1(j) Governance costs

Governance costs comprise all costs incurred in the governance of the charity. These costs include costs related to statutory audit together with an apportionment of overhead and support costs.

1(k) Fixed assets

There are no fixed assets held by the Charitable Trust Funds.

1(l) Donated assets

There are no donated assets held by the Charitable Trust Funds.

Charitable Trust Funds

1(m) Investment fixed assets

Investment Fixed Assets are shown at market value as at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year.
Property assets are not depreciated but are shown at market valuation.

Quoted stocks and shares included in the balance sheet are carried at market value based on the closing market value at the year end.

Other investment fixed assets are included at trustees' best estimate of market value.

1(n) Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1(o) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchased date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

1(p) Funds structure

Where there is a legal restriction on the purposes to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment fund. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as designated funds.

1(q) Pensions

The Charitable Trust Fund has no employees.

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

2 Analysis of voluntary income

	Unrestricted Funds £000s	Restricted Funds £000s	2015 Total Funds £000s	2014 Total Funds £000s
Donations from individuals	21	450	471	400
Corporate donations	0	0	0	11
Legacies	57	165	222	403
Grants	0	0	0	0
Other	0	6	6	38
Total	**78**	**621**	**699**	**852**

3 Gross investment income

	2015 Total Funds £000s	2014 Total Funds £000s
Gross income earned from:		
Fixed asset equity and similar investments	1,098	1,053
Fixed asset cash on deposit	0	0
Current assest investments	2	7
Other	0	0
Total	**1,100**	**1,060**

4 Incoming resources from charitable activities

There is no Income from charitable activities for Charitable Trust Funds for year ended 31 March 2015 (2014: Nil)

Charitable Trust Funds

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

5 Allocation of support costs and overheads

	2015 Total Funds £000s	Allocated to Governance £000s	Charitable Activities £000s	Basis of apportionment	2014 Total Funds £000s
Financial	0	0	0		0
Administration	129	129	0	Usage	158
Salaries and related costs	0	0	0		0
Staff training	0	0	0		0
Staff recruitment	0	0	0		0
Office rent	0	0	0		0
Internal Audit	0	0	0		0
External Audit	5	5	0	Usage	7
Telephone, Postage & Stationery	0	0	0		0
Bank Charges	0	0	0		0
Other professional expenses	0	0	0		0
Insurance	0	0	0		0
Other	0	0	0		0
Total	**134**	**134**	**0**		**165**

6 Analysis of charitable expenditure

	Grant funded activity £000s	Support Costs £000s	2015 Total £000s	2014 Total £000s
Medical research	0	376	376	371
Purchase of new equipment	0	342	342	374
Building and refurbishment	0	183	183	74
Staff education and welfare	0	385	385	302
Patient education and welfare	0	176	176	181
Other	0	7	7	40
Total	**0**	**1,469**	**1,469**	**1,342**

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

7 Analysis of grants

The Charitable Trust Funds have no grants in year ended 31 March 2015 (2014: Nil)

8 Transfer between funds

	2015 £000s	2014 £000s
Restricted Funds	0	0
Unrestricted Funds	0	0
Endowment	0	0
Total	**0**	**0**

9 Analysis of staff costs

The average number of employees on a full-time basis in the year was Nil (2014: Nil). The Charitable Trust is recharged a portion of Belfast Trust staff costs as administration charges each year.

10 Auditor's remuneration

The auditor's remuneration of £5,200 (2014: £6,750) related solely to the audit with no other additional work undertaken.

11 Total tangible fixed assets

There are no fixed assets held by Charitable Trust Funds (2014: Nil)

Charitable Trust Funds

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

12 Analysis of Fixed Asset Investments

12.1 Investments in a Common Investment Fund

	2015 £000s	2014 £000s
Market Value at 1 April 2014	41,253	38,948
Net Cash Inflow/(Outflow)	250	(350)
Share of income	1,098	1,053
Share of realised gains/(losses)	347	330
Share of unrealised gains/(losses)	2,433	1,272
Market Value at 31 March 2015	**45,381**	**41,253**

12.2 Movement in fixed asset investment

	2015 £000s	2014 £000s
Market Value at 1 April 2014	0	0
Less:Disposals at carrying value	0	0
add: Acquisitions at cost	0	0
Net gain / loss on revaluation	0	0
Market Value at 31 March 2015	**0**	**0**
Historic Cost at 31 March 2014	**0**	**0**

12.3 Market Value as at 31 March 2015

	Held in UK £000s	Held outside UK £000s	Total £000s	2014 Total £000s
Investment Properties :				
Investments listed on Stock Exchange	0	0	0	0
Investments in CIF - EHSSB area only	45,381	0	45,381	41,253
Investments in a Common Deposit Fund or Investment Fund	0	0	0	0
Unlisted securities	0	0	0	0
Cash held as part of the investment portfolio	0	0	0	0
Investments in connected bodies	0	0	0	0
Other investments	0	0	0	0
Total market value of fixed asset investments	**45,381**	**0**	**45,381**	**41,253**

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

13 Analysis of Debtors

		2015 £000s	2014 £000s
13.1	**Amounts falling due within one year :**		
	Trade debtors	0	0
	Prepayments	0	0
	Accrued income	0	0
	Other debtors	29	114
	Total	**29**	**114**
13.2	**Amounts falling due over one year :**		
	Trade debtors	0	**0**
	Prepayments	0	**0**
	Accrued income	0	**0**
	Other debtors	0	0
	Total	**0**	**0**

14 Analysis of Creditors

		2015 £000s	2014 £000s
14.1	**Amounts falling due within one year :**		
	Loans and overdrafts	0	0
	Trade creditors	0	0
	Other creditors	61	109
	Accruals	0	0
	Deferred income	0	0
	Total	**61**	**109**
14.2	**Amounts falling due after more than one year :**		
	Loans and overdrafts	0	0
	Trade Creditors	0	0
	Other creditors	0	0
	Accruals	0	0
	Deferred income	0	0
		0	**0**

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

15 Analysis of charitable funds

	Balance at 1 April 2014 £000s	Incoming resources £000s	Resources expended £000s	Transfers £000s	Gains & losses £000s	Fund at 31 March 2015 £000s
Endowment Funds						
RVH General C.I.P.	420	0	0	0	0	420
Frederick Street Nurses (Cap) RVH	182	0	0	0	0	182
BOAG Trust (Capital) RVH	339	0	0	0	0	339
EM Wiles Fund (Capital) RVH	117	0	0	0	0	117
Other (individually less than 5%)	497	0	0	0	0	497
Endowment funds total	**1,555**	**0**	**0**	**0**	**0**	**1,555**
Restricted Funds						
Renal BCH	1,622	101	(57)	0	106	1,772
NICC Treatment & Research	1,094	28	(5)	0	72	1,189
Other (individually less than 5%)	25,673	1,250	(1,117)	0	1,736	27,542
Restricted funds total	**28,389**	**1,379**	**(1,179)**	**0**	**1,914**	**30,503**
Total	**29,944**	**1,379**	**(1,179)**	**0**	**1,914**	**32,058**

Analysis of unrestricted and material designated funds	Balance at 1 April 2014 £000s	Incoming resources £000s	Resources expended £000s	Transfers £000s	Gains & losses £000s	Fund at 31 March 2015 £000s
RVH General	1,240	45	(49)	0	110	1,346
RMH General	2,321	60	(5)	0	152	2,528
RBHSC General	6,202	164	(138)	0	405	6,633
Mater General Fund	1,104	34	(79)	0	68	1,127
NICC General Fund	905	46	(55)	0	59	955
Other (individually less than 5%)	1,173	71	(93)	0	72	1,223
Total	**12,945**	**420**	**(419)**	**0**	**866**	**13,812**
Total Funds	**42,889**	**1,799**	**(1,598)**	**0**	**2,780**	**45,870**

BELFAST HEALTH & SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTES TO THE ACCOUNTS

16 Contingencies

The Trust Funds have no contingencies at year ended 31 March 2015 (2014: Nil)

17 Commitments

The Trust Funds have no commitments at year ended 31 March 2015 (2014: Nil)

18 Financial Guarantees

The Belfast HSC Trust Charitable Trust Funds have not given any financial guarantees as at 31st March 2015 (2014: Nil)

19 Related Party Transactions

During the year none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Belfast Health and Social Care Trust Charitable Trust Funds.

Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public.

Some of the Trust's Directors have disclosed interests with organisations from which the Trust purchased services from or supplied services to during 2014/15. Set out below are details of the amount paid to these organisations during 2014/15. In none of these cases listed did the Directors have any involvement in the decisions to procure the services from the organisations concerned.

	Payments to Related Party	Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
2014/15	**£000s**	**£000s**	**£000s**	**£000s**
Belfast Health & Social Care Trust	587	0	24	0
Queen's University Belfast	146	0	0	0
Belfast City Council	2	0	0	0
2013/14				
Belfast Health & Social Care Trust	386	0	15	0
Queen's University Belfast	146	0	0	0

Interests in the above organisations were declared by the following Board members:-

All Trustees of the Charitable Trust Funds are Executive or Non Executive Directors of the Belfast Health & Social Care Trust.
Mr JPJ O'Kane (Non-Executive Director) holds the position of Registrar and Chief Operating Officer for Queen's University Belfast.
Mr P McNaney (Chairman) held the post of Chief Executive of Belfast City Council until 31 March 2014

Transactions with these related parties are conducted on an arm's length basis. The purchase of goods and services are subject to the normal tendering processes under Northern Ireland Public Procurement Policy, Trust Standing Orders and Standing Financial Instructions. There are no provisions for doubtful debts against the related party balances owed. In addition, the Trust has not provided or received any financial guarantees in respect of any related parties identified.

The charitable funds of the Belfast Health & Social Care Trust are invested within a Common Investment Fund. Mr C Jenkins (Non Executive Director), Mr L Drew (Non Executive Director), Mr M Dillon (Director of Finance) and Mrs F Cotter (Co-Director of Accounting & Financial Services) are members of the committee established to manage this Fund. Since 1st April 2012 the Belfast Health & Social Care Trust has had responsibility for the administration of the Fund. Details of the investments with this fund can be found at Note 12.

Charitable Trust Funds

Trustees Report

Year Ended 31 March 2015

Annual Report of the Trustees of the Trust Funds held by the Belfast Health & Social Care Trust for the year ended 31 March 2015

Background

Under the Health and Personal Social Services (NI) Order 1972 (as amended by Article 6 of the Audit and Accountability (NI) Order 2003), the Trust is required to prepare annual accounts in respect of endowments and other property held on trust by it in a form determined by the DHSSPS. Further, under the requirements of the Statement of Recommended Practice (SORP) 2005 "Accounting and Reporting by Charities", is the requirement to produce an Annual Report.

Investment arrangements

In order to maximise the total return from investment of the Trust funds, the Northern Ireland Health and Social Services Charities Common Investment Fund was established by an Order dated 30 March 1995, made by the Department of Health and Social Services under Section 25 of the Charities Act (Northern Ireland) 1964. The charitable funds of the Belfast Health & Social Care Trust are invested within this Common Investment Fund. A committee has been established to manage the operations of the Common Investment Fund. During 2014/15 this committee consisted of the following individuals:

Mr Charles Jenkins (Chairman)	BHSCT, Non-Executive Director
Mr Les Drew	BHSCT, Non-Executive Director
Mr Martin Dillon	BHSCT Director of Finance & Estates Services
Mrs Fiona Cotter	BHSCT Co Director Accounting & Financial Services
Mr Neil Guckian	South Eastern HSC Trust Director of Finance
Mr Nigel Mansley	South Eastern HSC Trust Non-Executive Director

Since 1st April 2012 the Belfast Health & Social Care Trust has had responsibility for the administration of the Common Investment Fund.

Names of Trustees

Under the Health and Personal Social Services (NI) Order 1972, as amended by Article 16 of the Health and Personal Social Services (NI) Order 1991, the Board of the Belfast Health & Social Care Trust are the trustees of the Trust Fund. During 2014/15 the following acted as Trustees:

Chairperson	Mr Peter McNaney, Chairman
Non-Executive Directors	Mr Les Drew
	Mr Tom Hartley
	Mr Charles Jenkins
	Mr James O'Kane
	Dr Val McGarrell
Executive Directors	
Chief Executive	Dr Michael McBride (Appointed 08/12/14)
	Mr Martin Dillon (Acting 01/07/14 – 08/12/14)
	Mr Colm Donaghy (Left 30/06/2014)
Director of Finance	Mr Martin Dillon
	Mrs Maureen Edwards
	(Acting 01/07/14 – 08/12/14)
Director of Social Work / Childrens Community Services	Mr Cecil Worthington
Medical Director	Dr Cathy Jack (Appointed 01/08/14)
	Dr Tony Stevens (Left 31/07/14)
Director of Nursing and User Experience	Miss Brenda Creaney

Address of Principal office
A Floor
Belfast City Hospital
Lisburn Road
Belfast BT9

Charity Number: XT1874
The Trustees employed the following professional advisors during the year:

Auditors
Northern Ireland Audit Office
106 University Street
Belfast BT7 1EU

Bankers
Bank of Ireland
Belfast City Branch
Belfast BT1 2BA

Solicitors
Directorate of Legal Services
Business Services Organisation
2 Franklin Street
Belfast BT2 8DQ

(Advisors in relation to the Charitable Trust Funds Review)
Cleaver Fulton Rankin
50 Bedford Street
Belfast BT2 7FW

Principal Advisors
(Advisors in relation to the Common Investment Fund)
Brewin Dolphin Limited
Waterfront Plaza
8 Laganbank Road
Belfast BT1 3LR

Structure, governance and management

The Trust Board acts as “corporate trustee” for the Charitable Trust funds and is responsible for ensuring that these funds are held and managed separately from public funds.

The Trust Board has established a Charitable Funds Advisory Committee, which is authorised by the Board to undertake any activity within its terms of reference. It is authorised to seek advice from whatever source it deems to be appropriate in order to fulfil its function. Membership of the Charitable Funds Advisory Committee during 2014/15 was as follows:

Mr Les Drew (Chair)	Non Executive Director
Dr Michael McBride	Chief Executive (from 08/12/14)
Mr Colm Donaghy	Chief Executive (to 30/06/14)
Mr Martin Dillon	Director of Finance / Acting Chief Executive
Mrs Maureen Edwards	Acting Director of Finance (01/07/14 – 08/12/14)
Miss Brenda Creaney	Director of Nursing and User Experience
Dr Cathy Jack	Medical Director (from 01/08/14)
Dr Tony Stevens	Medical Director (to 31/07/14)
Mr Cecil Worthington	Director of Social Work / Children’s Community Services

The roles and responsibilities of the Charitable Funds Advisory Committee in relation to the management and governance of the Trust Fund are as follows:

- Oversee charitable funds in line with guidance in the Trust’s Standing Financial Instructions, Departmental guidance and legislation
- Ratifying the creation of new funds by the Director of Finance where funds and/or other assets are received from donors in circumstances where the wishes of the donor cannot be accommodated within the scope of an existing fund
- Make recommendations on the potential for rationalisation of funds within statutory guidelines
- Ensure that assets in ownership of, or used by, the Charitable Fund will be maintained with the Trust’s general estate and inventory of assets
- Ensure that funds are not unduly or unnecessarily accumulated
- Produce an annual statement on internal control over Charitable funds, being informed by reports from Management, the Internal Auditor and the External Auditor
- Ensure that a Trustees Report is produced as part of the production of annual accounts for charitable funds
- Ensure that expenditure from charitable funds is subject to appropriate value for money considerations including proper procurement procedures where applicable
- Ensure that Annual accounts are prepared in accordance with DHSSPS guidelines and submitted to the Trust Board within agreed timescales
- On behalf of the Trust Board, and on the advice of the Senior Management Team, the Committee will authorise appropriate policies and procedures in relation to charitable funds.

The Trustees have delegated the authority for expenditure decisions to the Charitable Funds Advisory Committee. The Trustees have also delegated expenditure decisions to specific individuals within the Trust to recommend expenditure from restricted funds. These recommendations were approved by a designated Director of the Trust.

In the Belfast Trust the delegated authorities will be contained in the Terms of Reference for the Charitable Funds Advisory Committee.

In addition, the Charitable funds Advisory Committee recognise the current and ongoing economic conditions in investment markets and its impact on the Charitable Trust Fund’s investments. The Charitable Trust Fund Advisory Committee will continue to ensure that there is:

- Continued representation on behalf of the Belfast Charitable Trust Funds on the Common Investment Fund Committee
- Continued discussion and review of Investment Management performance reports and forecasts.

As the Trustees are directors of the Belfast Trust, the policies and procedures followed for recruitment, induction and training of these officers applies also to their duties as Trustees.

During the year, none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Belfast HSC Trust's Charitable Trust Funds.

Objectives and activities

The objectives of the Belfast Health & Social Care Trust are to ensure that charitable donations received by the Trust are appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

The aim of the Trustees is to enhance the patient experience within the hospital through planned expenditure from the funds available. The Trustees have not undertaken any fundraising activities in 2014/15 and relied on voluntary contributions and donations.

Achievements and performance

The Trustees policy is to seek to balance the use of the Trust funds capital and income in a way which maximises the benefits to the hospital and patients and which sustains historical levels of income.

During the year the Trust Fund continued to engage in activities commensurate with its objectives. Over £1.4m was expended on charitable activities, in accordance with the Trust's policies and procedures in relation to expenditure from Trust Funds.

Where there are cash balances surplus to requirements the Trust transfers such balances to the Common Investment Fund, in order to maximise the return on investments.

Financial Review

Introduction

The financial statements have been prepared in accordance with 'Accounting and Reporting by Charities' The Statement of Recommended Practice issued in March 2005, and with relevant guidance issued by the DHSSPS.

Where there is a legal restriction on the purposes to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment fund. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as designated funds.

Review of the year

Income and Expenditure

For the year ended 31 March 2015 there was net income surplus of £201k (after excluding the notional audit fee).

Total income of £1,799k was received in comparison to £1,912k in 2013/14 representing an overall decrease of £113k in 2014/15.

Voluntary income accounted for £699k of the total income.
Investment income accounted for £1,100k.

Voluntary income decreased £153k on the 2013/14 figure of £852k.
Investment income increased £40k on the 2013/14 figure of £1,060k.
The increase in investment income is due to the additional return from a higher amount being invested in 2014/15 than in 2013/14.

The decrease in total income in 2014/15 is mainly due to a decrease of £181k in legacies received by the Belfast Trust in year, giving a total for legacies received of £222k for 2014/15 as compared to £403k for 2013/14.

The overall trend is upwards for donations to the Belfast HSC Charitable Trusts in 2014/15 and this is evidenced through an increase of £71k in donations from individuals.

The total resources expended for the year were £1,603k (£1,507k in 2013/14) of which total direct charitable expenditure for the year accounted for £1,469k, an increase of £127k on 2013/14.

Charitable Trust Funds

Total direct charitable expenditure on Medical Research, Building & Refurbishment, Staff Education & Welfare increased by £197k on prior year figures. Purchase of equipment & other expenditure decreased by £65k and Patients welfare decreased by £5k compared to 2013/14. Of the remaining expenditure, governance costs for the financial administration of the fund amounted to £134k representing 7% of total incoming resources.

Financial position at year-end

The total fund balance at 31 March 2015 was £45,870k an increase of £2,981k on the fund balance of £42,889k at 31st March 2014.

In 2014/15 the equity market unrealised and realised gains increased significantly from £1,602k in 2013/14 to £2,780k in 2014/15. The gain of £2,780k when added to the net income surplus of £201k resulted in the total increase of £2,981k to the fund. This increase to the fund is higher than the increase of £2,014k in 2013/14.This reflects the continuous recovery in equity and bond markets.

Financial controls

The Trustees are aware of their financial responsibilities for the money that is held on trust. Appropriate policies and procedures are in place to ensure these responsibilities are adequately discharged, and these are reviewed on a regular basis.

Statement of risk

The management of risk in relation to the Trust Funds is closely aligned with the Belfast Health & Social Care Trust's risk management procedures. These are outlined in detail in the Statement on Internal Control contained within the Trust Fund's annual financial statements.

Reserves policy

The Trust Fund does not currently enter into future commitments and so has not created any reserves for this.

Investment policy

For investment purposes the balances on the Trust funds of all Trusts in the greater Belfast area are pooled and invested in the Common Investment Fund.

Charitable Trust Funds review

The Trust continued to work on the advice and guidance of Cleaver Fulton Rankin Solicitors in respect of the review of funds and the Attorney General's requests regarding the format of submissions has been reflected in a second draft. The Trust has also engaged with the Charities

Commission Northern Ireland and secured agreement to delay the registration process until the review process is complete. The Charitable Trust Funds review working group regularly update and advise the Charitable Funds Advisory Committee of progress to date.

Plans for future periods

- Complete the court applications in line with the advice received from our legal advisors and the Attorney General's office
- Prepare for the implementation of the proposed new funding arrangements by communicating the proposed changes to Trust Staff
- Provide training for the new fund committees and the Charitable Trust Fund Team.

Funds held as Custodian Trustee on behalf of others

The Belfast HSC Trust does not act as Custodian Trustee on behalf of others.

Approved by the Trustees at a meeting of the Board on 4/6/15

Signed : Mr Peter McNaney
Chairman

Dr Michael McBride
Chief Executive

MAHI - STM - 300 - 2821

Belfast Health and Social Care Trust
caring supporting improving together

TRUST BOARD
SUBMISSION TEMPLATE

MEETING	**Trust Board**	**Ref No. 6.3**
DIRECTOR	**Director of Planning, Performance and Informatics**	**Date 6 October 2016**
Revised Trust Delivery Plan 2016/17		
Purpose	• **For Approval**	
Corporate Objective	• A Culture of Safety and Excellence • Continuous Improvement • Partnerships • Our People • Resources	
Key areas for consideration	**The Draft Trust Delivery Plan has been updated following comments from the HSCB.** **Supplementary comments to Sections 3.1 and 3.2. Have been noted in green for ease of reference.** **Section 4.1 Financial Strategy has also been updated**	
Recommendation	For approval prior to submission to HSCB	

Belfast Health and Social Care Trust

Trust Delivery Plan

2016/2017

TRUST DELIVERY PLAN 2016/17

Contents

1.0 Introduction

This document sets out the Belfast Trust Delivery Plan for 2016/17. The document provides details of the Trust response to the Health and Social Care Board Commissioning Plan 2016/17. Details are provided in relation to how the Trust will support the delivery of the Ministerial, Regional and Local Commissioning priorities (specifically the Belfast Local Commissioning Group priorities) for 2016/17.

2.0 Local Context

The Belfast Health and Social Care Trust is continuing to focus on the delivery of safe, effective and compassionate services.

Our particular organisational focus during 2016/17 will be improving service delivery across 6 cross directorate themes. These are set out in the Trust Corporate Plan for 2016/17:

- Reducing harm, variation and waste
- Improving services in the community
- Improving Elective Care
- Improving Unscheduled Care
- Implementing the Organisational Development Framework
- Developing Community Planning

The Trust has plans in place which set out actions across the areas above which will deliver improvements in service delivery. This is set against a backdrop of on-going financial challenge for the organisation in 2016/17.

The Trust will work with HSCB colleagues and the Belfast Local Commissioning Group in supporting delivery of the Ministerial and HSCB priorities in 2016/17.

3.0 Detailed Trust Delivery Plans

3.1 Trust response to DOH Commissioning Plan Direction

Summary Table – Achievability of Ministerial Targets 2016/17

Deliverability	RAG	Number	
Target achievable		30	63%
Target at risk to full or substantial delivery.		11	23%
PHA led – Trust comments provided/NIAS		6	13%
Target TBC	TBC	1	1%
Total number of targets	Total	48	100%

	COMMISSIONING PLAN DIRECTION OBJECTIVES		RAG
Desired Outcome 1. Health and social care services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.			
1.1	Obesity	In line with the Departmental strategy A Fitter Future For AI by March 2022 reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	PHA
1.2	Diabetes	In line with the Department's policy framework, living with Long Term Conditions, continue to support people to self-manage their condition through increasing access to structured patient education programmes. In 2016/17, the focus will be on consulting on and taking steps to begin implementation of the Diabetes Strategic Framework and implementation plan with the aim that by 2020 all individuals newly diagnosed with diabetes will be offered access to diabetes structured education with 12 months of diagnosis.	
1.3	Smoking Cessation	In line with the Department's ten year Tobacco Control Strategy, by March 2020 reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.	PHA
1.4	Self-Harm	By March 2020, to reduce the differential in the suicide rate across NI and the differential in suicide rates between the 20% most deprived areas and the NI average. Areas of focus for 2016/17 should include early intervention and prevention activities, for example through improvement of self-harm care pathways and appropriate follow-up services in line with NICE guidance.	PHA
1.5	Healthy Child / Healthy Future	By March 2018 ensure full delivery of the universal child health promotion framework for NI, Healthy Child, Healthy Future. Specific areas of focus for 2016/17 should include the delivery of the required core contacts by health visitors within the pre-school child health promotion programme.	
1.6	Children in Care	During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring that the proportion of children in care for 12 months or longer with no placement change is at least 85%.	
1.7	Children in Care	During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment,	

COMMISSIONING PLAN DIRECTION OBJECTIVES			RAG
		and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring a three year time frame (from date of last admission) for 90% of children who are adopted from care.	
Desired Outcome 2: People using health and social care services are safe from avoidable harm.			
2.1	Healthcare Acquired Infections	By March 2017, secure a reduction of [10 to 20%] in MRSA and Clostridium Difficile infections compared to 2015/16. [Final figure defined after examination of 2015116 statistics]	
2.2	NEWS KPIs	From April 2016, ensure that the clinical condition of all patients is regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.	
2.3	Delivering Care Framework	By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services.	
2.4	Care Standards in Homes	The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice.	
2.5	Care Standards in Homes	The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice and that subsequently attract a notice of decision.	
Desired Outcome 3: People who use health and social care services have positive experiences of those services			
3.1	Palliative / End of Life Care	To support people with palliative and end of life care needs to be cared for in their preferred place of care. By March 2018 to identify individuals with a palliative care need and have arrangements in place to meet those needs. The focus for 2016/17 is to develop and implement appropriate systems to support this.	
3.2	Inpatient Care same Gender	By March 2017, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need (or alternatively timely access to treatment).	
3.3	Inpatient Care Gender mixed	Where patients are cared for in mixed gender accommodation, all Trusts must have policies in place to ensure that patients' privacy and dignity are protected.	
3.4	Children in Care	HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	
3.5	Patient Experience	By March 2018, to increase by 40% the total number of patients across the region participating in the PHA Biennial Patient Experience Survey, with particular emphasis on engaging patients in areas of low participation.	PHA
Desired Outcome 4: Health and Social care services are centred on helping to maintain or improve the quality of life of people who use those services			
4.1	Access to GP Services	By March 2020 to have increased access to services delivered by GP practices. The focus for 2016/17 is on developing a comprehensive baseline of such activity, to be used to inform future	PHA

COMMISSIONING PLAN DIRECTION OBJECTIVES			RAG
		work.	
4.2	GP OOH	From April 2016, 95% of acute/ urgent calls to GP OOH should be triaged within 20 minutes.	
4.3	Life threatening calls	From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.	NIAS
4.4	Unscheduled Care ED access	From April 2016, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	
4.5	Unscheduled Care Triage	By March 2017, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	
4.6	Hip Fractures	4.6 From April 2016, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	
4.7	Stroke	From April 2016, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.	
4.8	Outpatients access	By March 2017, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.	
4.9	Diagnostics access	By March 2017, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	
4.10	Inpatients / Day Case access	By March 2017, 55% of patient should wait no longer than 13 weeks for inpatient / daycase treatment and no patient waits longer than 52 weeks.	
4.11	Diagnostic Reporting	From April 2016, all urgent diagnostic tests should be reported on within two days.	
4.12	Cancer access	From April 2016, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	
4.13	Mental Health access	From April 2016, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).	
Desired Outcome 5: People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community.			
5.1	Discharges	From April 2016, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.	
5.2	Unplanned Admissions – Long Term Conditions	By March 2017, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions.	
5.3	AHPs	By March 2017, no patient should wait longer than 13 weeks from	

COMMISSIONING PLAN DIRECTION OBJECTIVES			RAG
		referral to commencement of treatment by an allied health professional.	
5.4	Direct Payments	By March 2017, secure a 10% increase in the number of direct payments to all service users.	
5.5	Self Directed Support	By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.	
Desired Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.			
6.1	Carers' Assessments	By March 2017, secure a 10% increase in the number of carers' assessments offered to carers for all service users.	
6.2	Short Breaks	By March 2017, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	
6.3	Carers' Assessments	By March 2017, establish a baseline of the number of carers who have had a carers assessment completed and: • the need for further advice, information or signposting has been identified; • the need for appropriate training has been identified; • the need for a care package has been identified; • the need for a short break has been identified; • the need for financial assistance has been identified.	
Desired outcome 7: Resources are used effectively and efficiently in the provision of health and social care services.			
7.1	Hospital cancelled appointments	By March 2017, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.	
7.2	Complex & non-complex Discharges	From April 2016, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.	
7.3	Pharmacy Efficiency Programme	By March 2017, attain efficiencies totalling at least £20m through the Pharmacy Efficiency Programme, separate from PPRS receipts.	
7.4	Elective Care activity	By March 2017, to reduce the percentage of funded activity associated with elective care service that remains undelivered.	TBC
Desired outcome 8: People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide.			
8.1	Seasonal Flu Vaccine	By December 2016 ensure at least 40% of Trust staff have received the seasonal flu vaccine.	
8.2	Absence	By March 2017, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2015/16 figure.	
8.3	2015 Staff Survey	During 2016/17, HSC employers should ensure that they respond to issues arising from the 2015 Staff Survey, with the aim of improving local working conditions and practices and involving and engaging	

COMMISSIONING PLAN DIRECTION OBJECTIVES			RAG
		staff.	
8.4	Workforce Plans	By March 2017, Trusts are required to develop operational Workforce Plans, utilising qualitative and quantitative information that support and underpin their Trust Delivery Plans.	
8.5	Training Quality 2020	By March 2017, 10% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework.	
8.6	Complaints	By March 2017, to have reduced the number of patient and service user complaints relating to attitude, behaviour and communication by 5% compared to 2015/16. This will require renewed focus on improving the Patient and Client Experience Standards.	

3.1	Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)		
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired Outcome 1. **Health and social care services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.**			
1.1 In line with the Departmental strategy A Fitter Future For All by March 2022 reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	PHA Supplementary response The Trust continues to work with the PHA and others to deliver against targets in A Fitter Future for All by 2020 and will deliver on agreed targets in year. Currently the Trust is progressing with clinical and other health promotion activities across acute and community services to deliver, for example: • Clinical dietetic services for adults and children • Weigh to a healthy pregnancy programme • Training provision in partnership with the Eastern Childcare partnership. • Supporting Community and Voluntary sector, e.g. Trust Conservation Volunteers Dig it and eat it programme and through various other nutrition programmes e.g.: Choose to Lose pilot: Good Food Toolkit, Cook it! and Food Values programmes • Internal and external partnership links to work within the Trust to support activities aimed at promoting healthy staff and visitor catering • Health and Lifestyle Facilitators - trained to deliver a variety of nutrition and physical activity programmes and initiatives across community, voluntary and statutory sectors • Early Movers training targeting professionals who engage with 0-5yr olds, which aims to equip those attending with skills necessary to improve the physical activity levels of this age group. • A range of physical activity opportunities including: Walk Leader Training; Art of Healing Dance Training; On your Feet Training; and Chi Me training. Oral Health team address Nutrition as part of their programme delivery.	PHA Led	PHA
1.2 In line with the Department's policy framework,	The Trust is committed to developing service and will continue to work	Director of	

3.1	Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)		
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
living with Long Term Conditions, continue to support people to self-manage their condition through increasing access to structured patient education programmes. In 2016/17, the focus will be on consulting on and taking steps to begin implementation of the Diabetes Strategic Framework and implementation plan with the aim that by 2020 all individuals newly diagnosed with diabetes will be offered access to diabetes structured education with 12 months of diagnosis.	with HSCB to implement the strategic framework for Diabetes. Supplementary response The Trust has already set up the Structured Education Team within the Diabetes service and is moving forward with the recommendations. Meetings have taken place within the Trust focusing on the care of patients with Diabetes and the different specialty links that are involved (Diabetes, vascular, Orthopaedics, Podiatry, Interventional radiology)	Unscheduled & Acute Care	
1.3 In line with the Department's ten year Tobacco Control Strategy, by March 2020 reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.	The Trust Health Improvement Team will continue to prioritise work in the area of smoking prevention and cessation. The Trust introduced smoke free grounds in March 2016 and a significant public information and education campaign is being delivered which should contribute to a reduction in smoking rates. Through the smoking cessation team all staff who smoke are offered smoking cessation support and 12 weeks free Nicotine Replacement Therapy (NRT) and in particular a new smoking cessation service will offer support to staff in Bands 1-3. Two part time midwives are now providing smoking cessation support to pregnant woman and their partners. Smoking Cessation Support and Brief Intervention Training will continue to be provided across the Belfast Trust. Smoking prevention programmes will continue to be delivered in partnership with our community and voluntary partners at health fairs and local schools.	Director of Medical Services	PHA
1.4 By March 2020, to reduce the differential in the suicide rate across NI and the differential in suicide rates between the 20% most deprived areas and the NI average. Areas of focus for 2016/17 should include early intervention and prevention activities, for example through improvement of self-harm care pathways and appropriate follow-up services in line with NICE	PHA Supplementary response PHA have the protect life resources. The Trust continues to work with the PHA on delivering against this target.	PHA Led	PHA

3.1 Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
guidance.			
1.5 By March 2018 ensure full delivery of the universal child health promotion framework for NI, Healthy Child, Healthy Future. Specific areas of focus for 2016/17 should include the delivery of the required core contacts by health visitors within the pre-school child health promotion programme.	The Trust will work with the PHA and HSCB in the delivery of the target.	Director of Children's Community Services	
1.6 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring that the proportion of children in care for 12 months or longer with no placement change is at least 85%.	The Belfast Trust is committed to ensuring that the needs of children are met by a wide range of interventions. The Trust's PACS Project is there to support children on the Edge of Care and if admission to care is the best option to protect children, then there are LAC processes in place to ensure their needs are met, for example, Personal Education Plans, wrap around support to foster placements. Therapeutic Support to children and residential and foster care, LAC Nurse to meet health needs, etc. Every effort is made to sustain placements, however on occasion a change of placement maybe required to meet a child's needs and / or the Care Plan. For example, move to a Kinship or Adoptive placement. The Trust continues to work towards delivery against the target.	Director of Children's Community Services	
1.7 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring a three year time frame (from date of last admission) for 90% of children who are adopted from care.	Where the Care Plan is Adoption, children are presented to the Adoption Panel to receive a Best Interests Recommendation. Robust processes are in place to recruit a range of prospective Adopters to match with the children being considered for adoption. This will ensure the three year timeframe for placement for adoption, for the majority of children, from the date of their last admission to care will be met.	Director of Children's Community Services	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired Outcome 2: **People using health and social care services are safe from avoidable harm**			
2.1 By March 2017, secure a reduction of [10 to 20%] in MRSA and Clostridium Difficile infections compared to 2015/16. [Final figure defined after examination of 2015116 statistics]	The Trust will continue to work to deliver against HCAI targets. The Trust awaits clarification from the Commissioner on the tolerance levels for 2016/17.	Brenda Creaney	
2.2 From April 2016, ensure that the clinical condition of all patients is regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.	The clinical condition of patients is monitored in line with the measuring and recording of physiological observations policy. The frequency of recording and actions taken is dictated by the NEWS score. Compliance with NEWS is monitored regularly as detailed below: • Each ward audits 10 NEWS charts per week and results are included in the Care Bundle Balanced Scorecard. An action plan is put in place if there is any non-compliance. • Independent audits are carried out quarterly in all relevant areas. Results are included in the Balanced Scorecard. • USC&A have also carried out audits as requested by the Regional NEWS Working Group facilitated by HSC Safety Forum	Director of Unscheduled & Acute Care	
2.3 By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services.	The Trust has partially implemented phase one of the delivering care and fully implemented supervisory ward sister across the 54 wards and is on track to implement all four phases by March 2018.	Brenda Creaney	
2.4 The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number	The Regulation Quality and Improvement Authority has the primary role in the application of care standards in the delivery of Residential and Nursing care. The Trust has identified the need for a dedicated	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice.	multidisciplinary care home review team in light of the changing needs of residents of care homes. This team will provide support to care homes, provide a more consistent approach to adult safeguarding and signal a move away from reliance on annual care management reviews.		
2.5 The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice and that subsequently attract a notice of decision.	As above.	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired Outcome 3: **People who use health and social care services have positive experiences of those services**			
3.1 To support people with palliative and end of life care needs to be cared for in their preferred place of care. By March 2018 to identify individuals with a palliative care need and have arrangements in place to meet those needs. The focus for 2016/17 is to develop and implement appropriate systems to support this.	The Trust continues to work with the PHA on the new locality arrangements with both a Regional and Trust work plan in place for 2016. The Trust Service Improvement Lead has worked with all service directorates to develop and implement action plans with key priorities identified. These focus on patient identification and communication. The Trust uses the ELCOS checklist to ensure patients are identified ensuring their information is captured, recorded and shared to coordinate supportive care for the patient. This includes discussion on EOL Care, ACP and preferred place of death. A Palliative & End of Life care section of Trust Hub has been further developed and is available for all staff. Work continues on ensuring every patient identified as likely to be in their last year of life has a keyworker who is appropriately trained and has capacity to undertake this role. Final Journeys training has been rolled out for all staff across hospital and community. The Trust continues to work in partnership with the HSCB on an information sub group to revise data collection and monitoring arrangements for Palliative Care. Community Nursing has worked with NIAS to develop direct referral 24/7 to district Nursing for palliative and End of life patients.	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
3.2 By March 2017, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need (or alternatively timely access to treatment).	By March 2017, all patients in adult inpatient areas are cared for in same gender accommodation except in cases when that may not be appropriate for reasons of clinical need or alternatively timely access to treatment. The issue will continue to be monitored quarterly by the Trust Patient and Client Experience Working Group and progress reported at the Equality, Engagement and Experience Steering Group chaired by the Executive Director of Nursing and User Experience.	Brenda Creaney	
3.3 Where patients are cared for in mixed gender accommodation, all Trusts must have policies in place to ensure that patients' privacy and dignity are protected.	The Trust Policy on 'Privacy and Dignity' has been reviewed to include learning from the monitoring.	Brenda Creaney	
3.4 HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	The Belfast Trust is committed to ensuring that all Looked After Children have a clear plan for permanence to avoid drift in care. As part of the LAC review process and Pathway Plans children and young people are encouraged to participate in the review to have their views heard and to account for their wishes and feelings. To assist young people communicate their views, advocates are available through the Trust's partnership with VOYPIC.	Director of Children's Community Services	
3.5 By March 2018, to increase by 40% the total number of patients across the region participating in the PHA Biennial Patient Experience Survey, with particular emphasis on engaging patients in areas of low participation.	Supplementary response Whilst the PHA is taking forward work on the Biennial Patient Experience Survey, the Trust continues to work with the PHA through the Patient and Client Experience Steering Group and Working Group on developing innovative ways of increasing patient participation in this survey.	Nursing and User Experience	PHA

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired Outcome 4: **Health and Social care services are centred on helping to maintain or improve the quality of life of people who use those services**			
4.1 By March 2020 to have increased access to services delivered by GP practices. The focus for 2016/17 is on developing a comprehensive baseline of such activity, to be used to inform future work.	PHA	n/a	PHA
4.2 From April 2016, 95% of acute/ urgent calls to GP OOH should be triaged within 20 minutes.	Supplementary response The Trust regularly delivers or exceeds this challenging target. The Trust expects to continue to meet the target during 2016/17 and works with PHA & HSCB colleagues to monitor and report activity on a daily and weekly basis.	n/a	
4.3 From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.	NIAS	n/a	NIAS
4.4 From April 2016, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	The Trust is aiming to achieve a further 10% improvement in winter baseline against the 4 hour unscheduled care standard – RVH 69% and MIH 86%. The Trust has already reduced 12 hour waits by 75% in comparison to last year. The aim is to continue this improvement during 2016/17. Supplementary response The Trust has developed a detailed improvement plan with a series of actions and improvement targets in a number of areas includING Emergency Department, Medical and Clinical Assessment, Unit, Ambulatory Care, Discharge and Community capacity. A resilience plan is in place with regular monitoring within the Trust and locality	Director of Unscheduled & Acute Care	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	Network Group		
4.5 By March 2017, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	The KPIs for the management of Unscheduled Care are detailed in the Trust's Unscheduled Care Improvement Charter and Implementation Plan for 2016/17.	Director of Unscheduled & Acute Care	
4.6 From April 2016, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	During 15/16 the Fracture Service has been able to maintain the target of 95% of patients having their inpatient treatment for hip fractures within 48 hours, apart from one month (March 2016). The rest of the year was above target and ranged between 96 -100%. This was achieved through additional fracture lists being run at weekends, to facilitate access for urgent cases within 48 hours, as well as extra capacity the following week. It is planned to continue with this arrangement through 2016/17 and maintain performance against target.	Director of Specialist Hospitals and Women's Health	
4.7 From April 2016, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate	The Trust fully expects to meet this target.	Director of Adult and PSC	
4.8 By March 2017, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.	The delivery of the targets in 2016/17 will be challenging, due to lack of capacity in a number of specialties to meet current demand. In March 2016, 68% of patients on the Trust Acute OP Hospital Waiting lists were waiting longer than 9 weeks of referral (between April 2015 – March 2016, 60% of new outpatients who had been seen in the period received an appointment within 9 weeks of referral). In terms of the 52 week waiting time, specialties currently unable to deliver this include Cardiology, General Surgery, Immunology, Neurology, Ophthalmology, Orthopaedics, Rheumatology, Thoracic Medicine, Urology, Vascular.	Directors of Unscheduled & Acute Care, Surgery & Specialist Services, Adult Social & Primary Care, Women's Health & Spec Hospitals	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	Additional funded capacity would need to be secured and resourced.to address the waiting times greater than 52 weeks. The Trust will be seeking to maximise its outpatient capacity within available resources and is continuing with its OP Modernisation Project to support service reform in this area. Supplementary response The Trust OP modernisation work includes reviewing patient care pathways in a number of specialty areas to streamline referral and assessment processes, which should contribute to improved access. The Trust is also engaged in the Regional Outpatient Moderation work and is contributing to initiatives from this work including the development of CCG guidelines which should enable GP's to review appropriate pathways for referrals (including alternatives to secondary care). In terms of the 52 week target, out of 48 acute specialities, currently around half % specialities are achieving the target and the Trust will be aiming to maintain or improve this position in 16/17		
4.9 By March 2017, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	The table below shows the numbers waiting greater than 9 weeks at the end of March 2016. The Trust achieved 9 weeks and less in 2 areas, PET and Dexa and providing that demand levels do not rise this will be maintained. The Trust received non recurrent investment in MRI, CT, NOUS, Plain Film and Echo for the first half of 2016/17 and apart from MRI and Echo the majority of it has been directed to in house activity. This funding would need to continue into 2nd half of year. The Trust is also investigating a procurement arrangement to secure extra capacity for Nerve conduction studies using funding that it has secured from recurrent investment. The Trust has delivered	Director of Unscheduled & Acute Care	

<table>
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<tr><td></td><td>more capacity through in house and IS and this was included in the response, however no further funding has been confirmed yet. It is projected that if no further funding is received during 2016/17 for the following that the ability of the services to reach 26 weeks would not be met:

• GAMRI
• Cardiac MRI
• Echo
• Neurophysiology
The Trust is in discussion with the HSCB regarding MRI, CT and USS recurrent investment and depending on timescales and implementation of recurrent plans we will aim to bring these areas under 26 weeks. MPI has been maintained at 17 weeks for a number of years and the service will aim to keep it there. An independent sector solution was obtained during 2015/16 for this area but due to maternity leave is not available at the moment. The Trust has appointed resource into the sleep service and it is hoped with modernisation of patient pathways that a waiting time of 26 weeks can be met.

<table>
<tr><th>Specialty</th><th>Number of patients>9 weeks</th><th>Longest wait in weeks</th></tr>
<tr><td>MRI</td><td>2,799</td><td>35</td></tr>
<tr><td>GAMRI</td><td>165</td><td>91</td></tr>
<tr><td>CT</td><td>413</td><td>37</td></tr>
<tr><td>USS</td><td>419</td><td>25</td></tr>
<tr><td>PET</td><td>0</td><td>6</td></tr>
<tr><td>Dexa</td><td>0</td><td>9</td></tr>
<tr><td>Cardiac MRI</td><td>311</td><td>27</td></tr>
<tr><td>Echo</td><td>1,426</td><td>27</td></tr>
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<tr><td></td><td>
<table>
<tr><td>MPI</td><td>118</td><td>17</td></tr>
<tr><td>Sleep studies</td><td>85</td><td>56</td></tr>
<tr><td>Neurophysiology</td><td>1,796</td><td>52</td></tr>
</table>

Supplementary response

In terms of the 75% target, at the end March 2016 65% of patients on the waiting list for tests were waiting less than 9 weeks.

1231 patients were on the waiting list over 26 weeks.

If additional funding continues for diagnostics, this will support progress towards the delivery of the target.

Out of the 10 diagnostic areas noted on the table above, with ongoing funding from the HSCB, the Trust expects to deliver a 26 week waiting time in half.</td><td></td><td></td></tr>
<tr><td>4.10 By March 2017, 55% of patient should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks.</td><td>The delivery of the targets in 2016/17 will be challenging, due to lack of capacity in a number of specialties to meet current demand. In March 2016, 57% of patients on the Trust Acute Hospital IPDC Waiting lists were waiting longer than 13 weeks (between April 2015 – March 2016, 65% of elective patients who had been treated in the period were admitted within 13 weeks of being placed on a waiting list)

In terms of a 52 week waiting time, specialties currently unable to deliver this include, General Surgery, ENT, Orthopaedics, Urology, Vascular.

Additional funded capacity would need to be secured and resourced.to address the waiting times greater than 52 weeks. The Trust will be seeking to maximise its elective capacity within available resources and is continuing with its Elective Improvement Project to support</td><td>Directors of Unscheduled & Acute Care, Surgery & Specialist Services, Adult Social & Primary Care, Women’s Health & Spec Hospitals</td><td></td></tr>
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<tr><td></td><td>service reform in this area. This includes taking forward enhanced theatre capacity on the BCH and MPH sites which is urgently required.

Supplementary response

The Trust Elective Improvement Plan also identifies the opportunity for improved capacity related to investment in areas such as pre-assessment, admission of day of surgery capacity and utilising existing assets by delivering 50 weeks working in some elective specialties. The Trust will discuss these opportunities further with the HSCB as they will contribute to improving access for patients currently on waiting lists.

In terms of the 52 week target, out of 38 acute specialities, currently around 2/3 are achieving the target and the Trust will be aiming or improve on this position during the year.</td><td></td><td></td></tr>
<tr><td>4.11 From April 2016, all urgent diagnostic tests should be reported on within two days.</td><td>End March 2016 performance is outlined in the table below

Meeting the urgent reporting turnaround of 48 hours remains a challenge in all areas due to the use of waiting list initiatives, availability of 7 day reporting and specialist areas (MPI). The Trust will aim to deliver as close to 100% as possible.

<table><tr><th>Target - 100%</th><th>% Within 48 hours</th></tr><tr><td>Echo</td><td>89</td></tr><tr><td>Perfusion</td><td>57</td></tr><tr><td>MRI</td><td>78</td></tr><tr><td>CT</td><td>88</td></tr><tr><td>NOUS</td><td>92</td></tr><tr><td>Radio-nuclide</td><td>76</td></tr><tr><td>Neurophysiology</td><td>67</td></tr></table></td><td>Director of Unscheduled & Acute Care</td><td></td></tr>
</table>

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	Supplementary Response The Trust will monitor performance against those areas which are under 100% to investigate what changes in process can be made		
4.12 From April 2016, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	The Trust continues to work towards achievement of the 14 day breast target. It is anticipated that the 4th one stop clinic will be fully functional from August 2016 and performance will return to 100% unless there is a significant increase in demand or change in circumstances. The 31 and 62 day targets continue to be a challenge for the Trust. The key issues in the achievement of these targets include: • Gastro, colorectal, dermatology and red flag lung clinic outpatient capacity • Urology diagnostic and surgical capacity • CT Colonography (recent investment should improve turnaround) • Plastic surgery capacity across SET and Belfast • Late ITTs from other Trusts • Complex pathways/ difficult diagnostic pathways In addition there are a range of process issues and need for pathway redesign across a number of different tumour sites. Work is ongoing with Urology and an Upper GI improvement team has been established. Other opportunities for improving pathways across tumour sites will be sought throughout 2016/17.	Director of Surgery and Specialist Services	
4.13 From April 2016, no patient waits longer than: nine weeks to access child and adolescent mental health	From April 2016, the Trust will provide CAMHS services to Children and young people within 9 weeks. The instances of occasional breech	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).	to this are when there are episodes of sickness or vacant posts. The Trust, however, monitors this on a monthly basis and will place a recovery plan in place or an alert to the HSCB. Children and young people will also have access to Psychological Therapies within the agreed 13 weeks currently delivered by the Family Trauma Centre. The BHSCT is in negotiation with the HSCB regarding Adult Mental Health outpatients which continues to present significant challenges. A plan has been agreed in order to meet the target requiring significant internal reorganisation, unlikely to be delivered before the end of the financial year. In the interim a number of waiting list initiatives have been undertaken to address the significant numbers waiting for service outside the target. There remain significant issues in meeting the Psychological Therapies targets across all programmes of care – some of these challenges are related to staff recruitment and as above this will be reviewed to improve timely recruitment. However, there are areas of significant capacity issues and we will continue to discuss this with the HSCB and LCG. The target should be met in relation to Dementia Services. Supplementary Information CAMHS Current breaches of the 9 week waiting time are related to an increase in sickness level, maternity leave and vacant posts. The Trust has created an additional 7 slots per week in Belfast and an additional 4 assessment slots per week in SET which will bring the Belfast service back to 9 week waiting by October 2016 and SET by mid-October. Children and		

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	young people will also have access to Psychological Therapies within the agreed 13 weeks currently delivered by the Family Trauma Centre. AMH. The BHSCT is in negotiation with the HSCB regarding Adult Mental Health outpatients which continues to present significant challenges. A plan has been agreed in order to meet the target requiring significant internal reorganisation, unlikely to be delivered before the end of the financial year. In the interim a number of waiting list initiatives have been undertaken to address the significant numbers waiting for service outside the target. There are currently 24 assessment staff vacancies across Recovery and Primary Mental Health care in BHSCT. Whilst social work staff have been recruited and are expected to commence employment Oct/ Nov, there remain major difficulties in the recruitment of qualified nurses and the identification of suitably trained agency staff. The Trust has carried out a week long waiting list initiative in June and have a second initiative planned for October. The Trust is introducing the Envoy text alert system across the piece in order to help reduce the high DNA rates in mental health. The Trust expects to have designed and implemented a new assessment centre model for all referrals by April 2017 which we expect will have a significant improvement on performance across these services. In short the Trust expects to return to a maximum 9 week wait by April 2017.		

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired Outcome 5: **People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community.**			
5.1 From April 2016, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.	The Trust Mental Health service will endeavour to continue to meet this target in 2016/17. However, the capping of the supporting People budget at 2015/16 levels and no likelihood of further SP revenue will ultimately have a negative impact on the Trust's ability to discharge in a timely fashion in the future where supported housing is indicated. The Trust's ability to ensure the target for people with Learning Disability will be constrained also by the lack of additional SP revenue and the continuing lack of available specialist placements. The Trust is currently preparing a strategic outline case for the HSCB for the modernisation of MAH which would be dependent upon continued additional resource being identified to accommodate and support those currently delayed in hospital, in the community. There are potential placements identified for all 16 BHSCT patients currently on the delayed discharge list: • 3 for supported living service which are expected July 2016; • 1 for a residential unit which is expected in July 2016; • 5 for a residential service which is expected to open in September 2016; • 1 for a supported living service which is expected to open in October 2016; • 4 for a specialist nursing service expected to open in November 2016; • 1 for a specialist nursing service which is expected to open in	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	January 2017; and • 2 for Dympna House supported living scheme which is expected in June 2017. Timescales are approximate as plans are progressed depending on the needs of each individual.		
5.2 By March 2017, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions.	The Trust will endeavour to reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions by March 2017. Supplementary Information The ICPs services associated with long term conditions e.g. COPD / Stroke / Diabetes are being fully implemented in 16/17 and these additional services should contribute towards delivery of the target this year.	Director of Unscheduled & Acute Care	
5.3 By March 2017, no patient should wait longer than 13 weeks from referral to commencement of treatment by an Allied Health Professional (AHP)	• The waiting time in BHSCT remains above the Ministerial target in some sub-speciality areas of the AHP services as a result of capacity issues; however, some areas of the services are also experiencing a sustained increase in demand. • The Trust has had limited access to in year waiting list initiative funding and the AHP services have deployed, as far as it has been possible to do so, a temporary workforce to address the patients waiting longest for assessment and intervention in some sub speciality areas. • The Trust is also participating in ongoing discussions with the HSCB to review service demand and capacity issues. The Trust continues to take forward recruitment for a number of posts, with a view to addressing the capacity issues and reducing the numbers of patients waiting longer than the target.	Director of Unscheduled & Acute Care	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	• Delivery of the target remains a challenge without additional resources. The exception is podiatry which should largely achieve the target this year		
5.4 By March 2017, secure a 10% increase in the number of direct payments to all service users.	The Trust aims to achieve this target across all adult Programmes of Care particularly with the new focus on self-directed support. In Older People's services success will be dependent on the planned increase of social work resource to assess, enable and promote direct payments.	Director of Adult and PSC	
5.5 By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.	The Trust has already commenced a phased approach across PoCs and is committed to deliver this programme by March 2019 ensuring that everyone in receipt of social care will have a self-directed care plan by March 2019. In Older People's service achievability will be dependent upon establishing the appropriate workforce to deliver the volume required. This again will be dependent upon an increase in qualified social work posts to develop and maintain good support plans.	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired Outcome 6: **People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being**			
6.1 By March 2017, secure a 10% increase in the number of carers' assessments offered to carers for all service users.	Trust Adult services expect to achieve this target.	Director of Adult and PSC	
6.2 By March 2017, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	The Trust aims to achieve a 5 % increase in the number of community based short break hours received by adults across all programmes of care commensurate with available funding.	Director of Adult and PSC	
6.3 By March 2017, establish a baseline of the number of carers who have had a carers assessment completed and: • the need for further advice, information or signposting has been identified; • the need for appropriate training has been identified; • the need for a care package has been identified; • the need for a short break has been identified; • the need for financial assistance has been identified.	The Trust expects to have established a baseline of the number of carers with a carer's assessment completed and outcomes in accordance with the HSCB specification by March 2017.	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired outcome 7: **Resources are used effectively and efficiently in the provision of health and social care services.**			
7.1 By March 2017, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.	The Trust continues to put in place actions to reduce the number of hospital cancelled outpatient appointments including: • Detailed quarterly reports for hospital cancellations by speciality, consultant and reason have been widely circulated across service directorates. These have also been discussed at specialty elective reform meetings • The Trust is completing the implementation of Outpatient Review Partial Booking and this should assist in reducing cancellations during 2016/17. • Some data quality issues regarding hospital cancellations have been identified and guidance has been issued to admin staff. Delivery of a 20% reduction will, however, be a challenge by March 2017.	Director of Performance, Planning and Informatics	
7.2 From April 2016, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.	The Trust believes that the most effective way to ensure delivery on this target is the development of assertive community in-reach teams for each of its acute hospital sites to assist the active identification of patients whose discharge can be affected efficiently and safely to appropriate community placements. The Trust will be piloting the 'Discharge to Assess' model, initially within the RVH commencing July / August 2016. Further expansion of the model to remaining acute hospitals within Belfast will be dependent upon funding availability. An IT system is currently being piloted to provide accurate information	Director of Adult and PSC	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	on delayed discharges to all Trusts. The Trust secured funding from the HSCB for the development & implementation of a Community Service Access Centre (CSAC) which provides a single point for accessing community transitional services. The centre will reduce duplication, improve discharge flows & provide information to support performance and planning. The CSAC has been in operation from the 30th November 2015. The Trust continues to focus on improving performance but full delivery of the targets will remain a challenge. Supplementary Information As part of the Trust Unscheduled Care Plan for 16/17, a number of actions and targets have been identified to support improvement in delivery of the target. Robust monitoring arrangements are in place to review progress as part of the planning above.		
7.3 By March 2017, attain efficiencies totalling at least £20m through the Pharmacy Efficiency Programme, separate from PPRS receipts.	The Trust will make every effort to ensure the Pharmacy Efficiency Programme is a success through collective working across the primary and secondary care sector to drive improvements in the use of medicines across health and social care and deliver system-wide efficiencies.	Director of Surgery and Specialist Services	
7.4 By March 2017, to reduce the percentage of funded activity associated with elective care service that remains undelivered.	Maximising the delivery of activity within available resources is a priority for the Trust. This is in the context of ensuring safe, high quality services. Service delivery volumes are influenced by a range of issues and where this is not been in line with Commissioner expectations detailed explanations are provided (e.g. inability to fill vacant clinical posts due to lack of suitable applicants / impact of changing clinical practices e.g. introduction of Consultant of the week /	Directors of Unscheduled & Acute Care, Surgery & Specialist Services, Adult Social & Primary	TBC

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	availability of junior medical staff.). The Trust has established an elective improvement project with the aim of taking forward actions related further increasing delivery of elective activity volumes within available resources. Supplementary Information The Trust Elective Improvement Plan developed from the project identifies the opportunity for improved capacity related to investment in areas such as pre-assessment, admission of day of surgery capacity and utilising existing assets by delivering 50 weeks working in some elective specialties. The Trust will discuss these opportunities further with the HSCB as they will contribute to improving access for patients currently on waiting lists.	Care, Women's Health & Spec Hospitals	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
Desired outcome 8: **People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide**			

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
8.1 By December 2016 ensure at least 40% of Trust staff have received the seasonal flu vaccine.	The Trust have achieved less than 30% uptake over the past 2 years and has sought to understand the success of various Trusts in England who achieved 70% uptake. The Trust has collaborated with Flu fighters in England and an action plan has been compiled which includes a number of key targets within defined time periods including the establishment of a Flu Action Plan Co-ordination Group, the recruitment of peer vaccinators and a robust communication plan to work towards meeting the outcome. The Trust will work towards delivery of the target in 2016/17.	Director of Human Resources	
8.2 By March 2017, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2015/16 figure.	The Trust will continue to build on the successful 5.4% reduction in sickness absence levels as achieved in 2015/16 and will plan to deliver this target through a range of initiatives and measures. Collaborative working with Occupational Health to optimise current processes, systems and infrastructures will be strengthened. Revised sickness absence targets for each Directorate and Co Director area will be issued and the delivery of bespoke and mandatory training for managers and staff, further promotion of the Manager's Toolkit on Managing Absence, the provision of specialist advice and the further roll out of the award winning Bwell initiative and Health and Wellbeing Strategy and action plan will all contribute to reducing the absence levels.	Director of Human Resources	
8.3 During 2016/17, HSC employers should ensure that they respond to issues arising from the 2015 Staff Survey, with the aim of improving local working conditions and practices and involving and engaging staff.	The findings of the Belfast Trust Staff Survey have been widely disseminated throughout the Trust and shared with Executive Team, Trade Unions, Directorate Teams and through a series of road shows for all staff. Directorate presentations are being delivered and action Plans are being developed by Directorates specific to their findings and areas for improvement. Key Steering Groups are being provided with relevant findings to inform their action plans. The Trust will	Director of Human Resources	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	participate in the next regional HSC Staff Survey initiative and resurvey of the Engagement questions during 2017/18.		
8.4 By March 2017, Trusts are required to develop operational Workforce Plans, utilising qualitative and quantitative information that support and underpin their Trust Delivery Plans.	The Trust is working on a programme to develop Service Directorate Workforce Plans each covering a five year time frame. In regard to meeting the operational workforce requirements to meet the Trust Delivery Plan 2016/17 Service Directorates review and consider workforce requirements considering both, qualitative and quantitative data and professional input.	Director of Human Resources	
8.5 By March 2017, 10% of the HSC workforce should have achieved training at level in the Q2020 Attributes Framework.	The Trust has completed a scoping exercise to determine how Trust in house training programmes support participants to meet the requirements of Level 1 awareness of the Quality 2020 Attributes Framework. Further to the launch of the regional Level 1 E learning in June 2016, we plan to widely publicise its availability to staff as an effective and efficient means of completing training. We plan that through a combination of existing programme content, specific level 1 awareness training, bespoke targeted workshops and E learning that we will meet the target of 10% of our workforce to have met Level 1 awareness by March 2017	Director of Human Resources	
8.6 By March 2017, to have reduced the number of patient and service user complaints relating to attitude, behaviour and communication by 5% compared to 2015/16. This will require renewed focus on improving the Patient and Client Experience Standards.	The Complaints Department will continue to support Directorates by collating data on CH8 subject report codes for (1) staff attitude and behaviour and (2) communication. The Complaints will provide reports highlighting those departments with high levels of complaints in relation to attitude and communication which require focused action. It is anticipated that this data will continue to be monitored via the Complaints Review Group. This will facilitate further consideration of additional methods for collecting data and providing timely feedback to staff as well as any further actions required to support reduction of complaints in this area.	Director of Human Resources	

Trust Response to DOH Commissioning Plan Direction (Ministerial Outcomes and Objectives)			
COMMISSIONING PLAN DIRECTION OBJECTIVES	**PROVIDER RESPONSE**	**Director**	**RAG**
	There will be continued delivery of complaints awareness training, which includes information on the top 5 subjects which presently include staff attitude and behaviour and communication. To support learning up to date examples of these type of complaints are provided for staff attending these sessions. The Trust will work towards delivery of the target by March 2017.		

3.2 Trust response to relevant Regional / PoC / Local priorities (sections 5 & 6 of the Commissioning Plan)

Belfast Trust response to Commissioning Plan priorities				
POC 1	**Acute: Unscheduled Care**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective, integrated arrangements – organised around the needs of individual patients – should be in place in community settings to provide care for people at home, avoiding the need for hospital attendance/admission.	Trust responses should demonstrate how core primary and community care teams will be effectively resources and organised around the needs of individual patients. Trust responses should demonstrate how, working with appropriate partners, Acute Care at Home services and equivalent (offering demonstrably more specialist services than those that should routinely be delivered by core primary and community care teams) will be made available for patients throughout the Trust area, 24/7; and how these services will be integrated with other services delivered in the community, including linkages to core primary/community care teams and NIAS Alternative Pathways.	The Acute Care At Home (ACAH) team have been scaling up Trust-wide since August 2015. Referrals are accepted from primary care, directly from NIAS and from ED and BCH direct. Comprehensive geriatric assessment is commenced within 2 hours of referral and a person centred care plan is commenced. Carers' needs are assessed and supported. Community equipment, aids and appliances are provided to promote independence. Polypharmacy is assessed and a pilot with community pharmacies is being developed to create new ways of working across existing prescribing boundaries. A pathway for rapid access Diagnostics has been created with secondary care. IT mobile working pilot is underway to promote integrated working and sharing of information with other community practitioners such as District nursing and Integrated care teams. We are working towards developing a 7 day referral service to further impact on reducing unnecessary frail elderly attendance at hospital. Supplementary response A detailed BHSCT Unscheduled Care Improvement Charter and Implementation Plan has been developed, addressing a series of	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 1	**Acute: Unscheduled Care**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			actions across ED and all Unscheduled Service areas, supported by data and risk mitigation to deliver the following outcomes: • Maximise ambulatory care • Decrease over utilisation of hospital services • Optimise patient placement to ensure right care, right place • Improve the patient experience • Reduce avoidable patient harm Planning assumptions for 5 & 10% growth in ED attendances have also been included. A series of workshops and team reviews have been organised to ensure timely plan review and amendment.	
R2	Effective arrangements should be in place at the front door of hospitals to provide ambulatory, rapid-response services for patients on a same-day or next-day basis, avoiding the need for patients to be admitted to hospital.	Trust responses should demonstrate how, working with appropriate partners, comprehensive ambulatory care services will be made available for patients, initially at the larger hospital sites, on a seven-day basis and where appropriate linked to planned (elective) services.	The Trust has already established the Clinical Assessment Unit and the Ambulatory Care Centre during 2015/16. The Trust are in discussions with Commissioners with regards funding to extend the ACC to 7 day working.	Acute & Unscheduled Care Directorate
R3	Effective arrangements should be in place to optimise patient flow through hospital, both before and after the patient being declared medically fit.	Trust responses should demonstrate the particular actions to be taken in 2016/17, working with appropriate partners, to further improve LOS through timely, multi-disciplinary decision making and effective discharge arrangements on a seven-day basis, to include participation in the Unscheduled Care Ward Champions pilot arrangements.	The Trust has several initiatives ongoing within Medical and Surgical specialties. Funding was received during 2015/16 through the twice daily decision making case to help support weekend discharges on MIH and RVH sites. Work on discharge is ongoing through the IMPACT work stream. Supplementary response	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 1	**Acute: Unscheduled Care**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			The BHSCT Unscheduled Care Improvement Charter and Implementation Plan is a cross-Directorate summary of specific actions being undertaken within 2016/17 and has been shared with HSCB / LCG to provide assurance of the detailed planning work which has been undertaken. Arrangements cover ED / CAU (Clinical Assessment Unit); AMU (Acute Medical Unit); EmSU (Emergency Surgical Unit); ACC (Ambulatory Care Centre); Oncology & Haematology; Diagnostics; Supporting services including Pharmacy, transport and Escalation. Community Services, with particular focus on Complex Discharges, as well as the ongoing Trust-wide Discharge Project (via Impact), have pilot 'Discharge to Assess' pilots in place across 5 x RVH Wards (limited financial investment currently in place & discussions with LCG underway.) Planning for the Unscheduled Care Ward Improvement Projects (ISP) is underway, focused initially on 4 Wards across the Mater and RVH.	
R4	Effective arrangements should be in place to manage ambulance demand	The NIAS response should demonstrate how the Trust will ensure effective arrangements for	NIAS	n/a

Belfast Trust response to Commissioning Plan priorities

POC 1 Acute: Unscheduled Care

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
	across hospital sites, consistent with regional planning assumptions.	ensuring equitable demand across sites on a rolling, seven-day basis.		
R5	Effective arrangement should be in place to manage major Trauma. Each year around 370 people in NI suffer from major trauma, this is often life threatening and requires a prompt and coordinated approach.	All Trusts should participated in the establishment of a regional Trauma Network which seeks to reduce mortality and morbidity due to major trauma through coordinated care pathways, clinical leadership and participation in TARN (Trauma Audit and Research Network)	The Trust has already introduced new Trauma rotas and escalation processes. The Trust is working with PHA and Commissioners to identify and implement the Regional network. The Trust will participate in Regional Trauma Network arrangements.	Acute & Unscheduled Care Directorate
R6	Effective arrangements should be in place to manage Winter Pressures demand across the Trusts.	Trust responses should demonstrate the actions to be taken in 2016/17, working with appropriate partners to ensure effective arrangements to manage unscheduled care pressures to include the preparation of seasonally-adjusted, evidence-based resilience plans.	The Trust has put a detailed plan in place to effectively manage the unscheduled care service, aligning with community and elective services to coordinate actions and liaising with other Trusts, NIAS, HSCB and PHA to ensure a cooperative approach across the region. Measures of success have been identified and agreed with clinical teams. Some of the actions being undertaken are to: • implement the Discharge to Assess model and ensure a 20% improvement in the discharge of complex patients within 48 hours; • increase Reablement capacity and community rehabilitation by 50%; • ensure same day AHP assessments and radiology tests; and • revise arrangements for escalation and enhanced capacity; Expected outcomes, include: • the Acute Care At Home (ACAH) service will	Acute & Unscheduled Care Directorate Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities

POC 1 Acute: Unscheduled Care

<table>
<tr><th colspan="2">ISSUE/OPPORTUNITY</th><th>PROVIDER REQUIREMENT</th><th>PROVIDER RESPONSE</th><th>Directorate</th></tr>
<tr><td></td><td></td><td></td><td>prevent admission and enable early discharge of Frail Older People; and
• additional ambulatory pathway support for patients where clinically appropriate.

Monitoring arrangements will be implemented as appropriate.</td><td></td></tr>
<tr><td>BL1</td><td>By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population, an 8% increase in the population aged over 75 years, and an 8% increase in the population of children aged less than 16. These population changes will impact on the demand for unscheduled care services.</td><td>The Trust response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements:
1. To address each of the regional unscheduled care priorities as set out section 5.1.
2. To deliver the required volumes of service activity for 2016/17

In responding account should be taken of recent investments in Acute Care at Home, COPD/HOSAR, Stroke Early Supported Discharge, Diabetes, the Clinical Assessment Unit, Ambulatory Phase 1, RBHSC ED and the Short Stay PAU.</td><td>The Trust will work through the expected activity for Non elective admissions and Ed attendances in light of the investments and discuss adjustments to SBA with the HSCB during 2016/17.

The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service during 2016/17:
<table><tr><td>Currency</td><td>Opening SBA 16/17</td><td>Proposed Delivery 16/17</td></tr><tr><td>Non Elective admissions - all</td><td>49,371</td><td></td></tr><tr><td>ED Attendances</td><td>162,685</td><td></td></tr></table></td><td>Acute & Unscheduled Care Directorate</td></tr>
<tr><td>BL2</td><td>Effective arrangements should be in place to ensure unscheduled care services in the Belfast LCG/Trust area are safe, sustainable and accessible.</td><td>The Trust response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services at the Mater Hospital.</td><td>The Trust is undertaking a Strategic review of acute services as part of New Directions 2and will consult on its recommendations in the near future.</td><td>Acute & Unscheduled Care Directorate</td></tr>
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Belfast Trust response to Commissioning Plan priorities				
POC 1 Acute: Elective				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1.	Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs to hospital consultants for specialist assessment.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to support the development of new enhanced services in primary and community care settings in a range of specialities including: • General Surgery • Gastroenterology • ENT • Gynaecology • Dermatology • Rheumatology • MSK/Pain • T&O • Cardiology • Neurology • Urology • Ophthalmology	The Trust will continue to engage and support the regional scheduled care reform process. Trust clinicians and managers are already contributing in working groups related to a number of specialties.	Performance, Planning and Informatics Directorate
R2.	Effective arrangements should be in place at the interface between primary and secondary care, organised around the needs of patients with effective communication between GPs and hospital consultants.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to include further roll out of e-referral and e-triage arrangements.	The Trust will continue to engage with and support the regional scheduled care process and is taking forward the implementation of e-triage.	Performance, Planning and Informatics Directorate
R3.	Opportunities exist to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/daycase treatment) delivered by Trusts.	Trust responses should describe the specific actions being taken in 2016/17, working with appropriate partners, to improve elective care efficiency and effectiveness including: • Development of one stop ‘see and treat’ services,	The Trust has in place an elective care improvement plan and is taking forward a number of initiatives aimed at improving efficiency and effectiveness in this area. Resource issues continue to need to be	Surgery and Specialist Services & Performance, Planning and Informatics

Belfast Trust response to Commissioning Plan priorities				
POC 1	**Acute: Elective**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
		linked to unscheduled care services as appropriate • Application of Transforming Cancer Follow Up principles to transform review pathways • Maximisation of skill mix opportunities in the delivery of assessment, diagnostic and treatment services • Phased introduction of seven-day working for elective specialities • Plans to ensure maximum wait of 9 weeks for scopes by 31 March 2017. • Plans to address AHP staffing requirements in line with the recent AHP demand and capacity exercise. • More generally, actions to improve the efficiency and effectiveness of outpatients, diagnostics and treatment services.	discussed with the HSCB. Adoption of the Transforming Cancer Follow Up principles continues to transform review pathways across many disease sites including Breast, Gynae, Colorectal, Haematology, Urology and Lung. Recent significant investment, supported by FCC, Macmillan and HSCB in the CNS workforce will support further roll out to other tumour sites including Uro-Oncology, Skin and Head & Neck in the year ahead. Collaborative working with clinical teams to support the development and implementation of stratified care pathways across above tumour sites will ensure modernisation opportunities are realised. Supplementary response AHP staffing plans: Trust AHP services have fully participated in the development of regional elective care pathways and the capacity and demand analysis undertaken by the HSCB / PHA. All necessary Trust information and data has been submitted to the HSCB for consideration and a meeting is scheduled for the end of	Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 1	**Acute: Elective**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			September 2016 to move this work forward. Once this is completed it is anticipated that any gaps in the workforce required to deliver to the elective services will be identified. Supplementary response Adoption of the Transforming Cancer Follow Up principles continues to transform review pathways across many disease sites including Breast, Gynae-oncology, Colorectal, Urology and Lung. In 2016/17, nurse led clinics commenced for lymphoma follow up and work has begun looking at skin and Upper GI follow up pathways. Supplementary response Endoscopy waiting times continue to be managed and reviewed on a weekly basis. SBA has been maintained within 4% but demand continues to exceed capacity, in relation to waiting times, with both urgent and routine patients waiting longer than required. Planned patients are managed within scheduled waiting times and red flag patients continue to be given priority and seen within 2 weeks	

<table>
<tr><th colspan="4">Belfast Trust response to Commissioning Plan priorities</th></tr>
<tr><td colspan="4">POC 1 Acute: Elective</td></tr>
<tr><th colspan="2">ISSUE/OPPORTUNITY</th><th>PROVIDER REQUIREMENT</th><th>PROVIDER RESPONSE</th><th>Directorate</th></tr>
<tr><td></td><td></td><td></td><td>Additional funding has been made available and capacity has been secured in the Independent Sector.</td><td></td></tr>
<tr><td>BL1</td><td>By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population, an 8% increase in the population aged over 75 years, and an 8% increase in the population of children aged less than 16. These population changes will impact on the demand for elective care services.</td><td>The Trust response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements:

1. To address each of the regional elective care priorities as set out section 5.2.
2. To deliver the required volumes of service activity for 2016/17.</td><td>To follow

The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service during 2016/17:

<table><tr><td>Currency</td><td>Opening SBA 16/17</td><td>Proposed Delivery 16/17</td></tr><tr><td>Inpatients</td><td>20,802</td><td></td></tr><tr><td>Daycases</td><td>50,549</td><td></td></tr><tr><td>New Outpatients</td><td>159,984</td><td></td></tr><tr><td>Review Outpatients</td><td>377,641</td><td></td></tr></table></td><td>Performance, Planning and Informatics Directorate</td></tr>
<tr><td>BL3</td><td>Effective arrangements should be in place to ensure patients in the Southern LCG/Trust area have access to high quality ophthalmology services, to be delivered in 2016/17 by Belfast and Western Trusts.</td><td>The Trust response should demonstrate how it will work with the Southern LCG and Southern Trust to ensure from 2016/17 the provision of appropriate ophthalmology outreach services to the Southern population.</td><td>The Trust has published a consultation paper which sets out proposals for the modernisation of Ophthalmology Outreach services. Pending the outcome of the consultation, the Trust will work with the SHSST and Southern LCG to take forward the establishment of Ophthalmic Clinical Centres which will deliver a wider range of local services in the Southern area.</td><td>Performance, Planning and Informatics Directorate</td></tr>
</table>

Belfast Trust response to Commissioning Plan priorities				
POC 1 Acute: Elective				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
BL4	Effective arrangements should be in place to support the establishment of a NI Genome Centre	The Trust response should demonstrate plans to co-ordinate the planned investment in delivery of the NI Genome Centre to include IPT development for submission to the HSCB as required.	Preparations for the launch of work packages relating to the Northern Ireland Genomic Medicine Centre and the participation in the UK 100,000 Genomes Project (100KGP) are at an advanced level, with key appointments being made. Memoranda underlining NI's engagement (with Belfast HSC Trust as the lead organisation) with GEL are also nearing completion. This will allow the first patients to be formally recruited and to test the overall system for readiness for full operation. In addition the Trust and key stakeholders are working on proposals for the "legacy" after the main phase of the 100KGP to ensure Northern Ireland patients fully benefit from developments in Genomics and Precision Medicine.	Surgery and Specialist Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 2 Maternity & Child Health				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1.	Effective arrangements should be in place to ensure that maternity services are arranged to meet the needs of all pregnant women. Effective arrangements should be in	Trust responses should demonstrate how they will implement the agreed care pathway for antenatal care for women with low risk pregnancies. Trusts should evidence that they implement	This pathway has been implemented across the BHSCT Maternity Service in conjunction with the GAIN guidelines for Low risk maternity care in FMUs/AMUs. The BHSCT has achieved BF accreditation in	Specialist Hospitals and Women's Health

Belfast Trust response to Commissioning Plan priorities				
POC 2	**Maternity & Child Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
	place to ensure that the agreed regional antenatal care pathway is delivered. Effective arrangements should be in place to ensure that women with more complex pregnancies are offered the best possible care in line with national evidence based guidelines.	UNICEF Baby Friendly Initiative Standards. Trusts should also demonstrate how they will deliver services to meet the needs of more complex pregnancies. Plans should evidence; • How recent investment in ante-natal diabetic services is being used to improve care. • The implementation of the 'Weigh to a Healthy Pregnancy' programme targeting women with a BMI of >40. • How multiple pregnancies will be managed in line with NICE guidelines, including the delivery of dedicated 'twin clinics'. Trusts should continue to work with PHA/HSCB on the development and implementation of early pregnancy assessment and epilepsy care pathways both of which are based on NICE guidelines. Trusts should also work with PHA/HSCB to clarify and standardise the referral and clinical pathways for women who have recurrent miscarriages.	September 2015 with ongoing implementation of the standards. Work is ongoing to achieve a Breast feeding coordinator for NNICU to further implement the standards across this service 1. A Diabetic Specialist Midwife is currently being recruited for BHSCT Maternity services and will be used to improve care provision. 2. "Weigh to a healthy pregnancy" team continue to target suitable women for this project achieving an average 60% uptake in line with the PHA requirements. 3. A dedicated twin clinic is in place supported by 2 Consultant Obstetricians and the Fetal medicine department. BHSCT will continue to work with PHA/HSCB on the development and implementation of early pregnancy assessment and epilepsy care pathways both of which are based on NICE guidelines. The Trust will work with the PHA and HSCB to clarify and standardise the referral and clinical pathways for women with recurrent miscarriages. Current pathway is that: if a woman attending the Early Pregnancy Clinic experiences a third or higher order early pregnancy loss, we	Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 2	**Maternity & Child Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			discuss referral for genetic testing as per RCOG guidelines. We advise the woman to attend her GP to get a referral to relevant Consultant for further management.	
R2.	Effective arrangements should be in place to ensure that required data is captured to monitor service activity, compliance with standards and to underpin quality improvement work.	Trust responses should demonstrate commitment to collecting data to evidence best practice and identify opportunities for further service improvement. Plans should include evidence of full utilisation of NIMATS and Badgernet.	BHSCT Maternity services continue to support NIMATS and Badgernet systems and through a process of data and statistical analysis, facilitated by these systems are able to evidence best practice and opportunities for service improvement. Birth details and clinical information is updated on the Badgernet system and used for analysis of data and measurement against targets e.g. For retinopathy of prematurity. It is hoped to progress to a paperless system for the new maternity hospital but this will depend on funding and regional considerations.	Specialist Hospitals and Women's Health Directorate
R3.	Effective arrangements should be in place to ensure that opportunities to offer early intervention and prevention of long term disability by enhanced therapy services in neonatal units are realised.	Trust responses should evidence how recent investment in AHP services for neonatal units is resulting in the integration of AHP services into neonatal services with a focus on neurodevelopment and nutritional support.	Interviews have been completed for the 0.5 wte dietician for Neonatal unit RJMS and successful applicant offered post, which has been accepted. Completion of recruitment process may take another 2-3 months but it is hoped the candidate will be in place by end of September 2016 and integrated into the area to provide required support and increased focus in relation to neurodevelopment and nutrition of neonates.	Specialist Hospitals and Women's Health Directorate
R4.	Effective arrangements should be in place to ensure that paediatric services respond to patient need, are accessible	Trust responses should demonstrate how they: • Offer short stay assessment models of care with	RBHSC has a Short Stay Surgery Assessment Unit is open 24/7. Access for primary care remains through the Emergency Department,	Specialist Hospitals and

Belfast Trust response to Commissioning Plan priorities				
POC 2	**Maternity & Child Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
	and provided in a timely way. This should include arrangements for same day and next day assessment, short stay assessment and ambulatory models of care.	agreed access to for primary care professionals and opening hours agreed with HSCB and PHA to maximise their impact. • Continue to work with the HSCB/PHA to develop and test models of care which reduce the reliance on in-patient and secondary care paediatric services.	as previously agreed with Commissioners. The Trust will continue to work with the HSCB/ PHA to develop and test models of care, which reduce reliance on inpatient and secondary care paediatric services. This includes the Programme Treatment Unit and Outpatient Antibiotic Therapy Service, which reduce reliance on inpatient services. Supplementary response The RBHSC has opened a Short Stay Medical and Surgical Assessment Unit. This is open on a 24/7 basis. During the summer months this will be reduced slightly due to predicted staffing levels. Access for primary care remains through the Emergency Department, as previously agreed with Commissioners. The Trust will continue to work with the HSCB/ PHA to develop and test models of care, which reduce reliance on inpatient and secondary care paediatric services. This includes the Programme Treatment Unit and Outpatient Antibiotic Therapy Service, which reduce reliance on inpatient services.	Women's Health Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 2	**Maternity & Child Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R5.	Effective arrangements should be in place to ensure children and young people receive age appropriate care and that the regional upper age limit for paediatric services of 16th birthday is implemented.	Trust responses should demonstrate how their paediatric services operate a minimum upper age limit of 16th birthday. Trusts should also describe how they will ensure that children aged up to their 16th birthday, who are admitted to hospital, are cared for in an age appropriate environment by staff with paediatric expertise with input from paediatricians where necessary.	A project is ongoing within the Trust to review care of children in an age appropriate environment, led by Co- Director and Associate Medical Director. Supplementary response The Trust is fully committed to the development of an age appropriate environment for 14-16 year olds in hospital. A proposed timescale is April 2017 however this is dependent on the physical location being identified and revenue funding being made available.	Specialist Hospitals and Women's Health Directorate
R6.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multidisciplinary morbidity and mortality review.	Trusts should evidence how they are taking forward Departmental direction to implement a child death review pilot which is based on multidisciplinary mortality review.	There is a system in place within the Directorate which ensures that all child deaths are recorded on the MMRS system and then reviewed and discussed at a MDT M&M meeting. One of the elements of the M&M meeting is to discuss any learning.	Specialist Hospitals and Women's Health Directorate
BL1	By 2020 there is expected to be a continued increase in complex births in the Belfast LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 8% increase in	The Trust response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.	In line with the Maternity and Child health priorities on Section 5.3 of Commissioning Plan 2016/17, the Trust will ensure that we will actively review services as required to address changing patient demographics and need, within existing funding. We will also seek additional funding to improve on service delivery, in light of changing demand. The Trust has already submitted a business case in relation to increased demand for	Specialist Hospitals and Women's Health Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 2	**Maternity & Child Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
	the Belfast LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.		complex social need provision in maternity services and this includes teenage pregnancies. Maternity Services are continuing to implement the DHSSPS Maternity Strategy, PHA guidelines and Trust Action Plan normalising child birth by: - Continuing to reduce the number of caesarean sections and increase the percentage of births without medical intervention by March 2017. - Ensure an increase in normal births after a caesarean section with the aim to maintain a minimum of 20% by March 2017. - Increase uptake of mid- wife led antenatal care across the maternity service by March 2017. Maternity Services will continue to work with commissioners to implement the required Neonatal nursing support for the refurbished interim unit to support the opening of all commissioned neonatal cots by March 2017. Health Visiting Service will continue to deliver the HCHF programme to all children 0-4yrs within the BHSCT. There are ongoing discussions with PHA and at a regional level in	

Belfast Trust response to Commissioning Plan priorities

POC 2 Maternity & Child Health

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
			respect of full service delivery. The service hopes to achieve 50% of 3year contacts within the nursery placement as part of EITP. The appointment of an Infant Feeding Co-ordinator under HV service is to implement the standards of UNICEF Baby Friendly status. The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service during 2016/17:	

Currency	Opening SBA 16/17	Proposed Delivery 16/17
Obstetrics (Births)	6,931	
Health Visiting (Contacts)	43,886	

Belfast Trust response to Commissioning Plan priorities				
POC 3	**Family and Childcare**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	Trusts should demonstrate how service provision will meet the needs of children with complex health care needs and challenging behaviour.	Children with complex health care needs are appropriately managed in the community, school and home setting on a child specific basis by the community children's nursing team. Challenging behaviour is not associated with this cohort of children. This is the remit of the children with a disability social work team. Supplementary response CWD (Children with Disabilities Service) has partnered with Fostering Service to develop specialist shared care fostering services for children with complex needs. To date, 3 carers have been identified for assessment. This will increase to 6 carers. The Trust continues to develop Children's Therapeutic Services and currently has a Consultant Clinical Psychologist, specialised Behavioural Specialist, Behavioural Specialists x 2 and SLT in post. They are in the process of recruiting a Therapeutic Intervention Co-ordinator, Behavioural Support Workers and an Occupational Therapist. CWD continues to work closely with colleagues in assessment and treatment services and provides dedicated short breaks and residential care for families of children with challenging behaviours.	Children's Community Services Directorate

Belfast Trust response to Commissioning Plan priorities

POC 3 Family and Childcare

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
			The Trust has also invested in Positive Behaviour Support awareness training for all CWD staff and has recruited and trained 10 coaches to work across services. They are in the process of organising a conference with BILD which will include specific workshops for families of children with challenging behaviour.	
R2	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system.	Trusts should demonstrate how: • criteria will be set to ensure children become looked after where there is a clear indication that their long term outcomes will be improved or removal is required in order to safeguard the child/young person; • initiatives will be put in place to increase the number of placements and specify how these will be provided; • support will be provided to young (16/17 year olds), homeless individuals who are seeking to achieve a safe, stable return to a family; • Specialist Therapeutic Foster Carer placements in keeping with the needs of children and in line with regional criteria will be provided which will be monitored as part of the DSF process; • appropriate safeguarding measures will be put in place for extra-ordinary placements; • intensive edge of care interventions and family support will be provided to enable children to remain within their families where this is in the child's best interest.	The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service during 2016/17: Currency / Opening SBA 16/17 / Proposed Delivery 16/17 Residential Care / 194 / Foster Care / 2,189 / Other (placed at home, specialist facility etc.) / 493 / The Service area Resource Panel acts as an effective mechanism to ensure children come into care where they will be kept safe and long term outcomes improved. Initiatives in development include:- the Disability front line scheme which will increase number of placements for children with disabilities and these will be provided by	Children's Community Services Directorate

Belfast Trust response to Commissioning Plan priorities

POC 3 Family and Childcare

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
		• required volumes of service activity for 2016/17 will be delivered.	specialist foster carers recruited and assessed for this scheme; a specific annual recruitment campaign to increase the number of placements for children requiring permanence via long term fostering. Continuing development of the specialist adolescent scheme which provides foster placements for young people 12+ and is key to prevent unplanned admission into residential care PACS is operational as BHSCT intensive edge of care intervention and this includes PACS foster carers available to provide "time out" for young people and families in crisis in the community. Identified Social Work support is available to young 2016/17 year olds who become homeless and every effort is made to secure a return to family.	
R3	Effective arrangements should be in place to meet the ever increasing demand for Autism Services to include the creation of an integrated care system for Children, Young People with Developmental, Emotional and Mental Health services.	Trusts should demonstrate plans to address autism waiting lists in line with Autism Access Standard and support the development of an integrated service model to include assessment, early intervention, diagnostic and transitional services.	The Trust is in discussions with the HSCB with regards to an Action Plan to address the waiting lists. The Trust is moving forward with the establishment of an Early Intervention Service which will include a Single Point of Triage for children presenting with developmental and behavioural challenges. CAMHS are currently partners in this work, whilst not fully integrated in the delivery. The trust will be working with the HSCB in the implementation of a proposed new model for	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities

POC 3 Family and Childcare

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
			Children and Young People presenting with Developmental, Behavioural, Emotional and Mental Health needs. This model is to be presented and discussed in a regional forum.	
R4	Effective arrangements should be in place to establish a Managed Care Network for Children and Young People with Acute and High Intensity Care Needs as recommended by the independent review into CAMHS Inpatient Services.	Trusts should demonstrate plans to establish a Managed Care Network for Acute CAMHS which includes Secure Care, Youth Justice and Forensic CAMHS to deliver a more consistent service across the region and equitable access to acute services.	The Trust is currently leading the Regional CAMHS partnership Board and will be part of the establishment of the managed care Network and the on-going governance of the CAMHS Acute Services. The trust is also involved in the development of the CAMHS care pathway and the revision of the stepped care threshold criteria as part of the stepped care action plan.	Adult PSC Directorate
R5	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	Trusts should outline their reporting arrangements to the HSCB in relation to the regional action plan.	BHSCT has a database of information in relation to all young people known to the Trust who are at risk of CSE. Information from this is fed back to the HSCB. In addition, the HSCB requires the Trust to report back in relation to young people missing from care / home x 3 times. This requires the Trust to report in relation to steps taken to address the concerns / risks and clarify the support provided to address same. The Trust is represented on the Marshall implementation group and takes forward any actions emanating from that working group. The Trust is also represented on the Social Services Operational Group for CSE, chaired by HSCB and participates in any actions	Children's Community Services Directorate

Belfast Trust response to Commissioning Plan priorities

POC 3 Family and Childcare

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
			coming out of that. The Trust lead for CSE is co-located with PSNI, issues coming out of that are reported back to the HSCB via the regional CSE team meetings chaired by Sheila Simons.	
R6	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2016).	Trusts should demonstrate plans to • provide effective safeguarding services • ensure robust HSC child protection processes are in place • ensure safeguarding policy and procedures are in place relating to referrals, assessment, service planning, case management and record keeping • monitor and audit effectiveness of policy, practice and service provision in achieving specified outcomes for children and young people. • to ensure access to an effective range of therapeutic supports based on assessed needs.	The BHSCT Gateway Service thresholds all new child care / child protection referrals to determine the need for either an Article 17 or Article 66 response in order to safeguard a child(ren). The Service ensures that families and children who are involved in Initial Assessments have their needs met either via signposting to Tier 2 Services, transferred for progression for Family Support or Child Protection Pathway Assessment / Plans. Effectiveness of intervention is subject to robust measures, including staff supervision, audits. The Service is currently reviewing how best to progress service user engagement as a means of measuring outcomes. The Trust's Annual DSF and six-monthly Corporate Parenting reports provide an overview of the performance and assurance processes underpinning the discharge of its delegated statutory functions including those pertaining to safeguarding. The Trust's GAIN and ad hoc audit processes afford opportunities to review and assure the quality and outcomes of safeguarding service delivery. Learning from the audits	Children's Community Services Directorate

Belfast Trust response to Commissioning Plan priorities

POC 3 Family and Childcare

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
			informs action planning	
R7	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency placements where children are known to a Trust.	Trusts should demonstrate plans to ensure that admissions to care are planned and children are provided with placements matched to their assessed need to provide stability and continuity.	Processes are in place to ensure Family Group conferences and all family arrangements are considered at the point of admission into stranger foster care The BHSCT Resource Panel and Permanence Panel are also mechanisms to ensure planned admissions into care, and if children are admitted to care, plans for Permanence are made in timely manner. The diverse range of foster placements aim to ensure children are matched to assessed need which encompasses dual approval, concurrent and HOT placements, alongside availability of sibling, adolescent, kinship, short term and long term placements/carers.	Children's Community Services Directorate
R8	Effective arrangements should be in place to appropriately manage the increasing demand for CAMHs and to improve the interface between acute and community CAMHs teams including working arrangements with secure care and the regional Youth Justice Centre.	Trusts should demonstrate how placements will be provided and ensure the implementation of the regionally agreed CAMHS Integrated Care Pathway by October 2016.	The Belfast Trust is likely to take responsibility for the provision of mental health and well- being services in Woodlands within the next 6 months. The Trust has also recently taken responsibility for CAHMS forensic psychiatry and will ensure appropriate arrangements are in place to meet the objective.	Adult PSC Directorate
R9	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children.	Trusts should demonstrate how the number of placement moves will be minimised as per the Placement Services – Strategic Direction Paper.	Support to foster placements is crucial to ensure placements are sustained to provide stability for Looked After Children. This support is provided by fostering and fieldwork social work staff and the Trust's Therapeutic Support Service. There are occasions however, when children are	Children's Community Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 3	**Family and Childcare**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			required to move placement in keeping with their needs and the Care Plan. The Trust Care Pathways Review has resulted in a new pathway to ensure greater consistency of Social Work Involvement and oversight to assist with meeting this objective.	
R10	Effective arrangements should be in place to ensure that children's care plans explicitly state what is to be achieved by the admission to care, what is expected from parents in order for the child to return home and the anticipated duration of the placement.	Trusts should demonstrate how robust assessments (in keeping with policy and procedures) will be undertaken for all children who are to return home enabling the Trust to determine the feasibility of such a move and to identify any support required to maintain the placement and discharge any existing Care Order.	The LAC (Looked After Child) review process explicitly outlines what parents need to achieve for children to return home and the associated timescales in keeping with the children's needs. If considering a return home, the Trust ensures that due cognisance is given to the regulatory framework for the rehabilitation of children needs the Regulation and Guidance for placements with parents. Significant issues remain with Courts and GAL that prevent the discharge of Care Orders for Children and Home. The Trust are undertaking a project to highlight the same.	Children's Community Services Directorate
R11	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	Trusts should demonstrate how they will use information to assess the effectiveness of CAMHS and evaluate outcomes, fully implement CAPA and ensure effective case management in line with NICE guidance. Trusts should demonstrate plans to strengthen NICE approved Psychological Therapies to include a skills analysis and workforce plan to identify gaps	The Belfast HSC Trust collates the CAMHs information to the CAMHS data set and uses this information to review capacity and demand. The Trust have partially implemented CAPA with the step 3 service and a working group is in place to develop this into step 2 service which sits with single point of entry.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 3	**Family and Childcare**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
		in the delivery of evidenced based therapies and skill mix requirements to deliver a range of therapeutic interventions. Trusts should demonstrate how the findings from the Sensemaker Audit on service user experience of CAMHS (expected October 2016), will drive any required service improvements.	Care plans are in place for all cases that are in line with NICE guidance where applicable. A work force training analysis has been completed and the training plan is in place for the next 5 years. The Trust is part of the Sensemaker audit working group and will work in line with the regional action plan when the Sensemaker audit findings are available.	
R12	Effective arrangements should be in place to manage an increasing number of children who are looked after, those who are placed in kinship and non-kinship foster carers, in keeping with the provisions and entitlements of GEM	Trust responses should demonstrate how recent investments will ensure equitable access by all young people in foster care to avail of GEM.	All young people who are Looked After are fully supported to remain in their Kinship or Non-Kinship Foster Placements post 18, if this is their Care Plan. There is full entitlement under the GEM Scheme, with equitable access to GEM, in line with a young person's wishes and the Foster Carers' agreement to maintain the placement	Children's Community Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	Trust responses should demonstrate plans to deliver the recent demography in investment to meet the needs of the aging population.	The Trust's new enhanced Reablement service and the additional step down beds, both of which were put in place in 2015/16, aim to deal with demographic growth. Supplementary response The demography investment received this year has enabled the Trust's to enhance the capacity of its Reablement service and community rehabilitation service, facilitated the introduction of the single point of access, improved capacity in assessment and review functions, provided additional step down and Rehab beds, and weekend social work capacity, all of which were put in place to deal with demographic growth. However, the saturation of care Management resource and therefore available community care packages continues to lead to delays in the last stage of the system. In order to address this the service intends to undertake a review of all existing care managed and social work cases to ensure that these resources are being utilised as efficiently and effectively as possible. This exercise, which involves some cultural change will not happen overnight but is expected to release	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			efficiencies to help balance demand with capacity	
R2	Effective arrangements should be in place to optimise capacity to meet the numbers of people aged over 65 and over 85 which are projected to increase by 12% and 22% by 2022 respectively.	Trust responses should demonstrate plans to actively promote a range of health ageing initiatives in areas such as promoting good nutrition, social inclusion and falls prevention.	It is the primary role of the HSCB to conduct needs assessment of its current and projected populations. The BHSCT has submitted a revenue business case to the HSCB to develop four community hubs in each sector of Belfast. These hubs will provide for the coordination and development of locally based healthy ageing, socially inclusive preventative services. The Trust is currently developing an integrated falls pathway for the Belfast area. Supplementary response The Trust has received funding. The Trust is currently in discussion with the HSCB regarding clarification of the status of current funding for the further development of an integrated Falls Pathway and further correspondence is on its way to the HSCB seeking this clarification. The Service has plans to recruit posts once this clarification is received. All Older people in receipt of services are screened using MUST assessment on Nutrition and followed up if required.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R3	Effective arrangements should be in place to optimise capacity to meet the number of people with dementia which is projected to increase by 35% by 2025.	Trust responses should demonstrate plans to work within the regional strategic implementation arrangements to develop early intervention models and timely access to memory services.	The Trust has already established a single point of referral for memory services in Belfast and a community navigator role. The Trust has developed three dementia specific supported housing schemes with a fourth currently being built in West Belfast. These supported housing developments have been established in conjunction with the proactive development of dementia friendly community initiatives. The Trust is currently developing an accommodation needs assessment for Dementia.	Adult PSC Directorate
R4	Effective arrangements should be in place to ensure the implementation of requirements contained in Adult Safeguarding and Protection in Partnership (2015).	Trust responses should demonstrate plans to promote the development of the Adult Protection Gateway model.	The Trust already has implemented plans in regard to the Adult protection gateway model. An active process of planning is underway to ensure a more effective use of resources.	Adult PSC Directorate
R5	Effective arrangements should be in place to address the issue of delayed discharges from the acute sector and other institutional settings due to the non-availability of independent sector community based services especially domiciliary care.	Trust responses should demonstrate plans to examine the potential for progressing the tendering of services based on a more outcomes based approach to domiciliary care provision.	The Independent Sector remains the major provider of community based domiciliary services in the Trusts area. The Trust has gone out to tender for Independent domiciliary care services. This will help reshape the domiciliary care provision. The Trust is also continuing to develop Reablement models of domiciliary care to ensure individuals reach their maximum levels of independence. Supplementary response	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			The Trust is currently out to tender for domiciliary services with the intention of reducing the number of providers from 23 to 9 as well as reshaping the specification towards an outcome based approach. This will involve considerable cultural change across the system and will take time to evolve. This will help reshape the domiciliary care provision. The Trust is also continuing to develop Reablement models of domiciliary care to ensure individuals reach their maximum levels of independence. The Trust is also engaged in modernising its in house domiciliary service in order to maximise efficiencies.	
R6	Effective arrangements should be in place to support services for carers that can be developed to maintain individuals in their own home and address carers emotional and support needs.	Trust responses should demonstrate plans to expand and promote the availability of short breaks.	The Trust has benefitted in recent years from receiving increased recurrent financial investment, specifically for the further development of Carer support. This has been used to expand and enhance a range of short break provision, which is highly valued by Carers. The Trust continues to review its services for carers on an ongoing basis and is currently completing a revision of its Carer Strategy and Action Plan, in line with regional policy and legislation. Following significant consultation with Carers linked to all service areas, and in partnership with representatives from the Trust Carers Reference Group, four key priorities, have	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			been agreed as follows: • Reaching Carers of all Ages; ensuring the identification of carers at the earliest opportunity; • Developing a Carer Support Pathway; ensuring carers are appropriately informed, signposted and referred for support; • Supporting Carer Health and Wellbeing; ensuring Carers have an opportunity to have their needs assessed, support plans developed and greater access to a range of services, including short breaks, which are responsive to individual needs; • Communication with and Involving Carers; ensuring that Carers have access to timely information and opportunity to be involved in service design and development. It is envisaged that the strategy framework being developed, alongside greater investment in carer support, will ensure that Carers in Belfast are identified and supported to maintain their own health and wellbeing. This will deliver better outcomes, not only for the increasing numbers of Carers, who play a vital role in the provision of care, but also for those they care for.	
R7	Effective arrangements should be in place to ensure the promotion of	Trust responses should demonstrate plans to actively engage with the regional project implementation arrangements to optimise	The Trust is fully engaged with the Regional project and has already submitted plans to	Adult PSC

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
	personalisation through Self Directed Support to increase individual choice and facilitate responsive remodelling of service models.	opportunities for services tailored to user needs and include the training and development needs of staff.	the HSCB for their consideration.	Directorate
R8	Effective arrangements should be in place to review existing day opportunities for older people to ensure that they meet current needs and expectations.	Trust responses should demonstrate plans to review existing day care provision to make best use of resources.	The Trust will initiate a review of its day services and day opportunities involving Older People with a view to strengthening day servicers. This review will be subject to a public consultation.	Adult PSC Directorate
R9	Effective arrangements should be in place to further develop ICP initiatives targeted at frail older people.	Trust responses should demonstrate plans that engage with the range of integrated care initiatives/projects designed to maintain older people in the community.	The Trust is fully engaged with its local ICPs and a significant range of initiatives have already been implemented including: Integrated falls pathway, COPD, acute care at home, diabetes and heart failure pathways. These initiatives will be further built upon to further strengthen our ability to maintain older people living in the community.	Adult PSC Directorate
R10	Effective arrangements should be in place to support the full implementation of the regional model of Reablement.	Trust responses should demonstrate a review of local progress with Reablement, in line with the regional model and targets.	The Trust has fully implemented the Regional model of Reablement. Work is ongoing to achieve all of the outcomes. A full review was conducted in 2015/16 and new resources put in place to expand the reach of Reablement to ensure the majority of elderly patient's access the service. Supplementary response A significant element of delayed discharge	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
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ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			continues to be the lack of community capacity which has been creating an exit – block. The Trust is employing a number of strategies in an attempt to resolve this issue. The Trust is conducting a social work review of all cases, in order to manage patient flow out of hospital linked to levels of dependency. Domiciliary care remains a significant cost pressure within the Trust. The existence of delayed discharges across all transitional services attests to this and the service will want to have further discussions with the HSCB in respect of Demography funding.	
R11	Effective arrangements should be in place to support an appropriate balance of services between the statutory and independent sectors in relation to domiciliary and residential care.	Trusts should remain engaged with the current reform of statutory residential care and review the most appropriate balance and focus of statutory/independent sector domiciliary care provision.	The Trust carried out a full public consultation in 2009 about the future of its statutory residential homes. The outcome was that its statutory residential facilities were declared no longer fit for purpose and a decision to cease admissions was taken. This reflected the diversity of service development in line with older People's wishes to remain at home. The Trust has significantly invested in the development of supported housing for older people with Dementia. The Trust now intends to review its statutory EMI homes as numbers of occupants decrease and their accommodation design is	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			seriously inadequate. In relation to domiciliary care, in-house services have been on a major reform journey in order to provide value for money and an effective modern model of domiciliary care. Domiciliary services will be the subject of procurement.	
R12	Effective arrangements should be in place to support the development of intermediate/step down care to relieve pressures on acute care and promote rehabilitation.	Trust responses should demonstrate review options for remodelling existing provision or negotiating options with the independent sector to increase availability of these services.	The Trust has developed a significant range of Integrated care services for individuals including Sub acute beds, community Reablement, step down assessment and rehabilitation beds. These are highly effective and reduce the need for significant ongoing services. However, the Intermediate care solution needs to be further resourced. Evidence from National Integrated care audits suggest that integrated services require to be increased by 50% in order to address the level of patients with complex need delayed in acute and sub-acute hospital beds. Supplementary response Integrated care is significantly under resourced both National and locally. There remains a need for significant investment in intermediate care and Chronic disease pathways which the Trust will wish to discuss further with the HSCB.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 4	**Care of the Elderly**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R13	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with Dementia.	Trust responses should outline plans to work with ICPs to implement the New Stepped Care Model for Older People and for people with Dementia.	The trust is currently represented on a number of group supporting the development of development of a regional step care model. This includes representation from a POA Consultant and a Senior Manage on the regional Dementia Collaborative, representation from a POA Consultation and Senior Dementia Nurse Specialist on the regional Stepped Care Model working Group and representation by the Senior Dementia Nurse Specialist on the Dementia Informatics working group. Supplementary response In relation to the wider older peoples service the Trust is currently developing health & well-being hubs in order to coordinate the C&V sector to provide level 1 services and to build capacity and resilience in the community. A number of the challenges faced are similar to the issues identified around access to dementia services, i.e. there is a need to develop service navigation posts for older people's services in general. However, the Trust is not confident that sufficient resource exists within the C&V sector to add resource to level 1 in a stepped care model and the Trust intends to carry out a scoping exercise over the next 12 to 18 months.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities

POC 4 Care of the Elderly

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
BL1	By 2020 there is expected to be an 8% increase in the population aged over 75 years in the Belfast LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17.	To follow The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service during 2016/17:	Adult PSC Directorate

Currency	Opening SBA 16/17	Proposed Delivery 16/17
Domiciliary Care Hours	2,084,222	
Residential and Home Care Occupied bed days	924,874	
Community Nursing Contacts	256,905	
Acute Care at Home Bed days at Home	12,644	
Reablement Clients	1,560	

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to manage the increased demand for psychological therapies.	Trust responses should demonstrate the particular actions to be taken in 2016/17 to further develop and implement Primary Care Talking Therapy Hubs in partnership with ICP leads.	The Trust model has been adopted as the regional model. Primary Care Talking Therapy hubs have been fully implemented across the city of Belfast. The Trust is currently experiencing demand from service users and their GPs of 50% over agreed/ funded contracted levels. Supplementary response The Trust continues to review existing SLA's with the Community and Voluntary sector to veer resources to the hub to meet demand.	Adult PSC Directorate
R2	Effective arrangements should be in place to enhance clinical and personal outcomes by improving access to evidence based NICE approved psychological therapies including increasing the range and scope of Talking Therapies in primary care.	Trust responses should demonstrate how the range and scope of psychological therapies will be strengthened, including arrangements to ensure safe and effective case management.	Over the past year the Trust has further developed resources and staff in areas such as IPT and IDP as well as ongoing supports in psychotherapy and CBT. The model of care for the new mental health inpatient unit is currently looking at the range of inpatient psychological therapies required to match the psychological/talking therapies now available in the community. Supplementary response The Trust has developed a "learning collective" with C&V sector partners in the Hub to expand the range of skills and knowledge including psychological therapies.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R3	Effective arrangements should be in place to ensure that people with mental health needs and their families receive the right services, at the right time by the right combination of professionals.	Trust responses should demonstrate what specific measures will be taken in 2016/17 to further embed the Regional Mental Health Care Pathway and to strengthen the provision of psychological care within the role and function of Community Mental Health Services.	The Trust is a member of the Regional group and will adopt and comply with and the Regional mental health Care Pathway. Supplementary response The Trust is a member of the Regional group and has piloted several key developments as part of this Regional process. It is worth restating that the Belfast Psychological talking therapy Hub model has been adopted as the Regional step 2 approach to care.	Adult PSC Directorate
R4	Effective arrangements should be in place to improve the effectiveness of Crisis and Acute mental health interventions through the integration of Crisis Resolution, Home Treatment and Acute Inpatient Services and through the provision of modern therapeutically focused inpatient care to safeguard those people who are experiencing acute mental health needs	Trust responses should demonstrate plans to align and integrate their respective Crisis Home Treatment and Acute Inpatient Service into a single care service consistent with the development of a new regional High Intensity Care Pathway. Furthermore, Trust responses should outline plans to strengthen Acute Hospital Liaison Services in line with the principles of the RAID model.	The Trust has already aligned these services under one management structure. The Trust is currently and consistently experiencing demand for these services 40 % over and above current contracted levels. The Trust has submitted a bid of £2.2.m to the HSCB in order to implement the RAID model. Current hospital mental health liaison services remain unfunded by the HSCB and cannot be further extended without further funding. Supplementary response The Trust has submitted a bid to the HSCB in order to implement the RAID model. Current hospital mental health liaison services remain unfunded by the HSCB and cannot be further extended without further funding.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			In addition, demand for Acute Mental Health services remains unabated in Belfast with inpatient bed occupation at 110% which is consistent with significant pressure on unscheduled Care Mental Health services and well above commissioned service levels.	
R5	Effective arrangements should be in place to support the new Regional Mental Health Trauma Network arrangements to enhance services and integrate all existing mental health trauma care into a new single managed care network.	Trust responses should demonstrate plans to support and participate in the development and implementation of the Network in line with NICE guidance and to nominate two staff to undertake advanced Trauma Care training to facilitate the development of a dedicated psychological trauma clinical team.	The Trust will continue to be party to discussions with the HSCB to develop the mental health Trauma network. Supplementary response The Trust is committed to supporting the network however it is important to note the current recruitment difficulties being experienced in community Mental Health Nursing. This has a negative effect on waiting lists and availability of backfill for posts relevant to training. Notwithstanding that difficulty the Trust has nominated 3 staff to undertake advanced trauma care training across CAMHS and AMH.	Adult PSC Directorate
R6	Effective arrangements should be in place to strengthen approaches to support people on their recovery journey in line with the principles and objectives of the Regional ImROC Programme.	Trust responses should demonstrate how, building on the findings of the Sense Maker Audit, co-production across their mental health services will be strengthened, including the appointment of Lived Experience Consultant, Peer Support Workers and Peer Educators and Peer Advocates. Trust responses should also provide details of the next phase of recovery college development and	The Belfast Trust currently employ peer advocates, peer support workers and a service user/ lived experience consultant and are working up a proposal for peer educators. The Recovery college is up and running and has been co providing and co delivering a range of programmes and courses.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
		demonstrate the actions to be taken to promote the role and influence of carers across mental health services.	The case for the further development of the next stage of the Recovery College is currently being made across the mental health services in Belfast in order to achieve buy in and commitment to the transfer of some existing resource. Supplementary response The Belfast Trust currently employ peer advocates, peer support workers and a service user / lived experience consultant and are working up a proposal for peer educators. The Recovery college is up and running and has been co-providing and co-delivering a range of programmes and courses. The case for the further development of the next stage of the Recovery College is currently being made across the mental health services in Belfast in order to achieve buy in and commitment to the transfer of some existing resource. The next level would include securing a lease on a high street property/ offices, a coordinator and a further enhancement in the number of band 4 peer educators. However this places a significant burden on an already stretched resource to have to find a further £120k to take the Recovery model to the next level.	

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R7	Effective arrangements should be in place to develop condition / service specific care pathways in order to safeguard the physical wellbeing of people with mental health needs.	Trust responses should demonstrate how the recommendation of the RQIA Review into Eating Disorders will be implemented.	The Trust will continue to be party to discussions with the HSCB to develop condition / service specific care pathways in order to safeguard the physical wellbeing of people with mental health needs. A revenue business case from BHSCT for physical monitoring in mental health services has been forwarded to the HSCB for its consideration. (this included a projection for needs of Eating Disorders service). The Trust awaits the HSCB response. Meanwhile REDNG has been tasked by DHSSPSNI (following a press release about local in patient unit for ED by Health Minister) to do a feasibly audit on current treatment needs in light of the fact there are no extra funds available. The Regional Eating Disorders Network Group (REDNG) has completed an Eating Disorder specific Care Pathway based on the overarching Regional Mental Health Care Pathway. All teams contributed to this and the expect this to be launched this year.	Adult PSC Directorate
R8	Effective arrangements should be in place to ensure full implementation of the Choice and Partnership Framework in order to ensure the effective delivery of mental health and psychological care to patients.	Trust responses should demonstrate that the Choice and Partnership Framework has been fully implemented across all mental health services. Trust responses should also demonstrate that a full demand and capacity analysis has been completed in line with regional guidance and that each	The Trust continues to develop the CAPA model across **all** community services. In line with developments further work is required to ensure everyone has an agreed job plan based on CAPA.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
		community mental health professional has an agreed job plan.	Supplementary response There are currently 36 discrete services in Mental Health in BHSCT. We have undertaken a CAPA analysis in approximately 60 % of services.	
R9	Effective arrangements should be in place to ensure that the workforce delivering mental health care is appropriately skilled.	Trust responses should demonstrate the actions to be taken to implement the Mental Health Learning Together Framework. Details of Trusts' mental health workforce plans should also be provided.	The Trust has completed a workforce plan (attached). In addition, the Trust achieved the Bronze award in its IIP assessment and assessors singled out the AS&PC Directorate for significant improvement in performance in aligning training to future objectives. Supplementary response There are many changes, within mental health Services, across the 36 discrete service areas that have been identified in the workforce plan and will take place during the next five years. These changes vary in terms of the scope and size of the project ranging from the completion of the new Inpatient Unit during 2017 to the reorganisation of the Court Diversion scheme. There are other changes which, the Service is confident will take place over the next five years, but clarity as to the direction of travel has still to be obtained. In some cases the outcome may identify a variation of an existing Service such as the Court Diversion Scheme, whilst for others the review may lead to the	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			introduction of a new Service such as a scheme for people with eating disorders. These projects are awaiting the outcome of reviews, both internal and external to the Trust. These will impact on the Services that are provided within the Service area.	
R10	Effective arrangements should be in place to provide evidence of the impact of all mental health services.	Trust responses should demonstrate what measures are in place to ensure that an annual comprehensive analysis will be provided in line with the indicators set out in the new Mental Health Services Framework and that this will include an overview of presenting need, the volume of interventions provided, the outcomes achieved and the quality of people's experience of using the services.	The Trust already employs outcome scales for all its inpatient mental health wards. Psychological therapy/ talking therapy hubs all use Core net to evaluate their services and capture service user experience. Mental health services have achieved a range of peer accreditations in its inpatient and community services. Everyone resettled from inpatient wards and those accessing supported living options are involved in betterment audits with peer advocate review of outcomes for people. Supplementary response The Trust would appreciate clarification from HSCB on the indicators that have been agreed in line with the HSCB led "You in Mind" service framework.	Adult PSC Directorate
BL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United	The Trusts response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to	The Trust will continue to monitor the demand on all its mental health services on a month by month basis taking corrective action and alerting the HSCB to any	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities

POC 5 Mental Health

<table>
<tr><th colspan="2">ISSUE/OPPORTUNITY</th><th>PROVIDER REQUIREMENT</th><th>PROVIDER RESPONSE</th><th>Directorate</th></tr>
<tr><td></td><td>Kingdom. By 2020 there is expected to be a 1% year on year increase[1] in prevalence within the Belfast LCG area. These population changes will impact on the demand for Mental Health services.</td><td>include specific arrangements:
1. To address each of the regional Mental Health priorities as set out in section 5.6
2. Deliver the proposed volumes of service activity for 2016/17</td><td>emerging pressure points.

The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service during 2016/17:

<table><tr><th>Currency</th><th>Opening SBA 16/17</th><th>Proposed Delivery 16/17</th></tr><tr><td>Hospital Occupied Bed days</td><td>103,266</td><td></td></tr><tr><td>Residential and Nursing Home Occupied Bed days</td><td>57,461</td><td></td></tr><tr><td>Domiciliary Care Hours Delivered</td><td>96,592</td><td></td></tr><tr><td>Primary Care Talking Therapies Face to Face Contacts</td><td>32,000</td><td></td></tr></table></td><td></td></tr>
<tr><td>BL2</td><td>Effective arrangements should be in place to reduce the increasing number of people presenting to ED for Suicide and Self-Harm which are higher in Belfast area than the NI average.</td><td>The Trust response should demonstrate plans to address the cultural / lifestyle issues that may be contributing to self-harm / suicide with partner agencies.</td><td>The Trust recognises the multi-faceted and multi-layered reasons for suicide and self-harm in the City and continues to work with its partners through the BSP mental health & emotional well-being group. The Trust continues to take the lead in the management of the self-harm registry. The Trust is currently piloting the development of assertive outreach for high risk groups who</td><td>Adult PSC Directorate</td></tr>
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Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			do not otherwise engage with services.	
BL3	Effective arrangements should be in place to provide appropriate supported housing options across the Belfast LCG/Trust area.	The Trust response should plan to review current supported housing schemes in line with the current NIHE review of Supporting People funding.	The Trust has already commenced a review of its current supported housing schemes in advance of the NIHE review in order to identify opportunities for efficiencies and to release resources to potential new schemes in the absence of additional supporting people revenue funding. However, this exercise should not be expected to produce anywhere near the amount of funding required to continue to implement the existing plans for the development of supported housing across the city. At the 1st June 2016 the Mental health service had 52 service users who required community accommodation including supported housing. Forty percent are delayed in acute in patient Mental Health wards. At the same time the service is "exporting" between 20 and 30 Service Users each month to other Trust's Acute In-Patient facilities because Trust MH inpatient beds are fully occupied. Without further supported housing development the pressure on our acute mental health inpatient wards will grow, and will result in further silting up of acute mental health wards. As a result of the announcement by the NIHE that there will be no additional SP funding the mental health service have 4 existing planned schemes, potentially providing 20 new tenancies which can no longer proceed.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 5	**Mental Health**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
BL4	Effective arrangements should be in place to appropriately manage increasing occupancy rates related to increased length of stay in the Medium Secure (Shannon) Unit.	The Trust's response should demonstrate plans to redesign the current service to assist the implementation of the Community Forensic Service. This is to help to address case complexity, the increase in demand, adult safeguarding and assertive outreach.	The Trust's community forensic team continues to provide its service across Belfast and has close liaison with Shannon clinic. It should be noted that occupancy rates and LOS in Shannon are significantly affected by the lack of availability of post discharge accommodation solutions. See BL3 above. The Trust submitted a revenue only application to NIHE in December 2014 to provide 6 units of accommodation in South Belfast for people to be discharged from Shannon. The NIHE have advised that there is no SP funding available to progress this scheme for which accommodation had already being secured. The Trust expects the scheme to be lost with no likelihood of future SP funding to assist.	Adult PSC Directorate
BL5	Effective arrangements should be in place to appropriately manage bed occupancy rates within the Belfast which remain higher than the NI average.	The Trust response should demonstrate plans to ensure that inpatient bed requirement are in line with the approved Business Case for the Single Unit, including development of a High Intensity Care Pathway to align and integrate the Crisis Home Treatment and Acute Inpatient Service into a single care service	The Trust has already aligned and integrated the Crisis Home treatment and Acute inpatient service into a single care service under one management structure. The Trust continues to experience significant challenges in operating within the existing number of inpatient beds often having to place patients in other Trust areas. Home treatment caseloads remain consistently above commissioned levels by 40%.	Adult PSC Directorate

[1] *Delegated Statutory Functions reports submitted by Trusts*

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to increase the number of individuals availing of community based Day Opportunities.	Trust responses should demonstrate what specific actions will be taken in 2016/17 to further develop partnership working with community / voluntary / independent sector organisations to meet the needs of individuals already in services or coming through transition.	The Trust has developed comprehensive plans to further develop day opportunities and to shift "left" from day centre provision to day opportunities. However, following extensive consultation this will pose a significant challenge in terms of the expectations of service users, their carer's and the public at large. Plans are in place with a broad range of providers in the community & voluntary sector who have potential expansion of their day service/opportunities provision available. This will require an investment shift from a buildings based approach which may in turn require the availability of bridging finance which the Trust will discuss with the HSCB. Supplementary response The Trust will have completed its review of all non-statutory day activity services by the end of September 2016, after which the Trust will be in a position to identify those C&V sector organisations that may have potential to expand. Subsequently the Trust will be involved in negotiating renewed contracts with the C&V sector using the funds allocated to the Trust by the HSCB. The Trust plans to establish a steering group involving the C&V sector and other stakeholders to take forward	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			the Day Services strategy.	
R2	Effective arrangements should be in place to manage the increased demand on Day Centres for those individuals with complex physical and health care needs or behavior support needs.	Trust responses should demonstrate what measures are in place to ensure facilities are appropriately designed and meet the needs of individuals with complex needs.	The Trust plans to develop a review of the skill set in day Centre's in line with action taken in other Trusts and to introduce a nurse to each service to assist and support the complex physical health needs of those attending. This will also address the delegated tasks and competency reviews of staff undertaking service user specific interventions. The Trust continues to afford significant priority to capital works associated with the modernization of existing ID day center's to meet the needs of the new demographic. Supplementary response The Trust plans to undertake a scoping exercise to review the skill set required to fully provide for the physical and health care needs of clients in Day care services, identifying gaps and formulating a plan to assist and support the complex physical health needs of those attending. This will also address the delegated tasks and competency reviews of staff undertaking service user specific interventions. The Trust continues to afford significant priority to capital works associated with the modernization of existing ID Day Centers to meet the needs of the new demographic. The Trust estates department has recently	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			completed a condition report and recommendations in relation to all its Statutory Day Centres with a range of recommendations. No decisions have yet been taken and the recommendations will be taken back to the Steering group to agree priorities and establish action plans.	
R3	Effective arrangements should be in place to appropriately manage people with LD developing dementia and other conditions associated with old age including short breaks/respite which are varied and flexible in nature.	Trust responses should demonstrate how short breaks/respite will be extended outside of the traditional model in order to meet the needs of Families / Carer's including Dementia Memory Services and other appropriate services.	The HSCB has provided short term funding for a year to provide short breaks for people with ID and dementia. The Trust is currently conducting a process of identifying individuals and families who could and would wish to avail of this support. The Trust intends to conduct a short break service review including the extension of more informal forms of respite. This will however be informed by future funding financial and strategic plans. The Trust has developed a service for the specialist assessment of people with Learning Disability and dementia. The Trust continues to take part in ID steering group on dementia and the internal dementia strategy implementation group.	Adult PSC Directorate
R4	Effective arrangements should be in place to complete the resettlement of people from learning disability hospitals to appropriate places in the community.	Trust responses should demonstrate what processes are in place to complete the person centered resettlement of individuals from learning disability hospitals into the community, with appropriate long term support, in line with recent	The Trust has in place a dedicated care manager for the resettlement of Belfast Trust patients and Community Integration co-ordinator to link in with and liaise with all other Trusts with agreed processes in place	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
		investments.	to ensure the remaining PTL patients are resettled into the community with long term support. All of the remaining PTL patients for Belfast have an agreed plan in place with ongoing assessments continuing to ensure any change in the patient presentation and profile is managed in a timely manner to negate against further delays in their resettlement plans. It is anticipated that 4 Belfast PTL patients will remain in the hospital post March 2017 awaiting the new scheme at Dymphna House which is due for completion in June 2017. However there remains concerns regarding the selection process for the provider of this service has not been agreed by the NIHE as yet. The provider is required to be in place from January 2017 to ensure care planning for the resettlement of the remaining 4 complex patients is commenced as this will impact on the patients' ability to leave the hospital in June 2017.	
R5	Effective arrangements should be in place to manage the demand from individuals living with carers, specifically older carers, for future housing needs.	Trust responses should demonstrate what plans are in place to address future housing needs of those in the community through community integration.	The Trust has further developed the number and range of supported Housing facilities for adults with intellectual disability in Belfast over the last three years in response to the Bamford recommendations and the need to complete the resettlement process. However ongoing plans to develop a range of supported housing specifically for adults with	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			Learning Disability, Autism & complex need in response to demographic changes are now at serious risk of not proceeding as a result of the freezing of the Supporting People budget at 15/16 levels. These include plans for 9 units of accommodation for Autism & Challenging behaviour, 4 units in the extension of the Crescent service and 23 units of accommodation planned for young people with ID and highly complex needs at Abbey Road in Antrim. None of these schemes are now likely to proceed in a timely manner if at all, which will have significant impact on the Trust's ability to match the communities need for supported housing now and in the immediate future. The NIHE have indicated that the SP revenue for any new developments would have to be created through efficiency savings in existing schemes. The SP unit has also advised that it will be introducing tariffs and as a result will not be considering any future plans that intend to provide intensive supported housing. It is precisely this level of supported housing that is required in Belfast. Whilst the Trust has commenced looking for efficiency savings with its providers it is felt that the scale of resource required to manage demographic change and community demand is significantly greater than the most optimistic assessment of what efficiency might produce. In addition it is expected that Housing benefit will be capped in a similar	

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			way currently being proposed in England. It is expected that this will have a particularly negative impact on available housing benefit revenue for intensively supported schemes. These are critical matters facing all community PoCs.	
R6	Effective arrangements should be in place for discharge once the patient has been declared medically fit for discharge.	Trust responses should outline clear protocols, processes and procedures to ensure timely discharge from hospital with appropriate support, where required.	The Trust is currently reviewing admission and discharge protocols for the hospital to ensure that discharge planning commences at the point of admission to the hospital with an estimated date of discharge being identified in the first week of treatment. Process will be in place to ensure continued engagement of community professionals and care management to facilitate planning for discharge of complex individuals is commenced in a timely manner. Care and Treatment reviews will be undertaken on all admissions to the hospital with hospital and community teams to ensure that there is an understanding of the reason for admission, precipitating factors to the admission, what could have been done differently if any. Continued monitoring of those delayed to report on impact of availability of admission beds within the hospital.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R7	Effective arrangements should be in place to manage the increased demand for specialist services to respond to specific additional needs such as forensic services, behaviour support services etc.	Trust responses should demonstrate that specialist services are in place to meet the increased demand from individuals with complex needs in the community.	The Trusts Intensive Behavioural Support Service is up and running. The Trust has commissioned 6 specialist practice nurse training to commence in September 2016 to address the growing needs for behavior nurse and forensic nurse specialists to meet growing demand for interventions and treatments. Hospital Inpatient forensic service will continue to provide tier 4 specialist inpatient service to the region and support the community teams developing the required infrastructure. Supplementary response *The Trusts Intensive Behavioural Support Service is up and running. The Trust has commissioned 6 specialist practice nurse training to commence in September 2016 to address the growing needs for behavior nurse and forensic nurse specialists to meet growing demand for interventions and treatments.* However, the Trust does not have the posts to employ these staff once trained and there remains a gap between demand and capacity. *Hospital Inpatient forensic service will continue to provide tier 4 specialist inpatient service to the region and support the community teams developing the required infrastructure.* Additional funding for the	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			forensic service has been received and allocated in line with the Trusts proposals. However, the division of funding across the five Trusts has caused considerable difficulty in recruiting Forensic Psychiatry.	
R8	Effective arrangements should be in place to further enhance the current Learning Disability Service Framework including arrangements to provide an appropriate range and type of day opportunities for people with a learning disability transitioning from school.	Trusts should demonstrate plans to ensure that standards outlined within the LDSF Framework including the extension of the Transitions Planning Scheme.	The Trust fully participates in the HSCB led Regional Framework. A senior management group monitors progress and achievement against the requirements and identify any additional Regional action required. Supplementary response The Trust has received the Standards but awaits the targets associated with the standards to be communicated.	Adult PSC Directorate
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trusts response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.	The Trust continues to scope its population and in particular groups including Older carers, young people in transition, accommodation needs assessment, ID & Dementia, and physical health care needs. The Trust is giving greater focus on prevention and early support. The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service during 2016/17: Currency | Opening SBA | Proposed Delivery	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 6	**Learning Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**

	16/17	16/17
Residential and Nursing Home Care occupied Bed days	111,071	
Domiciliary Care Hours	251,557	

Belfast Trust response to Commissioning Plan priorities				
POC 7	**Physical Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to further develop services for the increasing number of people who are deaf-blind as a result of an ageing population.	Trust responses should demonstrate how existing services will be developed, awareness of the condition will be improved and appropriate staff training provided.	The Belfast Trust was involved in the regional analysis on Deaf Blindness which was carried out in 2014. Following this Trust staff within the Physical and Sensory Disability and Older Peoples Services received training in Deaf/Blind awareness and assessing the needs of people who are Deaf/Blind provided by the SENSE organisation. SENSE is currently completing training with staff from the Learning Disability and Children's Disability Services. The Belfast Trust has a Sensory Support Team consisting of social workers and rehabilitation workers. It has a multi-disciplinary approach towards meeting the needs of service users with sensory loss. The Sensory Support Team carry out assessments of the needs of people who are Deaf/Blind referred to the team and will maintain a database of the number of Deaf/Blind people. The team currently has two members of staff training towards the Diploma in Deaf/Blind Studies and is in the process of recruiting a full time Deaf/Blind rehabilitation assistant worker to support the existing rehabilitation staff.	Adult PSC Directorate
R2	Effective arrangements should be in place to manage the increased number of high cost packages due to increased life	Trust responses should demonstrate how domiciliary, equipment and staffing budgets will be targeted to provide appropriate service	The Physical & Sensory Disability Service Area is focusing on providing support to those with greatest need, endeavouring to support as many as possible to live at home. Systems	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 7	**Physical Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
	expectancy and an increased focus on supporting people at home.	responses for individuals with increased support needs.	are in place to ensure timely discharge from hospital and community referrals. Supplementary response The service will continue to use the systems it has in place to prioritise assessments of need and waiting lists to manage the increasing numbers of complex cases while providing for all those requiring care. The Trust will also use the application of self-directed support including direct payments to help manage the increasing demand.	
R3	Effective arrangements should be in place to ensure individuals are transitioned from Children's to Adult services in a timely manner.	Trust responses should outline clear protocols, processes and procedures to facilitate transition planning which includes inter programme coordination.	Children and Adult services have arrangements in place to ensure the early ID of predicted future service needs of Deaf Blind children/YP. We are currently expanding existing Transition protocols to ensure that this population is adequately represented and supported. As they move through a potentially difficult time. Supplementary response Children and Adult services have arrangements in place to ensure the early identification of predicted future service needs of disabled children and young people. The Trust is currently expanding existing Transition protocols to ensure that this population is adequately represented and supported as they move through a potentially difficult time. Inter –	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 7	**Physical Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			programme coordination is being co-ordinated through a working group established and lead by the service manager for Disabled Children's services to continue to improve early identification of the future adult needs of disabled children and to ensure smooth and timely transition. This working group includes all the relevant adult service managers including nursing, social work, psychology and AHPs.	
R4	Effective arrangements should be in place to further enhance the current PDSI Strategy arrangements.	Trusts should demonstrate plans to support, participate and lead in maintaining coordinated strategic planning arrangements outlined within the PDSI Strategy.	The Physical & Sensory Disability Service Area is participating in the current PDSI Strategy. The Service Manager is Co-Chair of the Supporting Independent Living and Training work stream. An Assistant Service Manager is participating on the Regional Sensory Implementation Group.	Adult PSC Directorate
R5	Effective arrangements should be in place to ensure there are appropriate accommodation options for people with severe disabilities in the community.	Trust responses should demonstrate how it will work within the existing Supporting People arrangements to examine the potential for further accommodation options.	The Physical & Sensory Disability Service Area has plans in plans for increased supported housing accommodation in the community for individuals with complex needs. Funding constraints in Supporting People/NIHE budgets has delayed progress in community integration plans.	Adult PSC Directorate
R6	Effective arrangements should be in place to ensure service information and advice is accessible to all service users and that Trusts have a skilled and informed workforce.	Trust responses should demonstrate plans to ensure that all health and social care staff have access to disability, equality and human rights training and are trained to communicate appropriately with people who are blind or partially sighted.	Belfast Trust provides Equality training, which is mandatory for both staff and managers and must be refreshed every 5 years. We are in the process of creating an online Equality training package with regional colleagues. Disability Awareness and Human Rights Awareness training is also provided regularly and across Trust sites and bespoke, tailored training	Adult PSC Directorate / HR

Belfast Trust response to Commissioning Plan priorities				
POC 7	**Physical Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			sessions can be arranged for staff teams upon request.	
R7	Effective arrangements should be in place to ensure that people with a disability receive a personalised package of care.	Trust responses should outline plans to change the pattern of service allocation including the promotion of Self Directed Support.	The Physical & Sensory Disability Service Manager is the Trust operational lead for Self Directed Support. Trust structures, training and an Implementation Plan is in place to ensure the promotion of Self Directed Support.	Adult PSC Directorate
R8	Effective arrangements should be in place to ensure the appropriate provision of Day Opportunities.	Trust responses should demonstrate how it will partner with the Community and Voluntary Sector to develop alternatives to existing service provision.	Two Community Access Workers have been appointed by the Physical & Sensory Disability Service Area to further develop partnership working with community/voluntary/independent organisations to increase the number of individuals availing of day opportunities and are already exceeding targets.	Adult PSC Directorate
R9	Effective arrangements should be in place to ensure that wheelchairs and equipment, and the maintenance and repair of the same continue to made available in line with demand.	Trust responses should consider the introduction of an access and eligibility criteria in order to ensure equitable allocation of equipment.	The Regional Wheelchair Service process all equipment referrals received from Commissioning Trusts. There were 3,387 wheelchair deliveries in 2015-16 (completed episodes). 75% of these deliveries occurred within the 13 week target set by the Board (Clock Start: Date wheelchair prescription agreed and Clock Stop: Delivery to client). The Approved Repairer contract remains in place with regards to maintenance and repair of wheelchairs. Commissioning Trusts have eligibility criteria for equipment allocation.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 7	**Physical Disability**			
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R10	Effective arrangements should be in place to ensure that people with Neurological conditions are supported to live as independently as possible.	Trusts should demonstrate plans to review the needs of people with neurological conditions, particularly those with life limiting circumstances, ensuring equitable access to support.	The Physical & Sensory Disability Service Area has responsibility for the Community Brain Injury Team and has been engaged in a service improvement initiative. The Trust has established a Working Group to take forward the recommendations of the RQIA Review of Brain Injury Services. Supplementary response The Physical and Sensory Disability Service Area has responsibility for the Community Brain Injury Team and community support to people with Huntington's and Motor Neurone disease. The Physical Disability team ensures seamless transition from inpatient facilities to the community. The Trust has also established a Working Group to take forward the recommendations of the RQIA Review of Brain Injury Services.	Adult PSC Directorate
R11	Effective arrangements should be in place to ensure to provide appropriate communication support for people who are deaf.	Trusts should demonstrate plans to use transformation funds to provide appropriate services and support.	Deaf and hard of hearing service users who require an interpreting service within the Belfast Trust area can access it via the HSCB contract who commission Action on Hearing Loss to deliver interpreting services. These include, BSL, ISL, Lip Speaking and Electronic Note Taking. At a regional level there are concerns of different procurement practices across Northern Ireland which results in inequity of service provision for deaf users. The Belfast	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities

POC 7 Physical Disability

	ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
			Trust is represented on the Regional Sensory Implementation Group (RSIG) and has had input into a Communication Support Review. The review has finished scoping the current demand and costs for interpreting services in Northern Ireland and recommendations are currently out for public consultation. The Belfast Trust was involved in a consultation event held for service users on 29th June 2016 and is promoting awareness of the consultation through the Trust Sensory Support Team. Feedback from all stakeholders will influence a proposed future model of practice that will ensure equity provision, standards in practice and value for money. The Belfast Trust provides training in BSL level for social care staff annually to promote communication with deaf service users.	
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trusts response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.	Reference PoC6. The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. The HSCB proposes to provide the following volume of service during 2016/17: Currency: Residential and Nursing Home Care occupied Opening SBA 16/17: 43,212 Proposed Delivery 16/17:	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities						
POC 7	**Physical Disability**					
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**			**Directorate**
			Bed days			
			Domiciliary Care Hours	353,971		

Belfast Trust response to Commissioning Plan priorities

POC 9 Family Practitioner Services

Local Family Practitioner Services

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. The population of Belfast LCG have poorer life expectancy, higher mortality rates for Cancer, circulatory and respiratory diseases and higher incidence of suicide than other LCG areas. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trusts response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Primary Care & Adult Community service priorities as set out in section 5.9. 2. To deliver the proposed volumes of service activity for 2016/17	To follow: The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. The HSCB proposes to provide the following volume of service during 2016/17:	Adult PSC Directorate

Currency	Opening SBA 16/17	Proposed Delivery 16/17
Stroke Early Supported Discharge Clients	260	
COPD Home Oxygen Service New Assessments	430	
COPD Home Oxygen Service Review Assessments	1,098	
Falls Prevention	2,520	
Falls Strength and Balance Programmes	208	
Community Foot Protection	60,000	
Diabetes Shared Care	252	

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Local Family Practitioner Services				
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
BL2	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the Belfast LCG/Trust area.	The Trusts response should outline plans to utilise senior community nurses to support GP Practices in the management of these patients in the Belfast LCG/Trust area.	Each of the 82 Practices across Belfast has an aligned District Nurse. Each senior nurse Lead from the Integrated care teams has established regular communication with G.Ps and their Practice managers to agree type and frequency of meetings and identify patients who have recurring complex needs and may benefit from earlier intervention . This involves regular multidisciplinary meeting. The Trust received investment from LCG in 2015 for band 5 staff to allow more time to provide holistic person centred care using appropriate evidence based documentation and risk assessment. The enhanced resource was to enable an increase in IV therapies delivered at home and increase the number of staff trained for Nurse Prescribing. A survey of all Practices is planned over the coming months to identify satisfaction levels of new communication arrangements. In 2015 an End of Life Care Workshop was held with General Practitioners and their aligned District nursing staff which was the first in a UK National Initiative to improve Primary Care Provision for patients nearing the end of their life .This was well attended and very positively evaluated	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Local Family Practitioner Services				
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			District Nurses have also worked collaboratively with NIAS to help prevent unnecessary hospital attendance and admission by accepting direct referrals for a range of conditions including Palliative patients .The Trust presented a Post Project Evaluation(PPE) to LCG in May 2016	
BL3	Effective arrangements and infrastructure should be in place to support an integrated model of care across the Belfast LCG / Trust area.	The Trusts response should outline how the Trust will work closely with ICPs to design and implement a fully integrated model of care which supports GP practices, including co-location, reconfiguration of services aligned to local need.	To follow	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Primary Care Infrastructure Development				
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to improve the quality of primary care facilities to meet all statutory standards	For Trust owned facilities, responses should demonstrate that facilities meet the minimum standards and provide adequate accommodation for services to be provided	The Trust shall carry out a review of all accommodation employed in the delivery of primary Care. We then shall bid against General Capital for funding to address any deficiencies identified. This shall take place during 2016 /17. Supplementary response To date the Trust has identified those properties which are used to deliver primary care. The Trust is about to commence an appraisal of their condition and compliance with statutory Standards, this shall identify any deficiencies which may require Capital to address.	Finance, Estates and Capital Planning and Redevelopment Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Cancer Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to deliver cancer access times.	Trust responses should demonstrate plans to deliver all cancer access standards across all relevant services.	Reference Trust response to Cancer Access Waiting Times targets in Appendix 2, 4.12.	Surgery and Specialist Services Directorate
R2	Effective arrangements should be in place to provide enhanced access to radiotherapy services for patients through the delivery of a new radiotherapy centre at Altnagelvin.	Trust responses should demonstrate that plans are in place to ensure that the new radiotherapy service in Altnagelvin will be operational by November 2016 to provide high quality, sustainable services consistent with national standards.	Although this project is led by HSCB and WHSCT the BHSCT is part of a tripartite group planning the various project aspects e.g. workforce planning, pathway management etc.	n/a
R3	Effective arrangements should be in place to deliver the recently introduced Acute Oncology Service across NI in line with the agreed service model and to consider further development of the service to provide a more sustainable acute care service for patients across all Trusts.	Trust responses should demonstrate how acute oncology services will be provided in line with the agreed service model. Trust responses should also indicate how the acute oncology service will be developed to meet patient needs.	The Acute Oncology service was launched in BHSCT in May 2016, comprising 2 wte Clinical Nurse Specialists and 4 sessions of Consultant Oncology time. This service is based in the Royal Victoria Hospital, and offers advice and support to clinicians, staff and patients who present with an acute oncological complication due to treatment, disease progression or for patients with an unknown or presumed cancer diagnosis. The Service aims to streamline current pathways, developing safer, effective and timely management for oncology patients on the Royal site, strengthening communication links and structures to improve continuity of	Surgery and Specialist Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Cancer Services				
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			care.	
R4	Effective arrangements should be in place to improve the patient experience of cancer care services.	Trust responses should demonstrate how the key findings from the recent Cancer Patient Experience Survey will be addressed, in particular, the specific actions to be taken to: work more closely with primary care to improve early detection; improve access to patient information across the pathway; improve access to clinical nurse specialists; and, increase recruitment to clinical trials.	The Trust has established a new structure for cancer services to review and improve patient experience, involvement and support across tumour sites. This forum will take forward the cross cutting issues from the cancer patient experience survey such as improving access to patient information. Site specific teams will also review issues for their tumour site and put in place action plans. The clinical trials unit have established a group to review and act on the results of CPES. Finally, the Trust will plan GP education events in 2016 to improve education around early detection in primary care.	Surgery and Specialist Services Directorate
R5	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in NI in line with national benchmarks, using a five-year phased approach.	Trust responses should demonstrate the particular actions to be taken in 2016/17 to expand the CNS workforce and, in doing so, how this will increase opportunities to modernise cancer care pathways and improve the patient experience of care.	The Trust has developed and agreed a CNS workforce plan in conjunction with HSCB and PHA and will recruit 8 new CNS posts in 2016/17. The Trust will look at new opportunities to transform care, follow up and improve patient experience once these posts are in place.	Surgery and Specialist Services Directorate
R6	Effective arrangements should be in place to implement a regional Teenagers and Young Adults (TYA) Cancer Service in NI.	Trust responses should demonstrate what measures will be put in place to offer age appropriate care to TYA patients with cancer consistent with the regional service model.	The Trust is working with HSCB and charitable partners to agree a model of care for TYA cancer services across NI, underpinned by recurrent charitable funding from the Teenage Cancer Trust and Friends of the Cancer Centre. The agreed regional service model will ensure	Surgery and Specialist Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Cancer Services				
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			age appropriate care is offered to TYA patients with cancer by the enhancement of Clinical Nurse Specialist roles, and the creation of new youth support roles and an MDT coordinator who will offer support and guidance to TYA within adult services and also provide a regional strategic input across NI.	
R7	Effective arrangements should be in place to address any issues arising from the peer review of cancer multidisciplinary teams to ensure the quality of cancer services can be sustained or, as needed, improved.	Trust responses should demonstrate that arrangements will be in place to take action to address matters highlighted by the peer review team, and that priority will be given to immediate and serious risks where these have been identified.	The Trust will develop an action plan in conjunction with HSCB and PHA to address the immediate risks and serious concerns arising from the peer review visits in June 2016.	Surgery and Specialist Services Directorate
R8	Effective arrangements should be in place to ensure timely access to chemotherapy.	Trust responses should demonstrate how chemotherapy services will be modernised in order to maximize current capacity and improve patient experience, with a particular focus on expanding non-medical prescribing.	The BHSCT continues to lobby HSCB colleagues for investment to support an expansion in non- medical prescribing roles and the Trust has completed scoping work to quantify the number of NMP roles the service would require. In addition, the BHSCT continues to work through implementation of the phlebotomy LES and would seek HSCB assistance in on-going communication with GPs regarding implementation. The creation of an Unscheduled care facility out-with Bridgewater Suite Day Hospital will assist to alleviate pressures on treatment capacity. The refurbishment of the BWS waiting area and introduction of patient text system should	Surgery and Specialist Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Cancer Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			streamline the patients' journey, improving communication and experience. In addition, the service is committed to the rationalisation of chemotherapy assessment clinics as a priority.	
R9	Effective arrangements should be in place to continue delivery of the Cancer Awareness Campaign in order to encourage people to seek medical advice at the earliest opportunity.	Trust responses should demonstrate plans to expand capacity to respond to potential increases in primary care referrals for patients with signs and symptoms suggestive of cancer.	The BHSCT will continue to work with Trust Health Improvement and PHA colleagues ahead of any cancer awareness campaigns to plan ahead for any service impact which may occur as a result of improved public awareness of signs / symptoms of cancer.	Surgery and Specialist Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Stroke				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to provide appropriate stroke services for younger people as 20% of all stroke occurs in people aged under 65	The Trust response should demonstrate plans to improve stroke services for younger stroke patients in line with the recommendations of the RQIA inspection report (2014) to include vocational rehabilitation	The Trust contracts with community and voluntary sector organisations which deliver programmes designed specifically around younger patients. The occupational therapists who work within the Trust's Community Stroke Team also deliver rehabilitation programmes which are tailored specifically to the needs and rehabilitation goals of each individual patient. They work with organisations which specialise in vocational rehabilitation, such as the Cedar Foundation, in order to support patients, young and older, for whom vocational rehabilitation is an achievable goal.	Adult PSC Directorate
R2	Effective arrangements should be in place to ensure that all stroke patients are admitted directly to a stroke unit in line with NICE guidance	The Trust response should outline plans to review their operational protocols for admission and develop processes that ensure that more than 90% of acute stroke patients are admitted to a stroke unit as the ward of first admission.	The Trust aims to ensure that all stroke patients are admitted to the Stroke Unit as their ward of first admission. However, this can be difficult to achieve in over 90% of admissions due to ED pressures. Supplementary response The Stroke Service works hard to discharge patients early in the day and use facilities such as the Discharge Lounge in order to free up	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Stroke				
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			beds early in the day into which stroke patients can be admitted. The recent investment received will consolidate the service's LoS. However, there are Trust processes within the wider hospital system which affect the service's ability to achieve this target and so a Working Group will be established with the Trust's Patient Flow Team in order to address these issues.	
R3	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	The Trust response should outline plans to work with the regional stroke network to develop a regional pathway for the management of spasticity after stroke.	The Trust will work with HSCB and the Stroke Clinical Network to develop a post-stroke spasticity service.	Adult PSC Directorate
R4	Effective arrangements should be in place to provide thrombolysis with alteplase as a possible treatment of acute ischaemic stroke.	The Trust response should demonstrate initiatives to ensure at least 15% of acute ischemic stroke patients, attending each of its hospitals, receive thrombolysis and that patients who receive thrombolysis do so within 60 minutes of arrival.	It is not within the Trust's control to develop initiatives which ensure that 15% of acute ischemic stroke patients will receive thrombolysis. The percentage of patients which receive thrombolysis is determined largely by the speed with which patients present at ED. The Trust has robust protocols in place which aim to deliver a Door to Needle Time of within 60 minutes. The Trust aims to implement telemedicine for thrombolysis in 2016/17 which will further support the achievement of a Door to	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Stroke				
ISSUE/OPPORTUNITY		**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			Needle Time of within 60 minutes. Supplementary response The Trust is achieving this target and will continue to work with NIAS and other stakeholders in order to continue to achieve it. The percentage of patients which receive thrombolysis is determined largely by the speed with which patients present at ED. The Trust has robust protocols in place which aim to deliver a Door to Needle Time of within 60 minutes. The Trust aims to implement telemedicine for thrombolysis in 2016/17 which will further support the achievement of a Door to Needle Time of within 60 minutes.	
R5	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention for selected stroke patients	The Belfast Trust response should demonstrate plans for the continued development of regional stroke mechanical thrombectomy services as per the NICE guidance.	Not within the stroke service's remit – this is a service delivered by INR colleagues within Imaging. Supplementary response An In Hours (n 9am to 5 pm) mechanical Thrombectomy service is in place; the Trust will continue to work with Commissioners to develop	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Stroke				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
			this service.	
R6	Effective arrangements should be in place to provide weekend outpatient assessment for TIA patients with high risk TIA patients assessed within 24 hours of an event and commence appropriate treatments to prevent stroke.	The Trust response should demonstrate plans to provide ambulatory services for suspected high risk TIA patients seven days a week, in line with NICE guidance.	The Trust is not in a position to provide weekend outpatient assessment for TIA patients. However, the expected investment in the Stroke Service's ESD service will allow for the enhancement of the current TIA service whereby GPs and OOH GPs can telephone a direct line for high risk TIAs, on a five day basis in the first instance, moving to a seven day service. The investment will also allow high risk patients to be assessed within 24 hours of an event and to begin appropriate treatment. Supplementary response The Trust is not currently in a position to provide weekend outpatient assessment for TIA patients. However, the investment received from for the Stroke Service's ESD service will allow for the enhancement of the current TIA service whereby GPs and OOH GPs can telephone a direct line for high risk TIAs, on a five-day basis in the first instance, moving to a seven-day service. The investment will also allow high risk patients to be assessed within 24 hours of an event and to begin appropriate treatment.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Stroke				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R7	Effective arrangements should be in place to facilitate, where appropriate, early supported discharge (ESD) of acute stroke patients from hospital.	Trust responses should detail how ESD services for stroke patients will be made available over seven days a week, able to respond within 24 hours of discharge, and provide required levels of therapy in line with transformation fund or demography investments.	The expected investment in the Stroke Service will allow the Trust to begin to offer ESD to appropriate patients on a seven day per week basis, responding within 24 hours of discharge and providing the appropriate level of rehabilitation therapy. Supplementary response The investment received by the Stroke Service from HSCB will allow the Trust to begin to offer ESD to appropriate patients on a seven day per week basis, responding within 24 hours of discharge and providing the appropriate level of rehabilitation therapy.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Diabetes				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to expand • the use of insulin pumps and consumables for adults and children with Type 1 diabetes • Consistent regional transition arrangements for children into adult services • consistent regional approach to the self-management and structured education programme	Trust responses should demonstrate plans to continue to work with commissioners to review uptake in line with NICE guidance. Additional resources will be made available in 16/17 from the Transformation fund.	Adults with Diabetes The following services are held. • Consultant led insulin pump clinic weekly • Nurse led service 1-2 clinics per week, • daily helpline, • pre pump assessment clinic once a month • monthly transitional clinic and bi-monthly young person clinic • Structured education programmes provided for Type 1 patients monthly Education programmes for Type 2 we provide 6 session per week across all of the Health and wellbeing Centres	Acute & Unscheduled Care Directorate
R2	Effective arrangements should be in place to reflect that current transition arrangements from paediatric to adult services can be associated with sub optimal care	Trust responses should demonstrate plans to ensure effective transition arrangements are in place including increasing the upper age limit for in-patients to 16 years	The Trust has effective transition arrangements in place as indicated in R1, above and the Education programme referenced in R8, below.	Acute & Unscheduled Care & Specialist Hospitals and Women's Health Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Diabetes				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R3	Effective arrangements should be in place for antenatal management and post-natal assessment of gestational diabetes.	Trust responses should demonstrate new models of care to be implemented in 2016/17 to manage the increase in numbers attending antenatal clinics/develop capacity in the post natal pathway.	From **August 2016** there will be Gestational Diabetic patients seen at a Monday pm clinic and RJMS are going to advertise for a Band 7 Diabetic Specialist Midwife imminently.	Specialist Hospitals and Women's Health Directorate
			The Trust already has a weekly nurse-led clinic for post-natal assessment of gestational diabetes. We will review the demand and capacity to ensure that this is addressed.	Acute & Unscheduled Care Directorate
R4	Effective arrangements should be in place to implement the Diabetic Foot Care Pathway	Trust responses should demonstrate plans to initiate the regional pathway work in 2016/17 in partnership with the commissioner.	There are two components of the pathway the community (Foot Protection Team - FPT podiatrists only) and the second component the hospital team (multidisciplinary diabetic foot team MDfT consisting of vascular and orthopaedic surgeons Consultant Diabetologists, podiatrists, orthotists, tissue viability and liaises with the multidisciplinary diabetic team - DSN and dietetics). The Foot Protection team is in place and there are plans to establish the MDfT in partnership with the Commissioner.	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Diabetes				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R5	Effective arrangements should be in place to ensure the implementation of the recommendations of current reviews, e.g. inpatient audits, Thematic Review of Insulin	Trust responses should demonstrate plans to complete the baseline assessment of the NICE Clinical Guideline and plans for improvement, implement amended areas of practice, e.g. recommendations around Continuous Glucose Monitoring for Type 1 patients, use information from Near Patient Testing Trust responses should demonstrate plans to review their management of hypoglycaemia and hyperglycaemia in hospital in patient settings, including theatre. This should be linked in with Unscheduled Care Locality Network Groups in each Trust area.	The Trust MDT group devises in-patient protocols for management of hypoglycaemia and hyperglycaemia in hospital. The Trust MDT group has: adapted NICE guidelines in relation to Continuous Glucose monitoring; and provided guidance / indications for Glucose monitoring criteria based on the NICE guidelines for use by all Consultants and Specialist Nurses. This work is linked to the IMPact group within the Trust.	Acute & Unscheduled Care Directorate
R6	Effective arrangements should ensure a consistent regional integrated pathway between primary and secondary care	Trust responses should demonstrate a commitment to participate in a workshop over the Autumn of 2016, to design new models of care for diabetes that clearly describes the delivery of Trust services in the overall care pathway.	Following the DHSSPS workshop attended by Trust staff, work steams have been established by Belfast Integrated Care Partnerships (ICP's) at which the Trust Clinical lead attends for Diabetes and Specialist Nurses, Dieticians and Podiatry managers attend work streams.	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Diabetes				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R7	Effective arrangements should be in place to enhance education of non-specialist health staff in diabetes through the use of competency frameworks, DNAV, WebEx or equivalent and Project ECHO.	Trust responses should demonstrate plans to ensure that educational resources are in place for all staff in hospitals to ensure: • Safe use of insulin • Effective management of hypoglycaemia • Effective management of hyperglycaemia • Early detection of foot problems when they arise in hospital	Intranet education/ guidelines for Trust staff Specialist Nurse provides training at mandatory training days for nursing staff. Staff complete on-line training module for safe use of insulin for Medical staff. Specialist Nurse provides training for Medical students at QUB and in house.	Acute & Unscheduled Care Directorate
R8	Effective arrangements should be in place to expand • the use of insulin pumps and consumables for adults and children with Type 1 diabetes • Consistent regional transition arrangements for children into adult services • consistent regional approach to the self-management and structured education programme	Trust responses should demonstrate plans to continue to work with commissioners to review uptake in line with NICE guidance. Additional resources will be made available in 16/17 from the Transformation fund.	Adult service currently has a waiting list for patients to commence insulin pump therapy. This is in part due to availability of pumps and staff to deliver the education, assessment and continuous care of these patients The Trust provides Education programmes for Type 1 & 2 patients. The Trust currently has a waiting list for access to these education programmes due to other service demands. However the service will seek solutions to address this demand.	Acute & Unscheduled Care & Specialist Hospitals and Women's Health Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Respiratory				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to ensure local health economies deliver appropriate integrated pathways for both Adults and Children across primary, community and secondary care.	Trust responses should demonstrate plans to use transformational funding to deliver: • Pathways for children with asthma, allergies and anaphylaxis • Adult asthma pathways • Timely access to diagnostics for patients with suspected asthma • The implementation of Home Oxygen Service.	In relation to Paediatrics, there are defined asthma pathways across all secondary and community care. Allergies and anaphylaxis are being developed as new services.	Specialist Hospitals and Women's Health Directorate
			The Trust is fully engaged with the Regional Development of the Adult Asthma Pathway chaired by Dr Cathy Jack and Dr Claire Butler will be the Trust lead for the proposed asthma audit across OOH, ED and secondary care. The diagnosis of patients with suspected asthma is made in primary care by GP colleagues. These patients can be referred if there is diagnostic uncertainty for additional lung function testing and a secondary care opinion if the diagnosis is unclear. The Home Oxygen Service is fully implemented across BHSCT	Acute & Unscheduled Care Directorate
R2	Effective arrangements should be in place to deliver findings from the Respiratory baseline assessment.	Trust and NIAS responses should demonstrate that plans are in place to deliver: • Development of Trust area Respiratory Forum, including ICPs and primary care • Ambulatory oxygen therapy for patients	In relation to Paediatrics, there is a funded service commencing 30th June 2016, with dedicated pathways. There is also a nurse led clinic insitu at point of presentation, with access to pulmonary function lab as required. There is an established home oxygen service via the asthma/ allergy/ anaphylaxis services.	Specialist Hospitals and Women's Health Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Respiratory				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
		continuing therapy outside the home • Access to discharge bundle for patients with COPD • Access to pulmonary rehabilitation courses and maintenance classes • Patients with a history of RF given alert cards in the event of conveyance • Patients should receive appropriately controlled oxygen when transported in ambulances to prevent acute hypercacnic failure • Maintenance of current service standards and where applicable, meeting minimum standards as outlined in the baseline review	The Trust is in the process of setting up a Trust area Respiratory Forum with ICP and primary Care representation. There is already a Trust and ICP multidisciplinary group established Ambulatory Oxygen assessments are part of the overall HOSAR Service for oxygen use outside the home. This is reported back through the ICP in terms of performance. The COPD Discharge Bundle has been fully implemented for over a year with 1008 bundles completed in 2015 There has been an increase in referral to pulmonary rehabilitation through the introduction of the bundle. Patients are then referred onto Health Wise or Chest Heart and Stroke for on-going exercise. Known patients with hypercapnic respiratory failure are given alert cards and the information relayed to NIAS	Acute & Unscheduled Care Directorate
R3	Effective arrangements should be in place to support the development of networked services across NI for the following diseases:	Trust responses should demonstrate a commitment to: • nominate a clinical lead for ILD patients who will work closely with the regional	A Clinical lead or ILD patients will be nominated. When this is developed for palliative MND patients in the NI Hospice the Ventilation nurse specialist will be part of the team but Dr	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Respiratory				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
	• Interstitial Lung Disease (ILD) • Non-Invasive Ventilation (NIV) • Obstructive Sleep Apnoea (OSA) • Bronchiectasis Services • Home Oxygen Services (HOSAR)	specialist ILD regional centre • Belfast Trust to proceed with plans for one stop shop between neurology and respiratory services • Belfast Trust to reduce waiting list for sleep studies • All Trusts work with ICPs to develop community based services for bronchiectasis • All Trusts n end-to-end HOSAR service with an annual assessment service for every patient (i.e. existing not just new) in a local area – this is an invest-to-save scheme	Collette Donaghy is the Neurologist planning for this 2 Consultants within an interest in sleep have been appointed. A plan will be developed. The ICP have funded 1 physiotherapist to provide a Bronchiectasis specific pulmonary rehab programme and review the more severe patients in their home. This has commenced. The HOSAR Service is reviewing all patients commenced on Oxygen therapy by Trust Services but there are approx. 348 patients unknown to the service and not referred to the team who have been historically commenced on oxygen therapy by Primary Care. Any savings realised through the HOSAR service do not come back into the Trust but will be with BSO who hold the Oxygen Contract	

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Respiratory				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R4	Effective arrangements should be in place to: • promote self-management, self-directed care and suitable training programmes for patients. • Provide access to psychological therapy and palliative care for all age groups.	Trust responses should demonstrate plans to deliver: • COPD Self-management programmes / pulmonary rehabilitation • Spirometry training programme • In-house or onward referral care pathways	The BHSCT already delivers 5 consecutive pulmonary rehab programmes which include detailed self-management and we refer patients to the CHS self-management programme We have ARTP approved spirometry trainers within the Trust who provide spirometry training through the RCN programme for practice nurses. Our respiratory palliative care patients remain under the care of the community respiratory team who then refer to all services, such as district nursing, OT etc. who can contribute to the overall management plan. We have a clinical psychologist 1 wte employed and embedded into the community respiratory team.	Acute & Unscheduled Care Directorate
R5	Effective arrangements should be in place to support 7 day delivery of COPD community support.	Trust responses should demonstrate plans to deliver this model in full across 2016/17	There are 2 members of the community respiratory team (either 2 RNS or 1 RNS and 1 Respiratory Physiotherapist) on duty 9-5pm Saturday and Sunday and a full respiratory service Monday-Friday 9-7pm	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities

POC 9 Family Practitioner Services

Long Term Conditions - Pain Management

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate
R1	Effective arrangements should be in place to enhance the skills and capacity and their capacity for integrated working.	Trust responses should demonstrate plans to; • Contribute to and participate in staff education and training for improved and integrated bio psychosocial management of persistent pain patients. • Contribute to the development and delivery of pain related public awareness campaigns and public awareness and other forms of information and education through the NI Pain Forum.	The Trust bimonthly governance meeting is focussed on education. Weekly MDT meetings are attended by all staff. The Trust provides undergraduate / post graduate medical education in long term pain management. Regional pain fellow participates actively in MDT and patient management. The Trust has specialist nurses in training posts. MDT attendance at Northern Ireland Pain Society Annual Study Day. Relevant members of the MDT attend the Regional Pain Forum.	Acute & Unscheduled Care Directorate
R2	Effective arrangements should be in place to ensure patients have timely access to supported self-management options alongside a stepped care model.	Trust responses should demonstrate plans for a range of self-management options in line with the NI Pain Forum's service specification and in collaboration with LCGs. Depending on local priorities, this may include: • reworking of existing contracts with voluntary providers of self-management programmes	Since 2013 the chronic pain service have been delivering an Information / education session to all new referrals with self-management as its theme. To date 3000+ patients have attended this session The pain management programme has recently been modernised to increase	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Respiratory				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
		and local support groups, • reconfiguration of community and primary care services • collaboration with other government agencies to booster condition management programmes	capacity A portion of the bimonthly governance meeting is reserved for review of capacity	
R3	Effective arrangements should be in place to ensure regional and local prescribing guidelines are followed and supported through pharmacy led regular medication reviews.	Trust responses should demonstrate plans to optimise prescribing practice, reduce risk of side effects, misuse and addiction as well as reduce prescribing costs by supporting services in secondary, primary and community care.	The chronic pain service reviews the efficacy of the red listed drugs such as Nabilone and ketamine to ensuring optimum benefit from these drugs. There is monthly participation in the CD audits Departmental prescribing is in line with BHSCT formulary	Acute & Unscheduled Care Directorate
R4	Effective arrangements should be in place to ensure patients are managed along regionally agreed integrated pathways to improve outcomes and patient experience.	Trust responses should demonstrate plans to support ICPs in developing integrated patient pathways for painful conditions including MSK conditions, fibromyalgia, chronic fatigue syndrome, endometriosis and other long term surgical and medical conditions.	Pain Clinic Staff have attended regional pain forums.	Acute & Unscheduled Care Directorate
R5	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to services.	Trust responses should demonstrate plans to develop referral pathways for pain management across inter-speciality based triage.	Effective patient triage has been recognised as a vital component of the pain service reorganisation We constantly review our referral criteria	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Respiratory				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R6	Effective arrangements should be in place to ensure patients are managed in line with evidence of effectiveness.	Trust responses should demonstrate plans to resource hospital based multidisciplinary teams so that patients can be followed up in an effective and timely manner, management plans can be developed, implemented and reviewed and only patients likely to benefit from interventional treatment receive it.	Following medication changes or interventions patients are reviewed by telephone by both medical and nursing staff resulting in patients being followed up in a timely and convenient way	Acute & Unscheduled Care Directorate
R7	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to services regardless of where they live and which secondary care team they attend.	Trust responses should demonstrate formalised referral pathways for pain management requiring expertise available only regionally like endometriosis, complex regional pain syndrome and interventional treatments	The BSHCT has developed a Pain Management Pathway which directs patients into a non -interventional or interventional treatment pathway At all times there is the opportunity to discuss complex patients at MDT meetings	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Palliative and End of Life Care				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to provide enhanced access to radiotherapy services for patients through the delivery of a new radiotherapy centre at Altnagelvin.	Trust responses should demonstrate that plans are in place to ensure that the new radiotherapy service in Altnagelvin will be operational by November 2016 to provide high quality, sustainable services consistent with national standards.	This objective is Western Trust only. There is collaboration in the commissioning of this Unit, however the required response relates to the timescale for opening of the Unit. Supplementary response Although this project is led by HSCB and WHSCT the BHSCT is part of a tripartite group planning the various project aspects e.g. workforce planning, pathway management etc	N/A
R2	Effective arrangements should be in place to deliver the recently introduced Acute Oncology Service across NI in line with the agreed service model and to further develop the service to provide a more sustainable acute care service for patients across all Trusts.	Trust responses should demonstrate how acute oncology services will be provided in line with the agreed service model.	The Acute Oncology service was launched in BHSCT in May 2016, comprising 2 wte Clinical Nurse Specialists and 4 sessions of Consultant Oncology time. This service is based in the Royal Victoria Hospital, and offers advice and support to clinicians, staff and patients who present with an acute oncological complication due to treatment, disease progression or for patients with an unknown or presumed cancer diagnosis. The Service aims to streamline current pathways, developing safer, effective and timely management for oncology patients on the Royal site, strengthening communication links and structures to improve continuity of care.	Surgery and Specialist Services Directorate

R3	Effective arrangements should be in place to improve the patient experience of cancer care services.	Trust responses should demonstrate how the key findings from the recent Cancer Patient Experience Survey will be addressed, in particular, the specific actions to be taken to: work more closely with primary care to improve early detection; improve access to patient information across the pathway; improve access to clinical nurse specialists; and, increase recruitment to clinical trials.	The Trust has established a new structure for cancer services to review and improve patient experience, involvement and support across tumour sites. This forum will take forward the cross cutting issues from the cancer patient experience survey such as improving access to patient information. Site specific teams will also review issues for their tumour site and put in place action plans. The clinical trials unit have established a group to review and act on the results of CPES. Finally, the Trust will plan GP education events in 2016 to improve education around early detection in primary care.	Surgery and Specialist Services Directorate
R4	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in NI in line with national benchmarks, using a five-year phased approach.	Trust responses should demonstrate the particular actions to be taken in 2016/17 to expand the CNS workforce and, in doing so, how this will increase opportunities to modernise cancer care pathways and improve the patient experience of care.	The Trust has developed and agreed a CNS workforce plan in conjunction with HSCB and PHA and will recruit 8 new CNS posts in 2016/17. The Trust will look at new opportunities to transform care, follow up and improve patient experience once these posts are in place. Supplementary response The pain service has reengineered its processes at triage stage to ensure that the pathway into which the patient enters the service suits the condition which the patient is presenting with. The first contact with the service is through an education session which has proved useful in directing the patients to the non interventional or interventional pathways as appropriate.	Surgery and Specialist Services Directorate

R5	Improved arrangements for identifying patients in their last year of life will support timely needs assessment and lead to more effective advanced care planning for these patients.	Trusts in collaboration with the palliative care locality board, including ICPs, should set out the specific arrangements to be put in place during 2016/17 to increase the number of patients identified as being in their last year of life and to ensure that this information is communicated across the HSC system.	The Trust has its Palliative and End of Life Coordination System in place for a number of years which supports measurement of numbers of patients identified as well as other key data. The accompanying communication guidance helps to ensure this information is appropriately shared across settings with those supporting and caring for the individual. In continuing to increase the proportion of patients identified, the focus for this year remains providing awareness and training to relevant staff to encourage continuous use of ELCOS, prognostic indicators and the coordination system as well as of specific tools and processes such as named key worker and advance care planning. The ongoing training provided to staff on both general awareness and the practical aspects of identification and ELCOS has proved beneficial in increasing numbers and quality of care. Supplementary response The pain service has already developed alternative pathways for patients along 2 areas – non interventional (psychology, AHP services, pain management programmes, self help, education and relaxation) and interventional (theatre based interventions). The service will continually review how these operate but at the moment do not have the capacity to address all treatment needs. A capacity gap has been discussed with the HSCB but to date has not	Adult PSC Directorate

			been funded	
R6	The keyworker function needs to be embedded within Trust arrangements to support care planning processes, improve communication with patients and their carers and ensure continuity of care for patients and families in hospital, community and other care settings.	Trusts in collaboration with the palliative care locality boards, including ICPs, should set out the specific actions to be taken during 2016/17 to further embed the keyworker function across all aspects of patient care.	The main key worker for palliative care is an integral part of the Trust's service improvement programme. There is clear guidance on the purpose, function and expectations of a main named key worker available to all staff alongside a quick reference guide. The requirement for a named key worker for palliative care at identification is embedded into various training. Further awareness sessions continue to be held across community settings to ensure that every patient identified (regardless of setting) is recorded appropriately on the coordination system and the named key worker appointed at this stage. Identified individuals remain on the district nursing caseload to ensure appropriate assessment and management throughout.	Adult PSC Directorate
R7	Support arrangements for patients and families should be in place out of hours (in conjunction with the voluntary sector as appropriate).	Trusts in collaboration with the palliative care locality boards, including ICPs, should ensure that out of hours arrangements are in place for generalist palliative care 24 hours per days 7 days per week.	Patients, their families and carers have access to 24/7 nursing care. Nursing care provided includes planned, crisis intervention and end of life palliative care as well as access to a responsive out of hours nursing. To ensure a seamless service is provided to palliative care patients over the 24 hour period the out of hours nursing teams and core services work closely together. The Trust's out of hours GP service works in collaboration with the 24 hour nursing teams to ensure palliative care patients and their family receive a responsive service that appropriately meets their needs in a timely fashion. The on call emergency duty social worker can be contacted by the OOH GP or nursing team if	Adult PSC Directorate

			there are urgent social care issues that need to be addressed. Marie Curie domiciliary staff and NI Hospice at Home overnight sits as part of normal service provision.	
R8	Effective arrangements should be in place to provide a range of specialist palliative care services.	Trusts in collaboration with the palliative care locality boards, including ICPs, should ensure that there is access to specialist palliative care services.	The multidisciplinary Community Oncology and Palliative Care (members of which either have specialist qualifications or extensive experience in palliative care) provides specialist advice and care to palliative patients with complex needs and also provides advice and training to community generalist staff. Additional resources have been requested to enhance the AHP service and for a Community Palliative Consultant post to support the specialist team and patients in their own home and in non-acute hospitals. NI Hospice In Patient Unit/On Call Practitioner can be contacted by the OOHs GP or nursing team for specialised advice and support.	Adult PSC Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Specialist Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to address the growth in the number of patients accessing approved specialist drug therapies for a range of conditions. Each year there is growth in the number of patients receiving specialist drug therapies previously approved by NICE.	Trusts responses should demonstrate how they will engage with the HSCB to inform the projected requirements associated with the increase in the number of patients on existing treatment regimes across a range of conditions including rheumatoid arthritis, psoriasis, IBD, Hep-CMS, HIV, specialist ophthalmology and cancer conditions.	There is a well established robust process in place between HSCB and Trust to review the annual changes to numbers requiring specialist drug therapies across a range of specialties, where both the drug costs and associated infrastructure are addressed	Surgery and Specialist Services Directorate
R2	Effective arrangements should be in place to develop the model for specialist neuromuscular services.	Belfast Trust response should demonstrate the agreed service model /pathways for adults and children (including transitional care) with specialist neuromuscular conditions incorporating baseline resources as well as more recent investment. The proposed model and implementation plan to be submitted by 30 June 2016	The Trust will be in a position to implement the first 22q transition is clinic from 22nd April 2016 & as per the submitted plan. Age related screening as per published guidelines will be provided /arranged at this clinic along with formal psychiatric assessment.	Surgery and Specialist Services Directorate
			Plans are in place for the recruitment of the Adult Neuromuscular Consultant and Nurse. In the meantime the Trust will continue to source additional capacity from a provider in London supported by specialist AHP resource. A stakeholder meeting is being arranged for September 2016 to help shape the services	Acute & Unscheduled Care Directorate
R3	Effective arrangements should be in place to continue to support the implementation of the NI Rare Disease Implementation	Belfast Trust response should demonstrate the implementation plan by 30 September 2016 to deliver the NI Rare Disease Implementation	(NF1 and NF 2 patients) The anticipated programme of in-reach and	Surgery and Specialist Services

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Specialist Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
	Plan through a programme of in-reach and networked services through formal alliances with tertiary and quaternary providers outside NI.	Plan.	networked services through a formal alliance with Central Manchester Foundation Trust, the tertiary and quaternary NF1 and NF2 provider will not be deliverable in 2016/17. The Trust's current understanding is that the NF1 Consultant post is expected to be replaced at the start of 2017 so there may be movement towards the end of this year/start of next financial year. The second consultant who specialises in Neurofibromatosis type 2 (NF2), is not currently available to provide in-reach to Belfast but we are still able to refer over & Prof Evans is there and available to see BHSCT patients.	Directorate
R4	Effective arrangements should be in place to ensure access to genetic tests in line with UKGTN recommendations.	Belfast Trust should submit an IPT by 30 September 2016 to ensure timely access to UKGTN tests approved for 2016/17 net of baseline costs.	An IPT will be presented to ensure timely access to new UKGTN tests approved in 2016/17 and also to address the on-going capacity and demand issues previously raised as cost pressures. Investment in IT Infrastructure and new genomic analysis technologies are required to facilitate modernisation of the service to ensure sustainable access to genetic testing in the future.	Surgery and Specialist Services Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Specialist Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R5	Effective arrangements should be in place to ensure access to new NICE TAs and other NICE recommended therapies approved during 2016/17.	Trust responses should demonstrate how they will deliver on the requirements of new NICE TAs in line with recent investment.	The corporate team coordinate dissemination of NICE guidelines and TAs to relevant Directorate colleagues, we follow up and collate Trust status in relation to compliance , providing assurance or flagging gaps etc., these processes are in place and have been for some time.	Surgery and Specialist Services Acute & Unscheduled Care Specialist Hospitals & Women's Health Directorates
R6	Effective arrangements should be in place for the provision of Paediatric Congenital Cardiac Services in line with Ministerial decision on the establishment of an All-Island Network including: • SLAs, with specialist centres to provide a safe and robust service for children from NI during the implementation period for patients with paediatric cardiac conditions. • Improved antenatal detection rates of structural cardiac anomalies by issuing a standardising regional protocol for the cardiac scan and putting in place a training and audit programme for staff in this area.	Belfast Trust should demonstrate how they will work with the HSCB to develop an IPT related to the elements of the Full Business Case for an All-Island Congenital Heart Disease Service specific to local developments in NI e.g. Paediatrician with Specialist Interest in Cardiology role, additional specialist nursing liaison support etc. Timelines for submission will be consistent with the requirements of the Departmentally Chaired, NI CHD Implementation Group. Trusts should ensure implementation of the regional scanning protocol, participate in the training and audit programme.	The Belfast Trust will work with the HSCB to develop an IPT related to the elements of the Full Business Case for an All-Island Congenital Heart Disease Service specific to local developments in NI e.g. Paediatrician with Specialist Interest in Cardiology role, additional specialist nursing liaison support etc. Timelines for submission will be consistent with the requirements of the Departmentally Chaired, NI CHD Implementation Group. There is already a fetal scan nurse in place in Royal Jubilee Maternity Hospital, who works in conjunction with the cardiologist on monitoring and detecting cardiac anomalies.	Specialist Hospitals and Women's Health Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Specialist Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R7	Effective arrangements should be in place to ensure the opening of the Phase 2B Critical Care Unit to accommodate the transfer of ICU/HDU capacity with service to be fully operational in 2017.	Belfast Trust response should (with input from the NI Critical Care Network) demonstrate that it will finalise the IPT for this development and submit a detailed project plan for staff recruitment/training by end of August 2016, with a view to opening in 2017.	The Trust has developed a detailed project plan which will be submitted to the HSCB. Nursing posts have been processed and start dates range from August 2016 through to November 2016. The staff will commence in cohorts of approximately 10 to ensure effective induction and support in acquiring the full range of ICU/specialty skills. Band 3 posts have been recruited and staff will be in post by September 2016 with the band 3 education programme commencing and running for 6 months. Consultant posts are in the process of recruitment with the 4 ST3 posts being taken forward with the Critical care network. All other posts for PCSS and AHP roles are also in the recruitment process.	Acute & Unscheduled Care Directorate
R8	Effective arrangements should be in place to ensure the development of weekend access to neuroradiology intervention for patients with subarachnoid haemorrhage, arising as a result of recommendations from the NCEPOD report 'Managing the Flow'.	Belfast Trust response should demonstrate that it will submit an IPT to achieve the NCEPOD recommendations with a project plan for establishment of the weekend access. Services expected to be in place by September 2016.	The Trust has received a revenue business case from the HSCB. This will be completed and the Trust will include a project plan for establishment of weekend access.	Acute & Unscheduled Care Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Specialist Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R9	Effective arrangements should be in place to ensure the further expansion of the NISTAR (NI Specialist Transport and Retrieval Service) for neonates, children and adults across NI and ROI. The service will ensure critical and supported clinical transports undertaken are managed consistently and to best effect. NISTAR will also work closely with the fixed wing Air Ambulance / Air Transfer provider.	Belfast Trust working with the NI Critical Care Network and the regionally established NISTAR group should bring forward proposals to identify phases of development for this service. This will include consultation with DGH and NIAS colleagues. The Belfast Trust should submit a final IPT by end of September 2016 with a view to services expanding on a phased basis from 1 December 2016.	The Belfast Trust are working with the NI Critical Care Network and the regionally established NISTAR group to bring forward proposals to identify phases of development for this service, including consultation with DGH and NIAS colleagues. The Belfast Trust will submit a final IPT by 1 October 2016 with a view to services expanding on a phased basis from 1 December 2016. This will provide a second tier transport service to cover Northern Ireland and the Republic of Ireland.	Specialist Hospitals and Women's Health Directorate
R10	Effective arrangements should be in place to improve access to specialist immunology services for adults and children through establishment of a tertiary referral arrangement.	Belfast Trust should submit proposals incorporating the operational arrangements to move this service to a tertiary referral service for adults and children and effect this change by 1 November 2016.	The Trust will submit proposals to the Commissioner outlining the necessary process to meet this objective. Supplementary response The Trust continues to work with the commissioner to develop the proposal for Immunology. The BHSCT is in the process of recruitment to develop capacity.	Surgery and Specialist Services Directorate
R11	Effective arrangements should be in place to improve access to specialist paediatric services through the establishment of regional networks.	Belfast Trust should submit by 31 July 2016, an IPT and associated action plan to provide centralised waiting lists and outreach services in respect of paed orthopaedics, paed gastroenterology, paediatric cardiology and paed surgery.	Revenue Business cases have been submitted for the outreach services and are awaiting approval of funding. It is hoped that the Revenue Business case for centralisation of paediatric waiting lists will be submitted by the end of June 2016.	Specialist Hospitals and Women's Health Directorate

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Specialist Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R12	Effective arrangements should be in place to ensure the introduction of cranial stereotactic radiotherapy in NI to reduce the need to send some patients for treatment in GB and provide more accessible service and plans to expand stereotactic ablative radiotherapy (SABR) to include the treatment of oligometastatic and oligo-progressive advanced cancer disease.	Belfast Cancer Centre should deliver a cranial stereotactic service to treat 50 patients with Cerebral Metastases in 2016/17 increasing to 65 patients in 2017/18. Belfast Trust will bring forward plans to extend SABR in the treatment of oligometastatic and oligo-progressive advanced cancer disease.	The Cancer Centre plans to treat its first patient with cranial stereotactic radiotherapy in October 2016, working towards 50 patients within the first twelve months. An IPT is in development for the use of SABR in the treatment of oligo-metastatic and oligo-progressive advanced cancer, although the Trust has not yet received a commissioner intent for this IPT.	Surgery and Specialist Services Directorate
R13	Effective arrangements should be in place to optimise drug efficiency savings.	Trust responses should demonstrate a co-ordinated approach to bringing forward proposals to maximise drug efficiency savings in line with key principles shared with Trusts during 2015/16.	The trust has a 2016/17 procurement plan in-situ to maximise medicines efficiency savings in line with the shared principles.	Surgery and Specialist Services Directorate
R14	Effective arrangements should be in place to optimise the use of specialist capacity through development of protocols to support timely discharge of patients in specialist acute beds.	Trust responses should demonstrate a schedule of specialist acute areas, with timelines, for review by 1 October 2016. Protocols will follow and will be available on a phased basis from 1 December 2016.	The Trust will work with the HSCB in relation to this area. This will include HSCB support for the implementation of repatriation protocols for patient from other Trust areas who are occupying regional specialist beds and can be transferred to local hospitals for on-going care and treatment.	Performance, Planning and Informatics Directorate
R15	Effective arrangements should be in place to appropriately manage the service demands associated with an increasing number of patients requiring specialist services.	The Trust response should demonstrate how the Trust will deliver the required volumes of service activity in light of the changing population need and demand for specialist services in 2016/17.	To follow The Trust will need to discuss the proposed volumes, set out below, further with the Commissioner. HSCB proposes to provide the following volume of service	Performance, Planning and Informatics Directorate

Belfast Trust response to Commissioning Plan priorities

POC 9 Family Practitioner Services

Long Term Conditions - Specialist Services

ISSUE/OPPORTUNITY	PROVIDER REQUIREMENT	PROVIDER RESPONSE	Directorate

during 2016/17:

Currency	Opening SBA 16/17	Proposed Delivery 16/17
Emergency FCEs Cardiology switch to procedural contract	8,920	
Elective Contract	7,427	
Daycase	10,027	
New OP	48,873	
Review OP	109,468	
Other (Changes to SBA including cardiology procedural contract and specialist drugs and inject SBA volumes including Cardiology)	31,453	
Beddays	23,744	

Belfast Trust response to Commissioning Plan priorities				
POC 9	**Family Practitioner Services**			
Long Term Conditions - Prisoner Services				
	ISSUE/OPPORTUNITY	**PROVIDER REQUIREMENT**	**PROVIDER RESPONSE**	**Directorate**
R1	Effective arrangements should be in place to develop care pathways for prisoners with complex needs, both in and out of prison.	All Trusts should outline plans to develop care pathways for individuals with complex needs in Primary Care.	To follow	Performance, Planning and Informatics Directorate

4.0 Resource Utilisation (see Appendix 4 of TDP guidance)

4.1 Financial Strategy

4.2 Workforce Strategy

4.3 Capital Investment Plan

5.0 Governance

6.0 Promoting Well-being, PPI and Patient Experience

4.0 Resource Utilisation

4.1 2016/17 Financial Plan

Executive Summary

The financial plan for the Belfast Trust was revised in early September 2016. The previous plan, included in the Trust's draft TDP at the end of July 2016, identified an anticipated year-end deficit of £7m. The Trust is now assuming a breakeven position for 2016/17.

The Trust began the 2016/17 financial year with an opening deficit of £62.5m which included:

- an underlying deficit of £16.2m brought forward from 2015/16 – DoH are well versed in the background to this figure which represents the amount the Belfast Trust feels it required to put itself on an equitable opening financial footing with other Trusts
- a recurrent gap against the Trust's 2015/16 savings target of £3.6m (£20.3m target versus £16.7m approved plan)
- a recurrent shortfall against the Trust's 2015/16 savings plan of £5m which was addressed non-recurrently in 2015/16
- a £37.7m gap between the indicative 2016/17 allocation and funding required in 2016/17 to cover increased national insurance (£14m), pay and price increases including social care uplifts (£21m), anticipated demographic pressures (£9m) and a number of other inescapable cost pressures

The £62.5 opening gap has been reduced on an in-year basis to £42m following a June monitoring allocation of £15.8m and a more recent allocation from HSCB towards cost pressures.

The Trust has undertaken a thorough, robust assessment of its total budget for 2016/17 and has explored all options for reducing expenditure. As a result, a range of cash-release savings, cost-avoidance measures and non-recurrent slippage/ contingencies have been identified to achieve a breakeven position in 2016/17 without impacting on patient and client services. A summary of this plan is shown in table 4.1 below.

Table 4.1: Summary Financial Plan 2016/17

	£'m	£'m
Deficit carried forward from 2015/16		24.86
2016/17 income gap		37.66
Non-recurrent income from June monitoring		(15.80)
Non-recurrent income from HSCB September 2016		(4.74)
Opening deficit net of in-year HSCB income		**41.98**
Trust planned savings 2016/17	(16.25)	
Regional pharmacy 'boost' savings to be confirmed	(1.34)	
In-year slippage on service developments	(6.83)	
Productivity/cost avoidance savings	(3.50)	
Other non-recurrent measures	(14.06)	
Total savings/expenditure reductions		**(41.98)**
Anticipated Surplus/(Deficit) 2016/17		***0***

It is clear from the detail behind the financial plan in the following sections that breakeven has only been possible with the help of £43m of non-recurrent measures achieved through a combination of non-recurrent HSCB income (£20.5m including June monitoring monies of £15.8m), non-recurrent savings (£1.2m), one-off slippage on investments of £6.8m (including £3m resulting from delays in implementing new 2016/17 investment in relation to phase 2B critical care and critical care transport), and a significant level of one-off accounting adjustments (circa £14m) which will not be available next year. **The recurrent deficit moving into 2017/18 is therefore expected to be in the region of £43m.**

There are a number of key risks and assumptions associated with the current financial plan which are discussed in detail below.

Introduction

Trusts are currently held directly accountable by the Health and Social Care Board (HSCB) through the Trust Delivery Plan (TDP) for the effective deployment of all the resources at their disposal. This includes income, expenditure, capital, workforce and estate.

This section provides details of the financial plan for the Belfast Trust for 2016/17. It sets out the strategic context and financial parameters within which the Trust is bound to operate for 2016/17. The income and expenditure positions are summarised and key areas of risk are highlighted.

The approach to financial planning for 2016/17 was set out in the Permanent Secretary's letter to HSCB dated 14 October 2015. In that letter the Permanent

Secretary asked HSCB to provide indicative income allocations to Trusts on the basis of prioritised population needs. Trusts were asked to review their total baseline budgets and develop savings plans to address any gap between anticipated spend for 2016/17 and the indicative income allocations.

A draft commissioning plan was provided by HSCB and the Board issued a draft Revenue Resource Limit (RRL) for 2016/17 which has been used as the basis of the Trust's income budget in its 2016/17 financial plan. The TDP financial plan builds on previous drafts shared with DoH and HSCB on 12 January 2016 and 9 May 2016 which provide more detailed information on the opening position, cost pressures and evaluation of potential savings. The current financial plan has been amended to reflect additional non-recurrent funding allocated through the June monitoring process.

In the financial plan, the recurrent opening deficit for 2016/17 and in-year position are identified, along with a review of planned efficiency, productivity and other cash savings.

A range of assumptions have been made in relation to both HSCB and other income and the Trust will work with its commissioners over the next few months to confirm those assumptions.

Financial Context for 2016/17

The Trust's financial plan for 2016/17 is set firmly within the context of the Department's overall HSC financial plan and the financial section of the HSCB's draft commissioning plan.

Despite the significant financial challenges facing the HSC, Trusts are expected to produce balanced financial plans for 2016/17. Given the scale of the Belfast Trust's brought forward deficit from 2015/16 and the gap between new income needed in 2016/17 to meet national insurance, pay and price and cost pressure requirements and the amount allocated, it is clear that financial balance could not be achieved through efficiency savings alone. A significant element of the opening gap will therefore be addressed on an in-year basis only through non-recurrent measures.

In developing the Trust's financial plan, we have undertaken a review of all expenditure, taking into account any comments or recommendations highlighted by DoH and HSCB earlier in the year. We have also given due consideration to the recommendations made in Lord Carter's efficiency report and believe that the key areas of opportunity highlighted in that report have been robustly assessed and included in our revised financial plan, where applicable.

The Trust will continue to ensure that it makes the best use of the resources available to it. The Trust will continue to embed its MORE (Maximising Outcomes, Resources and Efficiencies) programme which focusses on securing efficiencies through enhancing productivity, changing the way services are delivered, modernising and

driving improvements in health and social care, eliminating waste and maximising value for money.

Trust Opening 2016/17 Financial Position

In 2015/16, the Trust submitted a TDP with an anticipated year end deficit of £13.5m. This comprised a brought forward deficit of £9m relating to unmet bed savings (due to substantial increases in demand) and unfunded cost pressures of £4.5m. During 2015/16, a number of revisions to the TDP were made to reflect changes in assumed income, new pressures, in-year slippage on investments and additional income from HSCB.

As a result of these revisions, the Trust ended the 2015/16 year in a breakeven position. However, financial balance was only possible through a combination of non-recurrent income from HSCB (circa £4m), in-year slippage on a number of service developments (circa £11m), non-recurrent savings/contingency measures (£7m) and other non-recurrent support (£4m).

Consequently, the Trust commenced the 2016/17 financial year with an opening recurrent deficit of £24.86m, comprising a £16.23m gap carried forward from 2015/16 and an £8.63m recurrent shortfall against the 2015/16 savings target. This rolled forward position has been well documented since the 2015/16 TDP planning process and full details were provided to both DoH and HSCB in 2015/16.

Trust 2016/17 Financial Plan

The Trust submitted a draft financial plan in January 2016 which was updated on 9 May 2016 and more recently following the allocation of June monitoring monies. The current draft plan identifies an opening financial gap of £62.5m (£62.8m FYE), which includes the brought forward recurrent income shortfall from 2015/16 discussed above, and an in-year funding gap for 2016/17 of £37.7m after accounting for national insurance, pay and price uplifts and a range of new cost pressures including demographic growth. The £62.5m opening gap is summarised below:

Table 4.2 Summary Opening Financial Gap 2016/17

	£'000
Carried Forward Gap	
Brought forward underlying deficit	16,225
Brought forward savings gap from 2015/16	8,631
Total gap carried forward into 2016/17	**24,856**
2016/17 Position	
Income	
HSCB opening recurrent RRL	1,085,369
PHA opening recurrent RRL	10,938
Transformation income	3,073
3% superannuation	14,175
Additional recurrent funds	11,965
Additional income for LD community pressures	1,700
Funding in relation to regional pharmacy savings	1,500
Other inescapable service development pressures	9,673
Other Assumed Income	83,540
Total Income	**1,221,933**
Projected Expenditure	
HSCB	1,085,369
PHA	10,938
TYC Projects	3,073
Superannuation	15,175
Pay	8,077
Additional NIC 3%	13,910
GP OOHs NIC pressure	350
Non Pay (Incl Living Wage)	11,508
Additional cost pressure in relation to dom care and nursing & res homes uplifts above the 4%	1,720
FYE 2015/16 and 2016/17 Demography Pressures	9,000
Expenditure in relation to assumed income	83,540
Expenditure in relation to inescapable service developments	9,673
Inescapable Pressures	
Acute and community LD pressures	3,000
High Cost fostering placements	1,000
Interventional radiology pressures	1,000
Unlicensed drugs pressure	200
International nurse recruitment pressure	1,000
Other pressures	1,059
	1,259,592
2016/17 Income gap	**37,659**
Projected 2016/17 funding gap	**62,515**

Further detail on the component elements of the opening position above is provided in Annex 1. A reconciliation between the closing breakeven position in 2015/16 and the opening 2016/17 position is also provided.

Addressing the Trust's Anticipated Financial Gap

The Trust plans to reduce this gap in 2016/17 through a combination of non-recurrent funding from HSCB, recurrent and non-recurrent savings, in-year slippage on investments and one-off accounting adjustments. These measures are expected to address the 2016/17 gap without any real impact on patient and client services. The key proposals and summary plan are shown below:

- Non-recurrent funding from HSCB including June monitoring monies
- Recurrent and non-recurrent cash-release savings
- Recurrent productivity/cost avoidance savings
- In-year slippage on service developments
- Non-recurrent accounting adjustments

Table 4.3 Summary Financial Plan 2016/17

	£'m	£'m	FYE Position £'m
Underlying Deficit	16.23		
2015/16 savings plan gap (£16.7m approved plan v £20.3m target)	3.63		
2015/16 recurrent savings gap	5.00		
Total brought forward Deficit		**24.86**	**24.9**
In-year funding gap		37.66	37.9
Total 2016/17 Opening deficit		**62.52**	**62.8**
Recurrent savings proposals to address gap			
Efficiency Savings to address 2015/16 recurrent savings gap	(4.50)		
Approved savings plan against £3.6m carried forward savings gap	(1.75)		
Trust pharmacy savings proposals	(1.92)		
Other pharmacy savings above plans identified by Trust to meet regional pharmacy savings target	(1.34)		
Energy Savings	(3.50)		
2015/16 VES savings	(0.60)		
Procurement Savings	(1.30)		
Other directorate plans - assume further £1.5m recurrent	(1.50)		
Demography Productivity/cash savings	(3.50)		
		(19.91)	(19.9)
Opening Position after recurrent measures		**42.61**	**42.9**
Non-recurrent savings proposals to address gap			
Additional In-year funding via June Monitoring	(15.80)		
Additional In-year funding September	(4.74)		
Other directorate plans (to be determined)	(1.18)		
Anticipated slippage on 2015/16 investments	(1.41)		
Anticipated slippage on 2016/17 investments	(5.42)		
Reserves	(14.06)		
Total non-recurrent measures		**(42.61)**	
Projected 2016/17 Deficit		**-**	**42.9**

Further detail on each of the key elements of the financial plan is provided in Annex 2.

It should be noted that the opening deficit of £62.5m assumes that £18m of non-recurrent workforce savings achieved in 2015/16 are maintained in 2016/17.

In arriving at a breakeven position, the Trust is assuming that:

- additional efficiency savings of £10m will be delivered by the Trust with no material impact on service provision. At this stage, savings totalling £7.3m have been identified (initial pharmacy savings, energy, procurement and VES savings)
- the residual element of the Trust's £3.2m share of the regional pharmacy savings target of £10m will be achieved with clearly identified plans
- slippage on 2015/16 and 2016/17 investments will be retained by the Trust
- the assumptions upon which accounting adjustments have been released are valid
- a small number of outstanding income assumptions will be confirmed by HSCB or expenditure reduced to avoid potential deficits

Key Assumptions and Risks

In arriving at the overall financial position for 2016/17, the Trust has assumed income of around £129m (including £15.8m June monitoring monies and £4.74m notified in September) from HSCB/PHA in addition to amounts formally approved and confirmed for 2016/17. This includes income which has historically been awarded annually, on a non-recurrent basis, such as 'GP out of hours', Surestart, high cost cases and SUMDE which the Trust is confident will be funded by DoH and HSCB during 2016/17. For a small number of items, notably cardiac surgery, spinal surgery and independent sector elective care, legitimate costs are being incurred which exceed income levels recently advised by HSCB. Further discussion is required to ensure that no financial deficit is incurred by the Trust in these areas. It is important that income assumptions are confirmed as soon as possible to assist detailed financial planning and facilitate more accurate forecasting in the Trust during the year.

There are a number of risks in the Trust's draft financial plan, the most significant of which are:

- Deliverability of an additional £10m savings target in 2016/17 for which firm plans have only been identified for £7.3m (Annex 2)
- Deliverability of additional £4.5m savings identified to replace non-recurrent savings achieved as part of the £16.7m 2015/16 savings plan (Annex 2). There is a high risk associated with the sickness absence target in particular. Despite robust absence management procedures in the last few years, including for example early intervention by physiotherapy at considerable cost to the Trust, the Trust is finding it increasingly difficult to reduce sickness

levels and the pressure to backfill vacant posts on the grounds of patient safety is constantly rising.

- Sustainability of the £18m workforce management savings delivered in 2015/16 in light of ongoing staff shortfalls and recruitment difficulties particularly amongst medical staff in areas such as ED.
- The Trust's plans to achieve its £3.2m pharmacy target is dependent on achieving and retaining savings from procurement initiatives and switching drugs regimes in respect of high cost drugs which requires HSCB approval
- Indirect impact on nursing home costs as a result of the recent price increase by our main nursing home provider which could cause further pressure

There is also a considerable target for discretionary and general goods and services spend reductions in the 2016/17 plan despite the achievement of substantial savings in these areas in recent years. It would be unrealistic to assume that further contingencies could be delivered in this area should slippage occur elsewhere.

A number of assumptions have also been made in the plan. If these prove to be incorrect, the anticipated deficit will grow. The key assumptions at risk are highlighted below.

- Income for cardiac surgery and spinal surgery are still being debated with HSCB.
- It is assumed that outpatient washthrough costs and the cost of treatment for any inpatients referred before 1/4/16 but seen in 2016/17 will be funded in full or that costs can be contained within available resources.
- It is assumed that any cost pressures associated with a growth in high cost specialist drugs and therapies will be fully funded. Further work is being undertaken to clarify funding streams for these but on the basis of discussions held recently with Board colleagues, it would appear that adequate funding has been earmarked for the growth in treatment costs this year.
- It is assumed that there will no cost pressure in relation to winter pressures above the level addressed through demographic funding and productivity.
- It is assumed that no pressure will arise in relation to SUMDE income in 2016/17.
- It has been assumed that a number of additional pressures (circa £3m to £5m) which were addressed by slippage or non-recurrent contingencies in 2015/16 will be eliminated or addressed through new contingencies/ one-off monies during the year, including for example the current pressure in the statutory home care service, medical agency costs and labs demand pressures. These pressures are not reflected in the 2016/17 plan.
- The benefit arising from accounting adjustments is based on a number of assumptions in relation to unresolved HR issues. If the Trust position on such issues is proven to be incorrect this could give rise to a substantial cost pressure in 2016/17 or in future periods.

The Trust will continue to review and update the proposals and will keep DoH and HSCB advised of any material changes to the current estimates which will ultimately impact on the 2016/17 position.

The draft financial plan assumes that no material additional cost pressures will arise in 2016/17 above anticipated levels. It is important to emphasise that the Trust will have no capacity to deal with any new unfunded pressures as we proceed to implement our plan.

Finally, the current financial plan does not allow for any other unforeseen pressures relating to safety and quality for example, which may arise during 2016/17 and which are not included in either the Trust's plan or the HSC Board's overall HSC financial plan. It is assumed at this point that any such pressures will increase the anticipated gap for the HSC as a whole in 2016/17.

Summary 2016/17 Position

The Trust will begin the financial year with an opening deficit of £62.5m which will be reduced to £42m as a result of non-recurrent in-year funding from HSCB. The financial plan outlines a range of efficiencies, slippage and other measures which will be taken by the Trust to address its in-year deficit and achieve a balanced financial position by the end of March 2017. There are a number of very significant financial risks to the reported position, the greatest of which is the deliverability of the 2016/17 new savings plan of £10m in addition to sustaining workforce management savings of £18m.

A high level summary of the Trust's breakeven financial plan is provided in Table 4.4 below.

Table 4.4: Summary Financial Plan 2016/17

	£'m	£'m
Deficit carried forward from 2015/16		24.86
2016/17 income gap		37.66
Opening Deficit 2016/17		**62.52**
Trust planned savings 2016/17 including pharmacy	(17.59)	
Non-recurrent income	(20.54)	
In-year slippage on investments	(6.83)	
Productivity/cost avoidance savings	(3.50)	
Other non-recurrent measures	(14.06)	
Total Savings/funding		**(62.52)**
Anticipated Deficit 2016/17		***0.00***

In delivering this projected position, the Trust will be required to address, through HSCB collaboration and/or funding, any new cost pressures emerging this year. However, the plan cannot conceivably anticipate every eventuality and there is always a risk that material cost pressures could arise during 2016/17 which would alter the Trust's anticipated position. The Trust is committed to achieving its statutory duty to breakeven whilst delivering safe and effective, high quality services. However, given the scale of the financial deficit identified for 2016/17 and the range of non-service impact measures already brought forward to address the in-year gap, the Trust believes that there will be no capacity to address any new pressures should they arise during the year.

As always, the Trust will keep all pressures and assumptions under constant review and will work closely with HSCB during the year to ensure a shared understanding of any changes to the projected year-end outturn.

Overview of Recurrent Financial Position for 2017/18 and Beyond

Commissioners have provided limited high level information in relation to 2017/18 and it is not possible to produce a detailed financial overview at this point. It is clear, however, that the Belfast Trust will not be in run-rate financial balance by the end of 2016/17. At this stage, the Trust's best estimate of its opening 2017/18 deficit is £42.9m as shown in Table 4.3 above.

The Trust will continue to focus its efforts on containing costs within the income levels established at the beginning of each financial year. The Trust will ensure, as always, that service developments are not initiated without first securing recurrent funding. The Trust will also continue to pursue any unnecessary costs and will endeavour to maximise efficiencies where possible although it would appear, given the scale of the financial challenges ahead, that system wide change will be required to generate the level of savings required. Where unforeseen inescapable cost pressures do emerge, or where performance is at variance to the Trust's plan, continuing and regular dialogue with the HSC Board will be used as the forum to initially discuss these issues.

4.2 CAPITAL INVESTMENT PLAN

Introduction

The Capital Resource Limit (CRL) issued by DoH provides funding for the Trust to incur capital expenditure. Similar to other HSC Trusts, the Belfast Trust is required to live within its CRL.

The CRL for the Trust comprises specific capital allocations for major schemes and a general capital allocation which the Trust spends on smaller projects which are within its delegated limit.

DoH has issued a 2016/17 CRL which includes the following schemes:

Project	CRL 2016/17 £'000
Regional Children's Hospital	10,097
RGH – Maternity New Build	4,927
BCH – Mental Health Inpatient Unit	5,100
RGH Critical Care	3,449
BCH Centralisation of Endoscopy Decontamination	2,512
ICT	2,132
Congenital Heart Network	1,000
General Capital/ MES	12,379
Total	**41,596**

Approved Capital schemes

Redevelopment schemes continue across the Trust. The 2016/17 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

Work will continue on a number of major schemes. The BCH centralisation of endoscopy decontamination is scheduled to complete in 2017.

General Capital Allocation

Significant funding is required to maintain the infrastructure and replace essential equipment to ensure continuity of existing Trust services. In addition, compliance with fire code regulations and statutory standards across the Trust's estate also compete for capital funding. The Trust's general capital substantially reduced in 2015/16 compared with previous years, and 2016/17 funding levels remain low compared to pre-2015/16 levels of funding. In addition, the removal of funding for specific initiatives e.g. SAMMD, MES & CRC and a reduction in the capital threshold are increasing the pressure on a constrained capital budget. The Trust continues to allocate its available general capital funding to those schemes considered to have the highest priority.

The Trust will continue to avail of the opportunity to bid for additional capital funding through the in-year monitoring rounds.

Revenue Consequences of Capital Schemes

It is assumed that the revenue consequences of capital schemes, including any uplift required for inflationary, national insurance and superannuation increases, will be fully funded.

Asset Management

In order to achieve the regional target for the disposal of assets, the Belfast Trust, with DoH agreement, is planning to dispose of surplus land at Muckamore Abbey Hospital in 2016/17.

The Director of Finance, who has responsibility for capital planning, reports on the progress of asset disposals twice yearly through the Trust's accountability review process. The Co-director for capital redevelopment reports quarterly on progress to the Strategic Investment Group.

Annex 1

Detailed Analysis of 2016/17 Opening Position

Carried forward Position from 2015/16

As part of the 2016/17 planning process, Trusts were asked to revisit and critically review their opening positions given that all HSC Trusts achieved breakeven in 2015/16 and that run-rate expenditure appeared to have been falling in the latter part of 2015/16.

Staff expenditure run-rate in the Belfast Trust did indeed fall in the last six months of 2015/16. In the first six months, the Trust had not achieved its workforce management savings target (£18m for the year), due in part to targeted increases in staffing resulting from recent reviews such as Delivering Care, AHP and health visitor staff planning, making it more difficult to hold vacancies which had contributed to workforce management savings in previous years. The shortfall against the savings target at month 6 was alleviated in part by one-off savings in estates and a range of contingency measures. However, the position in relation to workforce management improved considerably in the last six months which is accredited to the collaborative project undertaken between directorates, finance and central nursing which led to the more effective use of the erostering system, with notable reductions in agency nursing costs. There was also a marked reduction in the use of high cost nursing agencies in the latter part of the 2015/16 year. This expenditure run-rate needs to be sustained in 2016/17 to ensure that the Trust achieves its £18m WFM target in 2016/17. In the context of growing medical agency costs and new costs in relation to international nurse recruitment this will be an enormous challenge.

The opening position for 2016/17 has been determined through a bottom-up approach, using the 2015/16 outturn as a starting point. A summary reconciliation from the 31 March 2016 position to the opening financial position for 2016/17 is shown below.

Table 4.5: Reconciliation of Opening Position to 2015/16 Outturn

	£'m
Closing 2015/16 Deficit/(surplus)	(0.09)
Add back:	
Non-recurrent slippage 2015/16	10.70
Non-recurrent water and rates rebate (re previous years)	1.25
Non-recurrent accounting adjustments	4.20
Non-recurrent Income from HSCB	3.50
Additional non-recurrent general demography funding	0.40
Non-recurrent 2015/16 Pressures	(2.75)
Non-recurrent savings against £3.6m	2.40
Opening £2m 2015/16 gap (ED, NN) addressed through contingency measures in 2015/16	1.65
Non-recurrent savings element of £16.7m plan	5.00
Other	(1.40)
Total brought forward deficit	**24.9**

Although financial balance was achieved in 2015/16, the analysis above shows that this was due to a large extent to non-recurrent slippage and one-off income or expenditure reductions.

In developing the financial plan for 2016/17, the same level of non-recurrent support cannot be assumed because:

- Anticipated slippage is much lower than in 2015/16 because:
  High cost drugs slippage: There was significant slippage in high costs drugs in 2015/16. Substantial additional high cost drugs funding was allocated late in the year but expenditure in relation to DMT and HepC drugs in the last quarter was considerably lower than anticipated.
  Other slippage: There was around £2m slippage on estates backlog maintenance expenditure in 2015/16 due in part to staff shortages along with a concerted effort to reduce the Trust's budgetary deficit. This level is not sustainable in 2016/17 given the scale of backlog maintenance.
- £3.5m of additional funding was provided in the last quarter of the year to achieve financial balance; this is not available in 2016/17
- Other non-recurrent income, for example £1.25m of rates and water rebates pertaining to previous years, is not repeatable in 2016/17
- The Trust benefitted from a one-off accounting adjustment of £3m in 2015/16 relating to a reduction in its holiday pay accrual

Opening Financial Position 2016/17

The opening TDP underlying deficit in 2015/16 was £13.5m. The £13.5m was reviewed with HSCB during the year and increased to £16.6m in January 2016 to reflect the full year effect of pressures; this was communicated formally to DoH and HSCB (letter dated 26 November refers). This underlying deficit was reviewed again recently and has fallen slightly to £16.2m. When added to the £3.6m gap in the 2015/16 savings target and the recurrent savings gap of £5m against the approved 2015/16 plan, the opening 2016/17 deficit is £24.9m. The bottom up reconciliation from the 2015/16 outturn to the opening position outlined above validates this position. In addition to this opening gap, the Trust anticipates a 2016/17 income deficit of £37.7m to arrive at a total opening gap of £62.5m. This in-year funding gap is attributable to a range of new cost pressures including demographic pressures, pay award and national insurance increases, inflationary pressures, social care price pressures and Trust specific cost pressures which have not been fully addressed by the 2016/17 additional funding allocation. These inescapable cost pressures are discussed briefly in turn below.

Learning Disability/Fostering/Interventional Radiology/Unlicensed Drugs

These cost pressures had been included in the Trust's financial plan submission to HSCB/DoH on 12 January 2016 (see Annex 3 for further detail). The learning disability pressure has fallen from £3.8m in January 2016 to £1.3m to reflect new learning disability community funding of £1.7m, in-year delays in the resettlement of clients and slippage on complex discharge funding.

National Minimum Wage (NMW) Pressure

The national minimum wage pressure of £0.53m relates to the NMW price increase from £6.20 to £6.70 in October 2015; domiciliary care prices were increased to reflect this in October 2015 but the full year effect of this increase will not be incurred until 2016/17.

Demography

Previous trends and information provided by HSCB/DoH have been used to estimate the financial impact of demographic growth in Northern Ireland for the Belfast Trust in 2016/17. We believe that the most marked increase in activity and costs will be in services for older people, impacting most significantly on our EDs and acute general medical wards and in the demand for residential/nursing and domiciliary care. We also believe that additional beds in respiratory, opened in previous years for winter pressures, are now a permanent requirement and require recurrent funding. There will also be cost increases across a range of areas including oncology/ haematology where year on year demand has been increasing.

The 2016/17 in-year demography pressure is expected to be in the region of £7m (FYE £9m). The Trust is setting itself a 50% savings target in relation to the anticipated demography pressure, i.e. £3.5m, which will be achieved in the main through increased productivity and new ways of working. We believe recent improvements in ED and reablement have already helped us cope with a level of demographic growth and that this can be further developed to some extent, for example through the expansion of our programme treatment unit (PTU) and reablement service. Given the level of demographic growth absorbed by the Trust in previous years without funding, we believe that this £3.5m productivity/cash avoidance savings target will be a huge challenge for 2016/17.

National Insurance

Employers' national insurance rates will increase by almost 2% in 2016/17. Pay expenditure will increase by around £14.3m in 2016/17 as a result.

Social Care Pressures

In addition to the 2% inflationary uplift and the additional uplift of £2.5m required to fund the living wage which were included in the Trust's initial financial plan in January 2016, the following new cost pressures have been added:

- Additional 1% for nursing/residential homes to bring total uplift of the regional rate to 5% as per HSCB direction (£1.0m)
- Additional 1% for domiciliary care to bring total uplift to 5% in line with other Trusts (£0.2m)
- Additional price uplift of 1.25% for domiciliary care providers, unique to the Belfast Trust, given our specific difficulties, to stabilise the sector and ensure an adequate supply of domiciliary care services (£0.25m)
- Impact of recent unavoidable price increases by two nursing home providers (£0.3m CYE, £1.0m FYE)

It should be noted that the last pressure relates only to new clients for our main provider and one other provider and ignores any impact this will have in terms of the knock-on effect on rates charged by other providers. There is therefore a risk of further pressure arising in 2016/17 in this area.

International Nurse Recruitment Pressure

The financial plan includes a cost pressure of £1m for international nurse recruitment which comprises the administrative cost associated with recruitment as well as the cost of backfilling the new international nurses during their 'supernumerary' training period as agreed by the regional steering group. Agency cost reductions associated with the recruitment of international nurses in 2016/17 will not be fully realised until the nurses have completed training in 2017/18.

Annex 2

Proposals to Reduce 2016/17 Deficit

The Trust will start the financial year with a £62.5m deficit, comprising the £25m deficit carried forward from previous years and a £37.5m 2016/17 funding gap.

The Trust plans to reduce this gap in 2016/17 through a combination of recurrent and non-recurrent savings, in-year slippage on investments and one-off accounting adjustments. These measures are expected to reduce the 2016/17 gap by £62.5m (£19.9m FYE) without any real impact on patient and client services. The key proposals are:

- Non-recurrent June monitoring funding/additional in-year allocation from HSCB
- Recurrent and non-recurrent cash-release savings
- Regional pharmacy savings
- Recurrent productivity/cost avoidance savings
- In-year slippage
- Non-recurrent accounting adjustments

These are discussed below in turn below. Beyond this, the Trust believes further savings could not be achieved without severe implications for patients, clients and staff.

Savings Plans to address the recurrent 2015/16 Savings Gap

The financial plan includes a £5m shortfall in the Trust's recurrent 2015/16 savings plan which is included in its rolled forward gap. Planned cash efficiency savings totalling £5m had been agreed internally to meet this shortfall and had been identified in previous drafts of the 2016/17 financial plan. However, early in 2016/17, it became clear that two of the savings schemes relating to the move from learning disability and mental health day centres to day opportunities would not be implemented in 2016/17 and any future potential savings would be used to develop day opportunities. The £0.5m savings relating to those initiatives has therefore been removed from the financial plan. The breakdown of the remaining £4.5m additional savings is provided in the table below:

	£'m
Demand Management Savings- Laboratories	0.5
Sickness absence savings	2.0
Admin Savings (service and corporate directorates)	1.0
FYE Waste management savings	0.3
Other discretionary Spend- various categories	0.2
Reductions in medical locum costs	0.5
LD/MH schemes not achieved in 2015/16	0.0
Total	**4.5**

The Trust will also implement savings of £1.75m approved by HSCB and DoH in January 2016. The £1.75m comprises:

- clinical excellence awards £0.47m
- estates rationalisation/energy £0.80m
- discretionary spend £0.15m
- respite care for learning disability clients* £0.18m
- service reconfiguration in amputee ward £0.15m

**Although this plan was not rejected formally by HSCB, the Trust has decided not to proceed with this initiative on the basis of a recent assessment of respite needs and feedback from the recent consultation on LD day opportunities. Other savings will be identified to address the resulting shortfall*.

Additional Trust Efficiency Savings in 2016/17

Following the Trust's meeting with DoH and HSCB in January 2016, the Trust had set itself an additional cash-release efficiency target of £15m and directors and their teams continue to identify savings to meet this target. To date, the following **recurrent** savings have been identified

- energy savings of £3.5m
- initial pharmacy savings of £1.9m
- 2015/16 VES recurrent savings £0.6m
- orthopaedics , cardiology and other procurement savings, totalling £1.3m

The total savings identified amounts to £7.3m. In the absence of definitive schemes for the remainder of the £15m target, and following discussion with DoH and HSCB, the Trust considered that it would be more realistic to plan for total savings of £10m in-year rather than the £15m.

Initiatives aimed at achieving further recurrent savings of around £1.5m are currently being developed and are likely to focus on the rollout of erostering work with ward sisters/charge nurses and additional administration and management savings. Workforce control and other contingencies are likely to make up the residual £1.2m. This needs to be set in the context of recruitment and agency pressures and the fact that there is risk associated with the existing £18m workforce target.

In addition to the pharmacy savings identified above as part of the Trust's 2016/17 savings plan, a further £1.3m of savings has now been identified in conjunction with the regional procurement hub. This will enable the Trust to meet its full regional pharmacy savings target of £3.2m.

In-year Slippage 2016/17

All new service developments and all transformation projects have been robustly reviewed for in year spendability and the potential for in-year slippage identified. In addition, Trust baselines have been reviewed and an assessment made of the level of uncommitted resources pertaining to prior year investments.

The following slippages have been identified. It is important to note that this is natural slippage, i.e. slippage due to normal delays in implementation relating to the timing of recruitment etc, and as such will not have an impact on planned service for 2016/17.

2015/16 Slippage - £1.41m

- COPD/Other 2015/16 demography £0.31m
- Specialist paediatrics £0.25m
- Neonatal services including transport £0.25m
- Children's services- high cost cases £0.3m
- Children's services- challenging behaviour £0.1m
- Children's services- other £0.1m
- Cancer drugs infrastructure £0.1m

2016/17 Slippage - £5.4m

- Phase 2B critical care – direct staffing £1.8m
- Phase 2B critical care – estates/PCSS £0.5m
- ED slippage pending recruitment of staff £1.0m
- Endoscopy suite £0.7m
- Urgent patient transport £0.9m
- CPAP £0.2m
- Other £0.3m

Productivity Savings 2016/17

As discussed in the demography section above, we are setting ourselves a 50% savings/cost avoidance target in relation to anticipated demography pressures, i.e. £3.5m, which will be achieved in the main through increased productivity and new ways of working. This will be an exceptionally challenging target given the levels of productivity savings achieved in relation to unscheduled and outpatient activity in previous years.

Accounting Adjustments 2016/17

We are assuming that the Trust will benefit from approximately £14m in terms of in-year accounting adjustments. The largest element of this relates to the reassessment of 2015/16 year end accruals following a review of extant guidance and audit advice.

Annex 3

Further Detail on Cost Pressures

High Cost Fostering Cost Pressure

Private Sector Fostering Placements are made with Barnardo's, Foster Care Associates, Action for Children and Core Assets.

The average placement of children with these private sector foster carers can cost from £800 per week to £1,800 per week depending on the specific needs of the child being placed. Placements have been required for children with complex disabilities that are currently costing around £2,500 per week in the independent sector.

From mid-2014/15 the level of referrals and the need for placements in this sector has grown sharply which had resulted in a material financial cost pressure of circa £1m by March 2016.

The growth in private sector foster care placements has come about due to a number of emerging issues as follows:

- a gradual rate of attrition in the numbers of available 'in-house' foster carers. Since January 2015, 29 foster carers have been de-registered from fostering
- impact of the growth in numbers of Looked After Children; there were circa 40 additional looked after placements in 2015/16 and the demand for placements continues to outstrip supply.
- impact of the very successful GEM scheme which means that children stay with established foster carers as they transition to adulthood. This, over time, represents a major change on previous years. In March 2014 there were 21 GEM placements, in September 2015 there were 37 GEM placements. Consequently this means that there is no throughput of available foster placements within this cohort of carers.
- private sector fostering is being perceived as being more financially lucrative. As a result, potential foster carers are more willing to sign up with private providers rather than with the Trust. Recruitment of foster carers is a significant challenge, particularly for the Belfast Trust as the four independent agencies are based in the Belfast area which increases the competition for recruitment of placements.
- The Trust experienced an increase in residence order payments by 15 placements in 2015/16 which caused additional pressure on the fostering budget.

Interventional Radiology

Interventional Radiology (IR) is currently showing a cost pressure of around £1.1m on the goods and services budget. While some increase in activity levels is contributing to this, the main reason for the pressure is changing casemix.

Technology has been evolving fast in this area. When older consultants have retired, their younger replacements have brought in skills in new techniques.

Procedures which were previously open surgery (eg vascular) are now often carried out via IR. There are also new techniques and technologies being employed where previously there was nothing to offer patients, for example to save lower limb vascular function thereby avoiding amputation.

Significantly, the IR service at BHSCT has, in the last two years, become very much regionally based which is in contrast to the service previously. For example 73% of the IR patients at RVH now have postcodes outside Belfast, and a similar % is also evident in BCH IR. The cost pressure attributable to increased used of IR stenting is approximately £0.5m. The pressure due to specialist M&S for complex procedures / new techniques is approximately £0.6m.

The reasons for increased expenditure can be further explained by:

- Extending indications, i.e. doing the same procedures as before, but on a wider range of patients
- Incremental improvements in existing medical devices, with associated increased cost.
- Changing referral patterns, i.e. different clinical groups starting to request procedures already done in IR.
- Completely new treatments, with newly developed devices.
- Increasing regional organisation in multidisciplinary meetings resulting in more patients being referred in for complex procedures from around the province.

Learning Disability

The £1.3m in-year LD cost pressure consists of a number of items that have been funded non-recurrently for several years by HSCB. HSCB has been able to provide non-recurrent funding because of slippage on our resettlement requirements and slippage from other Trusts.

Unlicensed Drugs

These were traditionally funded via the individual funding request (IFR) route until 2014/15 when the HSCB decided that the decision on whether to use any unlicensed drugs costing less than £50k would fall to Trusts and that Trusts would now bear the

costs which had effectively been fully funded previously by HSCB. The Trust responded to advise that this would have a financial impact. HSCB acknowledged that there would be a financial impact and allocated £200k non-recurrently in 2014/15 in respect of the reported Trust pressure. HSCB also provided £200k, again non-recurrently, in 2015/16. No funding has been allocated for 2016/17 and the Trust assessment is that costs of at least £200k will materialise in relation to unlicensed drugs.

4.2 Workforce Strategy

The Commissioning Plan for 2016/17 sets out the priorities to be taken forward by the Trust, to support the realisation of the HSC three strategic themes and statutory obligations identified by the Minister:-

- To improve and protect population health and well-being and reduce inequalities;
- To provide high quality, safe and effective care; to listen to and learn from patient and client experience(s); and to ensure high levels of patient and client satisfaction;
- To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred

The Belfast Trust in 2016/17 will launch its updated People Strategy that is also inextricably linked to the purpose of the Trust:-

'to improve health and well-being and to reduce health inequalities'

and to the realisation of its ambition set out within its Organisational Development Framework, 'Realising our ambition to be a World Leader in the provision of health and social care'

These will also incorporate the key workforce actions required to support the delivery of the Commission intent as set out within the Themes and in the Trust Delivery Plan.

4.2.1 To improve and protect population health and wellbeing and reduce inequalities

In 2016/17 a summary of the key Workforce Strategies relevant to the Trust Delivery Plan and set out within the Commissioning Intent Themes are as follows:

4.2.1.1 Improving Health and Wellbeing

The Trust will further roll out and champion the newly revised approach to staff health and wellbeing through its award winning **b well** initiative, focussed on helping staff to look after their own wellbeing. This includes a range of programmes and resources including the two new interactive tools for staff, the b well website (www.bwellbelfast.hscni.net) and the b well app. The annual wellbeing themes for 2016/17 are mental and emotional wellbeing and the ageing workforce, and a number of activities and initiatives will take place throughout the year to raise awareness. The Bwell Steering Group will approve a new Health and Wellbeing Strategy and Action

Plan, including a robust communication and marketing plan and the introduction of a wellbeing survey and Directorate wellbeing scorecards.

4.2.1.2 Attendance Management

The Trust will continue to build on the successful 5.4% reduction in sickness absence levels as achieved in 2015/16. A new Sickness Absence Focus Group comprising of representatives from Occupational Health and Human Resources has been established to collaborate with key stakeholders to enable the reduction of sickness absence across the Trust. The Group will review existing evidence surrounding the management of sickness absence, consider optimisation of current processes, systems and infrastructures, and clarify roles and responsibilities at organisational, management and employee level in addressing sickness absence.

Further actions will include the establishment of revised sickness absence targets for each Directorate and Co Director area, evaluation of the 2015 Attendance Management Initiative, delivery of bespoke and mandatory training for managers and staff, further promotion and roll out of the Manager's Toolkit on Managing Absence and completion of the 3 yearly review of the Managing Attendance Protocol.

The Trust will continue to monitor the recommendations as set out in the BSO Attendance Management Audit conducted in 2015. The Attendance Management Team will continue to provide specialist advice and support in relation to complex cases to managers, including establishment of close partnerships with key individuals via the new HR Business Partner model.

4.2.1.3 Flu Vaccination

To ensure maximum uptake of flu vaccination amongst the Belfast Trust employees during the 2016/17 flu campaign, preparations commenced in April 2016 for the Trust's annual flu vaccination campaign. A Flu Vaccination Action Plan has been compiled and includes how we will ensure our staff receive regular, informative messages about the importance of having flu vaccination. The plan also includes a target to recruit 450 peer vaccinators to ensure staff can readily access flu vaccinations and the need to have readily available and localised data to allow close monitoring of our progress. A Flu Action Plan Co-ordination Group will be set up to oversee, co-ordinate the action plan and share best practice.

Advice has been sought from Trusts in England who achieved 60-70% uptake amongst their employees. A number of successful initiatives used in these Trusts will be implemented within the Belfast Trust.

4.2.1.4 Improving Working Lives

A range of initiatives are in place to ensure the Trust remains an Employer of Choice. The Trust's ninth Summer Scheme will be extended to a fourth venue for the first time, increasing scheme places to approximately 450 children of staff - enabling staff to work more effectively to meet service needs over the school holiday period. A scoping exercise will be undertaken in relation to further expansion of childcare provision during other school holiday periods.

The full range of Improving Working Lives initiatives including the work life balance policies, child care vouchers and special leave arrangements (in particular the new Shared Parental Leave entitlement) will be promoted and facilitated through a programme of HR Drop In Clinics, staff health fairs, training courses and the b well website. Further initiatives including support for staff who are carers will be explored.

4.2.1.5 Employment Equality

The Trust will work to achieve the objectives set out in its third Employment Equality and Diversity Plan 2014–2017 with a particular focus on continuing to provide mandatory equality training for staff and managers. The recommendations of the Trust's second Article 55 review under FETO will be taken forward in 2016/17 in relation to agreed affirmative action and outreach measures with the Equality Commission and Section 75 employment equality screening responsibilities will be met. As an accredited employer of excellence by Employers for Disability the Trust will continue to develop its employability and best practice initiatives for staff with disabilities under the Disability Action Plan.

4.2.1.6 Development of Section 75 Action Based Plan to address inequalities

The Trust will engage and formally consult with key stakeholders on the development of its forthcoming Section 75 inequalities action based plan, which will span the period 2017-2022. It is imperative that the Trust involves Section 75 representatives and individuals in the formulation of the plan so that it is meaningful, relevant and timely in terms of the inequalities that it will address. The Trust's Action Based Plan to promote equality of opportunity and good relations is based on the functions of the Trust and will be implemented through the Framework of the Trust's Equality Scheme. The measures contained within this Plan are linked to the Trust's Corporate Plan in order to ensure that equality of opportunity and good relations are incorporated and mainstreamed at a strategic level into the business of the Trust and aim to address inequalities in health and social care for all of the S75 categories – men, women, persons with and without a disability, persons with or without dependants, persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation. This will constitute the Trust's third action based plan.

4.2.1.7 Disability Action Plan 2017-2022

Similarly to the aforementioned point, the Trust will involve disability representative organisations and people with a disability in the conception of a new Disability Action Plan. Under the Disability Duties in Northern Ireland, the Trust is required, when carrying out its functions, to have due regard to the need to: promote positive attitudes towards disabled people; and to encourage participation by disabled people in public life .Under Section 49B of the DDA 1995, the Trust is also required to submit to the Equality Commission a Plan showing how it proposes to fulfil these duties in relation to its functions. The Trust works collaboratively with other HSC Trusts and bodies in the

development and delivery of the actions to maximise resources and to ensure regional consistency.

4.2.1.8 Good Relations Strategy

The Trust will evaluate the effectiveness of its Good Relations Strategy "Healthy Relations for a Healthy Future" and its associated action plan during this period. This evaluation along with pre-consultation with key stakeholders and partnership working with the Belfast City Council with help inform the development of a new action based plan to promote good relations amongst people of different religious beliefs, racial backgrounds and political opinions. It is envisaged that this work will help encompass and mainstream the aims of the Executive Office's strategy Together Building a United Community within the Trust's functions.

4.2.1.9 Human Rights Based Approach in Emergency Department

The Trust will progress its pioneering pilot work in the Emergency Department by developing a human rights based approach. This work is overseen by the Human Rights Steering Group and is conducted in partnership with the Northern Ireland Human Rights Commission. It is anticipated that a suite of digital training resources and a decision making framework based on human rights will be two of the tangible outcomes from the project.

4.2.2 To provide high quality, safe and effective care; to listen to and learn from patient and client experience; and to ensure high levels of patient and client satisfaction

4.2.2.1 Organisational Development

In 2015/16 the Belfast Trust Organisational Development (OD) Framework 'Realising our ambition to be a World Leader in the provision of health and social care' was developed, informed and agreed. In 2016/17 the Trust will commence its journey of realising this shared ambition. It is characterised by leading and embedding a culture of continuously improving, high quality safe, compassionate health and social care and how we will make this a reality. Using this Framework we aim to improve outcomes for our patients and clients by delivering positive change across three priority areas. These priorities were identified through discussion with our staff, patients and clients, from the findings of Francis, Berwick, Donaldson and others and through leading edge research including the King's Fund and the Institute of Health Improvement. They are:-

- Safety and Quality : to deliver safe and improving high quality care
- Research and Innovation : to drive continuous improvement through research and innovation

- Collective Leadership : to grow a culture of collective leadership where everyone at every level has the capacity to deliver improvements for our Trust as a whole, not just their own roles of work areas

The implementation of the Trust's OD Framework has been identified as one of the six key themes to be progressed in 2016/17.

In 2016/17 in support of implementation of the Trust's OD Framework, the following key actions will also be taken on Leadership, Learning and Development:-

- To launch and commence implementation of the new Trust 'People Strategy' and embed caring supporting improvement together
- To commence implementation of the updated 'Leadership and Management Framework', driving forward collective leadership
- To continue implementing the Trust's Learning and Development Strategy 'Growing our People Today for Tomorrow' focusing on safety, quality and continuous improvement, succession planning, engagement, values and team development
- Support the implementation of Quality 2020 through the development and provision of training aligned to the quality attributes framework and in line with the Trust Quality Improvement Plan
- To implement Supporting Belfast (2), a learning and development strategy for Support Workers Bands 1 – 4
- To develop a continuous improvement plan for IiP and identify and commence actions for transition to Generation I
- To work towards increasing Employee Engagement levels within the Trust and to improve engagement with Medical staff across the Trust

4.2.2.2 Quality 2020

In our Trust's Organisational Development Framework, launched April 2016, we have set out Safety and Quality as a core priority alongside collective leadership and research and innovation. The Framework clearly sets out our commitment to grow the culture and behaviours to sustain safety and quality, in line with Quality 2020, and supported by life-long learning. We aim to develop internal capacity and capability for safety and quality across all our working practices and also to implement planned activities that directly and positively impact how we protect and improve the safety and quality of the health and social care we deliver.

We have been making steady progress to build on the foundations for Safety and Quality and will further develop and strengthen these in 2016/17. In particular we plan to develop a Safety and Quality strategy for the Trust that will be launched as part of our annual 'Safetember' campaign that is designed to further engage staff to focus on patient and client safety and quality improvement and support a culture which prioritises the quality of care above all else and delivers a relentless pursuit of continuous quality improvement.

4.2.2.3 Level 1 Awareness Quality Attributes Framework

The Trust has completed a scoping exercise to determine how our in house training programmes support participants to meet the requirements of Level 1 awareness of the Quality 2020 Attributes Framework. The content of these programmes has subsequently been refreshed to ensure that all aspects of level 1 are integrated and effectively covered e.g. nurse support induction programmes, accredited programmes for healthcare support, Clinicians induction programme. Further to this exercise, a short classroom based learning programme was designed and incorporated into our annual published training portfolio that is open for application for all staff. In addition to this, bespoke awareness training sessions are provided to groups of staff in their own locality. We have used our established communication methods and networks to promote the availability of these and, in particular, we have targeted information at 'hard to reach' staff who are not desk based, such as home care staff and patient and client support services. Further to the launch of the regional Level 1 E learning in June 2016, we plan to widely publicise its availability to staff as an effective and efficient means of completing training. We plan that through a combination of existing programme content, specific level 1 awareness training, bespoke targeted workshops and E learning that we will meet the target of 10% of our workforce to have met Level 1 awareness by March 2017.

4.2.2.4 Level 2 Delivering Improvement Quality Attributes Framework

In 2015/16 a new Quality Improvement programme that is aligned with Level 2 of the Quality 2020 attributes framework has been designed and delivered to the inaugural cohort of 53 participants.

The programme successfully launched in December 2015 and provides a combination of monthly seminars by expert speakers, online IHI modules and participation in a multi-disciplinary improvement project. All of the design and programme arrangements have been undertaken by the working group comprising the two Patient Safety Leads, Human Resources and an Adept Trainee supported by a wider network of QI mentors.

Participants have identified and are working on completion of 19 improvement projects that have been aligned with the Trust's Quality Improvement plan.

Plans are now in place to significantly extend this training opportunity through the provision of training to a cohort of 150 people who will commence in September 2016.

4.2.2.5 Level 3 & 4 Driving and Directing Improvement Quality Attributes Framework

In 2016/17 we plan to undertake further scoping to determine the staff groups to target to meet the requirements of level 3 and 4 of the Attributes Framework and to identify suitable training programmes that can be provided to meet these needs.

4.2.3 To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred

4.2.3.1 Workforce Modernisation

The Trust has a track record of implementation of its Strategic Reform and Modernisation programmes. A main focus of the Trusts Workforce Management efficiencies continues to be absence management, workforce productivity, reduction in backfill, review of agency and locum expenditure, vacancy management, harmonisation of staffing levels grade and skill mix.

An integral aspect of the Human Resources Modernisation and Workforce Planning Team within the Trust is supporting the Trusts Strategic Reform and Modernisation programmes, leading effective change management in support of service redesign, implementing service reconfiguration and making change happen.

In 2016/17 in order to achieve and support the successful delivery of the Trust's Delivery Plan and Reform and Modernisation programme the following workforce actions have been identified:-

- To support the development of New Directions (2), Improving Elective Care and Unscheduled Care and supporting more people to live at home.
- We will continue to engage and consult with our Trade Unions at local and regional level, as applicable, and the local community and other key stakeholders as set out within the Trust's updated 'Good Practice Consultation and Communication Guide'

4.2.3.2 Workforce Planning

Inextricably linked to Workforce Modernisation is Workforce Planning. In 2016/17 the focus will be on developing a Trust wide high level workforce plan to support New Directions 2 and to create a programme to develop Service Directorate Workforce Plans each covering a five year time frame.

In 2016/17 progress against the workforce plan developed for the period 2015 to 2020 within the Adult Social & Primary Care Directorate will be monitored and evaluated.

4.2.3.3 Medical Recruitment and Retention Strategy

The Trust will work to ensure that the actions agreed within the recently approved Medical Retention Recruitment Strategy are completed to ensure the Trust realises its aim of becoming an employer of choice for medical staff and an organisation that is recognised as caring both for its staff and service users.

This strategy has the following 5 key overarching aims which the Trust will be focusing on this year:

- Raise the profile of the Trust as a great place to work and as an 'Employer of Choice'
- To introduce new and innovative ways of recruiting 'hard to fill' medical posts and to maximise the effectiveness of recruitment advertising
- Improve medical workforce planning and explore the introduction of new roles and ways of working.
- To explore what incentives can be offered by the Trust.
- Improve staff retention, overall job satisfaction and medical engagement.

4.2.3.4 Medical Agency and Locum

The Trust are committed to reviewing current practices across the Trust in relation to the appointment of locum and agency medical staff with the overarching aim of optimising resources whilst reducing costs and have accordingly established a Medical Workforce Sub-Group tasked with achieving this aim.

In the context of the above mentioned Retention and Recruitment Strategy for Hard to fill Medical Posts, the Medical Workforce Sub-group will:

- Undertake a review of current medical vacancies across the Trust and the means by which those vacancies are currently being filled.
- Share best practice and consider innovative ways to fill long standing medical vacancies.
- Undertake a review of current practices within directorates in relation to the appointment of locum and agency medical staff in order to standardise processes and to ensure consistency of practice.
- Encourage and promote the use of HSC E-locums for filling junior doctor and middle grade posts
- Develop and implement a standardised template for recording medical agency information
- Reduce the cost of both locum and medical agency spend across the Trust

4.2.3.5 Workforce Governance

The Safer Recruitment and Employment Group will develop and progress the annual Action Plan for 2016-17. Key issues include the Trust's Safer Recruitment and Employment Framework, associated Audits and transition to Shared Services Recruitment, Policy Reviews, Working Time Regulations and the introduction of new regional Controls Assurance Standards. The Trust will participate in BSO Audits and take forward appropriate action in relation to the 2016/17 Audit Plan with a particular focus on audit of Agencies and Locums.

4.2.3.6 BSTP / HRPTS / Shared Services

The transition of transactional Recruitment services to BSO was phased in over a period of six months to allow for an appropriate transfer of services whilst maintaining

an effective recruitment function for the Trust. Compounded by significant workforce shortages in key professional areas, the transition to Recruitment Shared Services has been difficult and has resulted in delays in filling posts. The HR team has worked hard to identify any delays within our own processes and has committed the time of a senior manager to meet with directorate leads on a weekly basis to resolve any issues. The BSO has developed a Recovery Plan for the Recruitment Service and has established a Task and Finish Group which meets fortnightly to review progress; the Trust is represented at Co-Director level on the group. During 2016/17 we will continue to work in partnership with the BSO to ensure sustained improvement in the delivery of the recruitment service.

Despite the challenges previously outlined, the HR directorate continues to develop innovative approaches to recruitment such as the very successful 'Recruitment One Stop Shop' initiatives. In 2016/17 we will continue to utilise this blueprint for future recruitment campaigns in order to give the Trust a competitive advantage at a time of significant workforce shortages in key professional groups.

4.2.4 Maximising Opportunities for Innovation

In response to feedback from the HR Survey and in recognition of the increasing pressures to meet payroll closedown deadlines, 'Your HR – Delivering Excellence' was developed. A new model of service delivery, 'Your HR' has a three tier approach to the delivery of HR services including a dedicated telephone number for contacting the HR team, a HR portal which contains a wealth of information and answers to Frequently Asked Questions and direct access to more specialist advice as required. The introduction of 'Your HR' has improved communication for staff contacting the HR directorate and has improved overall customer satisfaction with the HR service. 'Your HR' will continue to be developed in 2016/17 as part of the directorate's commitment to the provision of a professional, timely and responsive HR service to meet the needs of the Trust. 'Your HR' has been shortlisted for the HPMA National Awards in the Innovation category.

4.2.4.1 'Your HR – Delivering Excellence'

In response to feedback from the HR Survey and in recognition of the increasing pressures to meet payroll closedown deadlines, 'Your HR – Delivering Excellence' was developed. A new model of service delivery, 'Your HR' has a three tier approach to the delivery of HR services including a dedicated telephone number for contacting the HR team, a HR portal which contains a wealth of information and answers to Frequently Asked Questions and direct access to more specialist advice as required. The introduction of 'Your HR' has improved communication for staff contacting the HR directorate and has improved overall customer satisfaction with the HR service. 'Your HR' will continue to be developed in 2016/17 as part of the directorate's commitment to the provision of a professional, timely and responsive HR service to meet the needs of the Trust. 'Your HR' has been shortlisted for the HPMA National Awards in the Innovation category.

4.2.4.2 Electronic Document and Record Management System (EDRMS Solution Build)

EDRMS is a business improvement project which has transformed how we operate in HR. All 27,000 current staff files (including bank) are now available to HR online. The project has enabled us to develop in partnership with Microsoft, automated intelligence, internal IT – a bespoke online integrated HR record management system. The EDRMS Project has been fully implemented and is now moving into Benefits Realisation phase. A Benefits Realisation Plan is being developed and will provide actions for the year 2016/17.

Significant benefits have been delivered, not least from the integration of MS technologies to transform HR business processing in how HR information is accessed, shared and stored – as a springboard to more effective and efficient HR business working to deliver quality improvements in HSC service provision for the Trust. Additional benefits over the coming year will result in a reduction of costs in respect of offsite storage for HR records which will no longer be required. This will contribute to the Directorates savings; costs and the electronic documents record system will also improve data security thereby meeting internal audit requirements and improved governance. HR staff have used the opportunity to develop new skills as HR champions for their own HR area and all HR staff have acquired new knowledge and skills in IT and streamlining their services.

4.2.4.3 Digitalisation

In 2016/17 we plan to develop a technology strategy to maximise the use of digital technologies to support a range of HR functions. We will introduce and up-skill staff to use a range of digital learning technologies and scope the use of online technologies to support pre-boarding and on-boarding activities and expand our current model of delivery for Statutory and Mandatory training.

4.3 Capital Investment Plan

4.3.1 Introduction

The Capital Resource Limit (CRL) issued by DHSSPS provides funding for the Trust to incur capital expenditure. Similar to other HSC Trusts, the Belfast Trust, is required to live within its CRL.

The CRL for the Trust comprises specific capital allocations for major schemes and a general capital allocation which the Trust spends on smaller projects which are within its delegated limit.

The DHSSPS have issued a 2016/17 CRL which includes the following schemes:

Project	**CRL 2016/17 £'000**
Regional Children's Hospital	10,097
RGH – Maternity New Build	4,927
BCH – Mental Health Inpatient Unit	2,500
RGH Critical Care	3,449
BCH Centralisation of Endoscopy Decontamination	2,512
General Capital/ MES	10,753
Total	**34,238**

4.3.2 Approved Capital schemes

Redevelopment schemes continue across the Trust. The 2016/17 capital programmes cover a wide area of service provision and are in line with previously agreed investment priorities.

Work will continue on a number of major schemes. The Trust will require the CRL to be increased for the Mental Health Inpatient Unit to allow it to meet its contractual commitments

The BCH Centralisation of Endoscopy Decontamination is scheduled to complete in 2017.

4.3.3 General Capital Allocation

Significant funding is required to maintain the infrastructure and replace essential equipment to ensure continuity of existing Trust services. In addition, compliance with fire code regulations and statutory standards, across the Trust's estate, also compete for capital funding. The general capital programme is not only constrained by the availability of capital funding but also the Trust's delegated limits. The DHSSPS are currently reviewing Trusts' delegated limits with a view to increasing them. The Trust's General Capital substantially reduced in 2015/16 compared with previous years and 2016/17 funding levels remain low compared to pre 2015/16 levels of funding. In addition, the removal of funding for specific initiatives e.g. SAMMD,MES & CRC and a

reduction in the capital threshold are increasing the pressure on a constrained capital budget The Trust continues to allocate its available General Capital funding, to those schemes considered to have the highest priority.

The Trust will continue to avail of the opportunity to bid for additional capital funding through the in-year monitoring rounds.

4.3.4 Revenue Consequences of Capital Schemes

It is assumed that the revenue consequences of capital schemes, including any uplift required for inflationary and superannuation increases, will be fully funded.

4.3.5 Asset Disposal Plan

In order to achieve the regional target for the disposal of assets, the Belfast Trust, with the DHSSPS's agreement is planning to dispose of surplus land at Muckamore Abbey Hospital in
2016/17.

The Director of Finance, who has responsibility for capital planning, reports on the progress of assets disposals twice yearly through the Trust's accountability review process. The Co-Director for Capital Redevelopment reports quarterly on progress to the Strategic Investment Group.

5.0 Governance

5.1 Introduction

The Board of Directors of the Belfast HSC Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, visitors and staff and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled.

The Assurance Framework is an integral part of the governance arrangements for the Belfast HSC Trust and should be read in conjunction with the Corporate Plan.

The Assurance Framework (and Principal Risk Document) describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation.

5.2 Assurance

The Board can properly fulfil its responsibilities when it has a full grasp of the principal risks facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

The Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of reasonable rather than absolute assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

The Assurance Framework defines the approach of the Board of the Belfast HSC Trust to reasonable assurance. It is clear that assurance, from whatever source, will

never provide absolute certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

5.3 Assurance Framework

The Board has an approved Assurance Framework; this was reviewed and updated in June 2015 to reflect changes to the structure of the Trust and the process of setting objectives in response to DHSSPS and HSCB commissioning targets at that time. During 2016 a further review is planned and an interim updated version is scheduled for approval in July 2016. The Assurance Framework outlines the Chief Executive's overall responsibility and accountability for risk management. The Framework also sets out a system of delegation of responsibility at Trust Board, Executive Team and Directorate levels. While ensuring local ownership in managing and controlling all elements of risk to which the Trust may have been exposed, there is a clear line of accountability through to Trust Board.

The Assurance Framework allows an integrated approach to performance, targets and standards which include controls assurance standards and quality standards for health and social care. The Assurance Framework describes the relationship between organisational objectives, identified potential risks to their achievement and the key controls through which these risks will be managed, as well as the sources of assurance surrounding the effectiveness of these controls. The Assurance Framework incorporates the Risk Management Policy and establishes the context in which the Belfast Trust Management Plan was developed, as well as determining the mechanism through which assurances were provided to the Trust Board.

5.4 Risk Management

Risk management is at the core of the Belfast HSC Trust’s performance and assurance arrangements. The Trust Board has approved a Risk Management Strategy and the associated Risk Management Action Plan which was reviewed and updated in June 2015 and this scheduled to be completed for the current year in July 2016. The Strategy is underpinned by its policy on risk. The Trust has established an Assurance Committee whose membership includes a Non-Executive Director and is chaired by the Trust’s Chairman. This provides Board level oversight in this key area. The Assurance Committee reports directly to the Trust Board. This Committee, along with the Audit Committee, will continue to scrutinise the effectiveness of the Risk Management Strategy. The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service. The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will continue to involve its service users, public representatives, contractors and other external stakeholders in the implementation of the Risk Management Strategy.

Risk management is integral to the training of all staff as relevant to their grade and situation, both at induction and in-service. To support staff through the risk management process, expert guidance and facilitation has been available along with access to policies and procedures, outlining responsibilities and the means by which risks are identified and controlled. Actions taken to reduce risk have been regularly monitored and reported with trends being analysed at Directorate, Corporate and Board levels. Dissemination of good practice has been facilitated by a range of mechanisms including systems for the implementation and monitoring of authoritative guidance, clinical supervision and reflective practice, performance management, continuing professional development, management of adverse events and complaints, multi-professional audit and the application of evidence based practice.

5.5 Assurance Committee/Assurance Group

The Assurance Committee is supported by an Assurance Group which is chaired by the Chief Executive. The Assurance Group last reviewed its membership and terms of reference in June 2015, and will be considered in September 2016 as part of current review of the Assurance Framework. It has an established sub group, the Risk Register Review Group that scrutinises the evaluation of all significant risks arising from Directorate and Controls Assurance Risk Registers. The Assurance Group has reviewed its arrangements to scrutinise the efficiency and efficacy of the professional and advisory committees and Directorate assurance committees to consolidate the arrangements for integrated governance. Each Directorate has maintained and further developed systems to identify risk, assess impact and likelihood of harm occurring, and to maintain control in line with the Assurance Framework and the Risk Management Strategy. These risks are used to populate e operational Risk Registers, which are updated on an on-going basis and which feed into the Belfast Trust's Corporate Risk Register and Assurance Framework Principal Risks and Controls.

5.6 Controls Assurance Standards

Controls Assurance will remain a key process for the Belfast Trust. The Belfast Trust has identified key Directors to be accountable for action planning against each standard. The results will continue to be used to inform the Trust's corporate risk register and will be mainstreamed with other aspects of the Trust's Delivery Plan through the Assurance Framework as required.

The Belfast HSC Trust assessed its compliance with the Controls Assurance Standards and achieved substantive compliance against all twenty two standards in 2015/2016.The Trust has developed individual action plans for each standard to provide on-going improved compliance and address any gaps in controls or assurance identified in the self-assessment process.

6.0 Promoting Well-being, PPI and Patient Experience

The Trust believe that investment in prevention is a key contributor to reducing future demand for health and social care and therefore we will drive and support the implementing of Making Life Better the whole systematic strategic framework for public health. The Trust will work in partnership across health and social care, government departments and a range of delivery organisations in statutory, community, voluntary and private sectors to coordinate action to improve health and reduce health inequalities. This will include delivery on the main themes of

- Giving Every Child the Best Start
- Equipped Throughout Life
- Empowering Healthy Living
- Creating the Conditions
- Empowering Communities
- Developing Collaboration

The Trust will continue to work with the whole Belfast population while targeting programmes at key disadvantaged groups i.e. BME, travellers, LGB&T, looked after children, older people, men, disadvantaged communities and those with a disability. The Trust will also further develop evidenced based health improvement programmes, information and support services covering a wide range of area's including obesity, tobacco, suicide prevention and self-harm, alcohol, sexual health, poverty – fuel, food and financial, long term conditions, early intervention and parenting programmes.

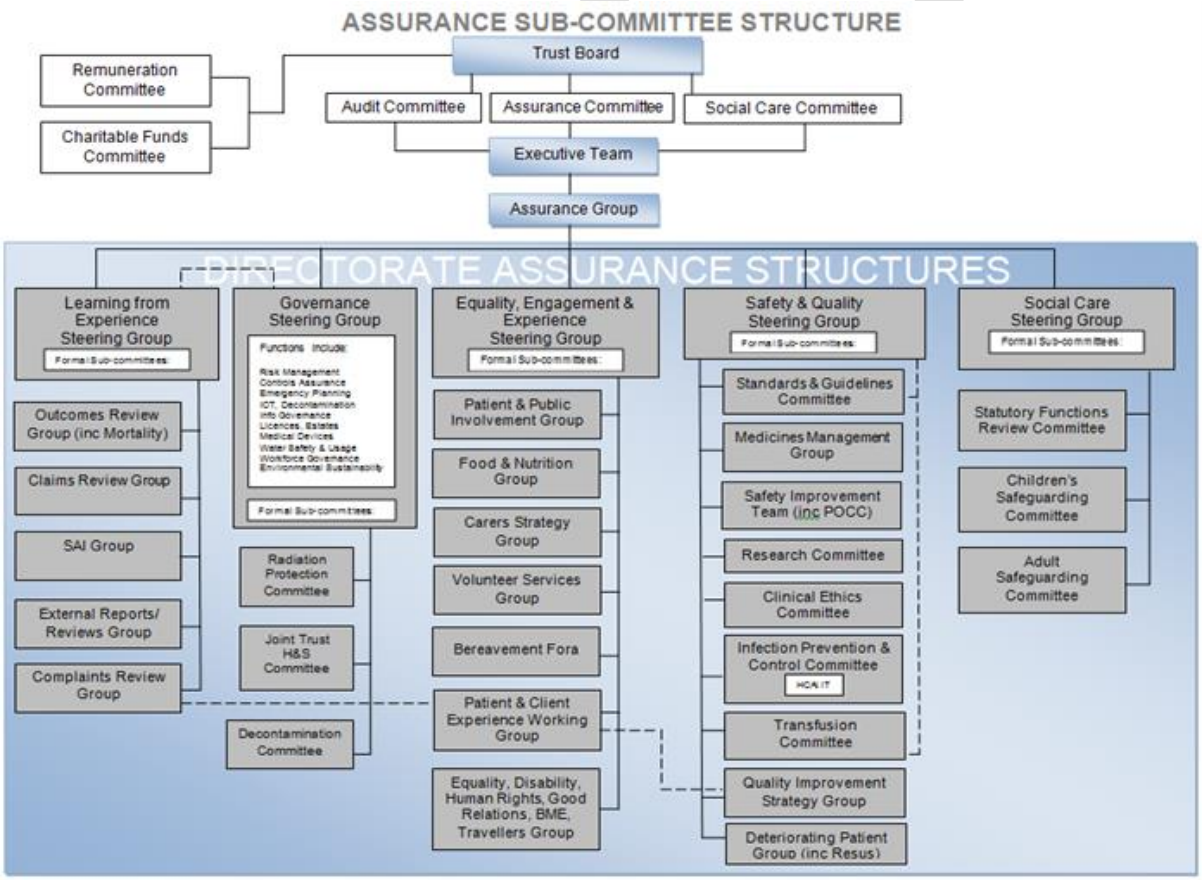
The Trust will continue to integrate health improvement and community development principles into all Directorate's planning and activities, to ensure the achieving of Making Life Better objectives and encourage healthier choices. This work will be supported by the Trust Health Improvement and Community Development teams, with effort targeted on reducing inequalities in health and wellbeing. In particular, the teams will work closely with Trust Directorates, the local community, the Local Commissioning Group and Integrated Care Partnership's to ensure prevention is given priority.

The Health Improvement and Community Development Teams will work with local community groups and partnerships to support them in improving the health of the local population, through training, advice, funding and delivery of programmes.

The teams will continue to look for innovative ways to improve the service that we deliver within reduced resources and we will maximise this potential by exploring new opportunities of working in partnership. In particular, the Trust will continue to work with the Public Health Agency and Belfast City Council through the Belfast Strategic Partnership to contribute to the implementation of the Framework of Action as well as supporting community planning with local government, to improve health and social wellbeing and reduce health inequalities.
The Trust has recently launched a new PPI Framework which will further support the development of PPI across the organisation. This framework will enable the Trust to continue to embed PPI in all Directorates and adhere to the standards and key performance indicators for PPI.

The Trust will continue to deliver PPI training for staff, using the recently launched Engage and Involve training programme. This training aims to provide a context for PPI within Health and Social care and to increase awareness and demonstrate the value of PPI. It offers staff an opportunity to develop the knowledge and skills needed to facilitate PPI and encourage them to reflect on current practice and areas for development. The Trust will continue to be represented on the Regional PPI Forum and its associated sub-groups.
Within the Trust Framework Directorates will be supported to develop PPI Action Plans for their services and the Trust will ensure that accountability is strengthened by reporting to Trust Board via the Engagement, Experience and Equality assurance group.

The Trust will work with the PHA to develop regional initiatives to support PPI and will continue to be active in taking a community development approach to working with community and voluntary sector partners to explore opportunities for engagement.
The Trust will continue work with the PHA to look at systematic evaluation of PPI activity.



MAHI - STM - 300 - 2996

Belfast Health and Social Care Trust

Minutes of the 26th Assurance Group of the Belfast Health & Social Care Trust

Boardroom, BCH

Wednesday 22 April 2015

Present

Dr Michael McBride	Chief Executive (Chair)
Mr Martin Dillon	Deputy Chief Executive / Director of Finance, Estate & Capital Planning
Dr Cathy Jack	Medical Director
Ms Brenda Creaney	Director of Nursing & User Experience
Mrs Bernie Owens	Director of Unscheduled & Acute Care
Mrs Jennifer Welsh	Director of Surgery & Specialist Services
Mr Damian McAlister	Director of Human Resources & Organisational Development
Mr Cecil Worthington	Director of Children's Community Services
Mr Shane Devlin	Director of Performance, Planning & Informatics
Mrs Bronagh Dalzell	Head of Communications
Ms Claire Cairns	Co-Director, Risk & Governance

In Attendance

Mr Colin McMullan	Senior Manager, Corporate Governance
Ms Fiona Gribben	Assurance Co-ordinator

1.0 Apologies

Mr Brian Barry	Director of Specialist Hospitals & Women's Health
Ms Catherine McNicholl	Director of Adult Social & Primary Care

2.0 Minutes of Previous meeting

The minutes of the meeting were approved.

3.0 Matters Arising

There were no matters arising.

4.0 Chair's Business

4.1 Conflicts of Interest

It was agreed to defer Item 8 re Learning from Experience to the end of the meeting when Mr Dillon will Chair. This will allow Dr McBride to leave the meeting during any specific discussion in relation to SAIs or Early Alerts, which might conflict with his role as Chief Medical Officer.

It was agreed to move Learning from Experience to the end of future agendas.
ACTION: Ms Cairns

Dr McBride asked if the extant arrangement in relation to Early Alerts has been circulated. Ms Cairns agreed to progress.
ACTION: Ms Cairns

4.2 Emerging Issues

This was discussed under Item 5.

5.0 Agenda for Assurance Committee – For Approval

Ms Cairns presented the Assurance Committee Agenda for approval. She highlighted the inclusion of a Patient Story dvd at the start of the meeting.

Ms Creaney requested that correspondence from 'Whistl UK Ltd' in relation to the SAI re Loss of Postal Correspondence be included under Matters Arising.
ACTION: Ms Cairns

Although not for Emerging Issues, Mrs Welsh asked the group to note that she proposes to raise the issue of the Urology call-back exercise. As the report is due at the end of April, she suggested it would be timely to report at Assurance Committee at this time. It was agreed to include under Matters Arising.
ACTION: Ms Cairns

A number of other issues were agreed for inclusion under Emerging Issues: Human Rights Inquiry Report Factual Accuracy Check; an update on RQIA Review of Unscheduled Care; MPH Transfer of Fracture Patients; and correspondence from the Permanent Secretary in relation to the cessation of all referrals to the Independent Sector.
ACTION: Ms Cairns

6.0 Assurance Framework

6.1 Assurance Framework Principal Risk Document inc Corporate Risk Register Extract (Draft April 2015)

Ms Cairns presented the Assurance Framework Principal Risk Document and highlighted the Risk Comparison report at Appendix 1. She advised that this report

shows which Corporate Risks are included in the PR Document and those that are not included are listed in detail.

Ms Cairns advised that updates to the Principal Risk Document are highlighted in blue, and noted that there are no new or de-escalated risks. Ms Cairns introduced Colin McMullan, the newly appointed Senior Manager, Corporate Governance.

Ms Cairns reported that 2 Corporate Risks (ENT40, AD01) have been downgraded to their respective Operational Risk Registers, and LD13 has been closed. Dr McBride referred to SQ19 in relation to Cardiac Surgery and suggested that this will require further updating to include current controls. He asked for an update on M01 in relation to Mandatory Training. Mr McAlister provided a brief outline of progress. He highlighted the intention to use elearning in preference to classroom-based training, and noted that the requirement for all staff (including administrative staff) to attend MAPA training is unnecessary. Directors agreed.

Discussion followed in relation to how best to revise the Principal Risk Document. Mr Dillon stated that once the key objectives are right, the PR Document should include the real high-stake risks to achieving those key objectives. He suggested that best practice would be to present 2 to 3 risks in detail at each Assurance Committee, when Directors could critically examine each risk in detail to ensure that the right controls are in place, and to examine the residual risk. Dr McBride agreed and stated that Assurance meetings should be structured to ensure challenge in a strategic way. He suggested proposing this to Assurance Committee. Mr Dillon advised that initially, the Executive Team will hold a workshop to decide how to do this. Mr Dillon agreed to progress with Ms Cairns.
ACTION: Mr Dillon and Ms Cairns

Ms Cairns asked the group to note that current processes are ongoing; however, since Mr McMullan is new in post, now is an ideal opportunity to look at risks afresh. Ms Cairns advised that Mr McMullan would be keen to meet with Directors individually to progress. Directors agreed.
ACTION: Mr McMullan

7.0 Internal Audit Reports

Mr Dillon advised that the Internal Audit Reports will be confirmed at Audit Committee tomorrow.

8.0 Learning from Experience Steering Group - *Dr McBride left the meeting for this Item*

8.1 Assurance Update

Ms Cairns presented the Learning from Experience Steering Group Assurance Update and gave a short overview.

Mr Dillon stated it is important to highlight at Assurance Committee the decision to include Clinical Negligence Shared Learning Reports at Speciality Mortality Review and Patient Safety meetings, and also that MMRS is at 62%.

8.2 SAI Report (Apr 2014 – Mar 2015)

Dr Jack presented the report and provided a brief summary. She advised that 89 SAIs were reported under Criterion 2 in the HSCB SAI procedure re child deaths. There followed discussion in relation to when this criteria will be removed, following the recommendation in the Donaldson report.

Mr Dillon referred to Table 6 on page 7 of the report in relation to Service User / Family / Carer Notification of SAIs, and asked if the 5 awaiting confirmation could be confirmed as soon as possible and before Assurance Committee.
ACTION: Ms Cairns

Discussion followed in relation to Shared Learning. It was agreed to include Shared Learning Reports and Safety Matters issued during the year as an Appendix to the report for Assurance Committee.
ACTION: Ms Cairns

Mr Dillon referred to Table 8 on page 9 re Emergency Department SAIs, and suggested the descriptors are quite stark. Ms Cairns explained that this information is extracted from Datix codes, however she agreed there may be further information available at this point.
ACTION: Ms Cairns

Mrs Welsh highlighted challenges with managing SAI investigations that are reliant on external organisations for expert advice. She asked the group to note that because of this, the tight timeframes set by HSCB can be difficult to achieve.

8.3 Trust Incident Report (Apr 2014 - Dec 2014)

Ms Cairns presented the Trust Incident Report April – December 2014, and gave a short summary.

Ms Creaney referred to page 11 in relation to falls and reported that although there is no regional approach; work within the Trust is ongoing. Dr Jack referred to page 24 in relation to infrastructure or resources incidents. Mr McAlister suggested it would be helpful to have sickness absence rates included. Ms Cairns agreed to investigate.
ACTION: Ms Cairns

8.4 Legal Services Quarterly Report Oct 2014 - Dec 2014

Dr Jack presented the Legal Services Quarterly Report and provided a short overview.

Mrs Welsh highlighted that Directorates do not receive detailed information on claims. Discussion followed. Dr Jack agreed that Dr Julian Johnston would be best placed to discuss cases in detail.

Mr Dillon asked for an update on progress with the correlation of information relating to claims, SAIs and complaints. Ms Cairns advised that there are challenges with providing meaningful information; however progress with the triangulation of data is ongoing. After discussion it was agreed that learning from claims is essential and remains at the core of quality improvement within the Trust.
ACTION: Ms Cairns

8.5 Complaints Quarterly Report Oct 2014 - Dec 2014

Dr Jack presented the Complaints Quarterly Report and provided a brief summary. She reported a decrease in the number of complaints received. Discussion followed in relation to 10k Voices, training in the management of complaints processes and customer care.

Mr Dillon queried if there could be further analysis of complaints in elective and unscheduled care, in and out of hours. Ms Cairns advised that the system should allow for extraction of this information and agreed to progress.
ACTION: Ms Cairns

9.0 Governance Steering Group

9.1 Assurance Update

Mr Devlin advised that Governance Steering Group meets three times annually and has not met since the last Assurance Group meeting.

9.2 Controls Assurance Report

Ms Cairns presented the Controls Assurance report and highlighted that all 22 Standards maintained substantive compliance by achieving an overall score of 75% or above. She reported that all standards maintained or improved their compliance with the exception of Infection Control, which decreased by 2% due to benchmarking, and Emergency Planning, which decreased by 1% due to reduction in resource for training in year. Ms Cairns asked the group to note that action plans are in place to support improved compliance during the coming year.

In relation to Emergency Planning and evacuation protocols, Dr Jack highlighted the significant amount of work around Phase 2B in the RVH. She advised that the Trust's lead for Emergency Planning now carries out this role part time, which is a significant ongoing gap.

10.0 Social Care Steering Group

10.1 Assurance Update

Mr Worthington presented the Social Care Assurance Update and gave a brief outline of progress to date. He advised that there is an Internal Audit of the Discharge of Statutory Functions, the report of which will go to Assurance Committee in June 2015. In relation to the Regional Social Work Strategy, Mr Worthington reported that the Trust is engaged in a regional review of social work and social care provision policies. With regards to Children's Safeguarding, he highlighted the development of a Trust-wide action plan to implement the recommendations of the Marshall Report and the pending publication and recommendations of the Thematic Review into Child Sexual Exploitation.

11.0 Safety & Quality Steering Group

11.1 Assurance Update

Dr Jack presented the Safety & Quality Steering Group Assurance Update and provided a brief summary.

11.2 Trust Quality Improvement Plan 2014 – 2015 DRAFT (inc graph set)

Dr Jack presented the Trust Quality Improvement Plan. Dr McBride expressed concern at the data in relation to children's which he said could not be submitted without further explanation. Dr Jack agreed and advised that audits have occurred but have not been recorded. She agreed to ensure the report is updated in time for Assurance Committee.
ACTION: Dr Jack

Dr McBride noted the absence of a cover sheet for the Trust Quality Improvement Plan and requested that one be provided for Assurance Committee and further meetings going forward.
ACTION: Dr Jack

11.3 Controlled Drugs Annual Report – April 2015

Mrs Welsh presented the Controlled Drugs Annual Report. She advised that the Head of Pharmacy and Medicines Management will attend Assurance Committee.

12.0 Equality, Engagement & Experience Steering Group

12.1 Assurance Update

Ms Creaney presented the Equality Engagement and Experience Steering Group Assurance Update and provided a short summary. She advised that the Food & Nutrition report will be presented at Assurance Committee in June 2015.
ACTION: Include on Agenda for Assurance Committee in June 2015

13.0 External Reports

13.1 RQIA Thematic Review Update

Dr Jack presented the RQIA Thematic Review Update and gave a brief summary.

Dr Jack highlighted a recent meeting with RQIA at which the mechanism for closure of action plans was discussed. She explained that this discussion is timely given that management of these has significant resource implications. She agreed to include this information in the cover sheet for Assurance Committee.
ACTION: Dr Jack

Dr McBride highlighted the need to discuss the link between Trust Board reports and those for Assurance Committee, and how best to use external reports as both external assurance to improve arrangements and take forward actions. He suggested presenting examples of external reports from a variety of external bodies at future meetings in order to provide assurance across the whole spectrum. After discussion, Dr McBride recommended that a select number of relevant and high-profile reports presented over the course of a year would provide a breadth of assurance.
ACTION: Executive Team to progress

13.2 RQIA Regulated Providers Inspections

This report was noted.

14.0 Professional Reports

There were no professional reports.

Ms Creaney advised that the Nursing Supervision report will be presented at Assurance Committee in June 2015.
ACTION: Include on Agenda for Assurance Committee in June 2015

15.0 AOB

There was no other business.

16.0 Details of the next meeting

Date: Wednesday 10 June 2015
Time: 9.30am
Venue: Boardroom, A Floor, BCH

MAHI - STM - 300 - 3003

Adult Social and Primary Care Directorate
RQIA Inspections
01 October 2015 to 31 December 2015

Regulated Providers Inspections

Older Peoples

Inspection Date	Facility	Facility Purpose	Inspection Type	Recommendations
08/10/2015	Carlisle Day Centre	Day Centre	Announced Estates Inspection	0
08/10/2015	Killynure	Residential Care Home	Announced Care Inspection	0
13/10/2015	Ballyowen Day Centre	Day Centre	Announced Estates Inspection	2
22/10/2015	Killynure	Residential Care Home	Unannounced Medicines Management Inspection	4

Adult Social and Primary Care Directorate
RQIA Inspections
01 October 2015 to 31 December 2015

Regulated Providers Inspections

Learning Disability

Inspection Date	Facility	Facility Purpose	Inspection Type	Recommendations
13/10/2015	Annadale	Supported Living	Unannounced Care Inspection	0
16/10/2015	80 Malone Road	Residential Care Home	Unannounced Medicines Management Inspection	0
16/10/2015	Mertoun Park	Residential Care Home	Unannounced Care Inspection	5
17/11/2015	Mica Drive Day Centre	Day Care	Announced Care Inspection	0

Mental Health and Learning Disability Wards

Inspected under the *Mental Health (NI) Order 1986*, RQIA has specific responsibility for keeping under "review the care and treatment of patients with a mental disorder"

01 October 2015 to 31 December 2015

Learning Disability

Date of Inspection	Hospital	Ward	Inspection Type	Recommendations
16/11/15	Muckamore Abbey Hospital	Cranfield Women	Unannounced Inspection	0
18/11/15	Muckamore Abbey Hospital	Moylena	Unannounced Inspection	1
24/11/15	Muckamore Abbey Hospital	Killead	Unannounced Inspection	14

Mental Health

Date of Inspection	Hospital	Ward	Inspection Type	Recommendations
26/10/2015	Mater Hospital	Ward L	Unannounced	1

MAHI - STM - 300 - 3006

Adult Social and Primary Care Directorate
RQIA Inspections
01 October 2016 to 31 December 2016 - Regulated Providers Inspections

Older People

Date of Inspection	Facility Name	Facility Type	Type of Inspection	Recommendations	Requirements	Requirement Met
07/10/2016	Ballyowen House	Residential Care Home	Unannounced Medicines Management Inspection	0	0	n/a
11/10/2016	Community Rehab Services	Intermediate Care	Unannounced Care Inspection	0	0	n/a
13/10/2016	Intermediate Care Services	Community Rehabilitation	Unannounced Care Inspection	0	0	n/a
17/10/2016	Enler	Day Care	Unannounced Care Inspection	1	5	Yes
27/10/2016	Grove Wellbeing Centre	Day Care	Announced Premises Inspection Report	2	0	n/a
15/11/2016	Chestnut Grove	Residential Care Home	Announced Premises Inspection Report	2	6	6
22/11/2016	Hemsworth Court	Supported Living	Unannounced Care Inspection	0	0	n/a

Adult Social and Primary Care Directorate
RQIA Inspections
01 October 2016 to 31 December 2016 - Regulated Providers Inspections

Mental Health

Date of Inspection	Facility Name	Facility Type	Type of Inspection	Recommendations	Requirements	Requirement Met
18/10/2016	Home Treatment House	Nursing Home	Unannounced Finance Inspection	1	0	n/a

Learning Disability

Date of Inspection	Facility Name	Facility Type	Type of Inspection	Recommendations	Requirements	Requirement Met
01/11/2016	Edgecumbe TRC	Day Care	Announced Premises Inspection Report	3	1	Yes
11/10/2016	80 Malone Road	Residential Care Home	Announced Premises Inspection Report	9	1	Yes
11/10/2016	Hanna Street	Residential Care Home	Unannounced Care Inspection	0	0	n/a
22/11/2016	Trench Park	Supported Living	Unannounced Care Inspection	4	1	Yes

Report information valid on the RQIA reports received back to Adult and Social Primary Care Directorate to date as of 6th January 2017.
Requirements – these are based on HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and the relevant regulation pertaining to the type of facility and must be met.
Recommendations – these are statements based on relevant minimum standards pertaining to the type of facility, research or recognised sources which is adopted by the registered person may enhance service quality and delivery.

Mental Health and Learning Disability Wards

Inspected under the *Mental Health (NI) Order 1986*, RQIA has specific responsibility for keeping under "review the care and treatment of patients with a mental disorder"

01 October 2016 to 31 December 2016

Mental Health

Date of Inspection	Hospital Name	Ward Name	Type of Inspection	Recommendations
14/11/2016	KHCP	Rathlin	Unannounced	11

Learning Disability

Date of Inspection	Hospital Name	Ward Name	Type of Inspection	Recommendations
28/10/2016	Muckamore	Killead	Unannounced	1

For wards – Recommendations are made in accordance with the Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in HPSS 2006.

Belfast Health and Social Care Trust

caring supporting improving together

Chief Executive
Dr Michael McBride

Chairman
Mr Peter McNaney, CBE

Ref MMCB/amu

6 December 2016

Mr Richard Pengelly
Permanent Secretary
Department of Health
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Mr Pengelly

Re: Supporting People to live in their community and the role of Supported Housing

The Belfast Health & Social Care Trust has worked closely with the NIHE over recent years to build homes within the community for many of our citizens who had previously resided within Trust facilities. In particular, additional funding had been in place for the period 2012/3-2015/6 to support 're-settlement' of people within mental health and learning disability hospitals (Bamford Review recommendations) and all parties have worked collectively to secure resources to enable the resettlement of vulnerable individuals from Muckamore Abbey Hospital and Knockbracken Health Care Park.

However, the NIHE has advised Belfast Trust that, now that the funding for the "resettlement" process under Bamford has ceased, the NIHE focus will be **"on new service developments to meet the needs of the Homeless Strategy and the implementation of the new Housing Solutions".** NIHE Supporting People team have advised that the 2016/17 Supporting People budget is capped at the 2015/16 level. This has led to paralysis on decisions about Supported Housing schemes already in planning or being considered for the future.

The scale of current planned and future developments is significant (see attached Table 1.0 for BHSCT). It is clear that any further delays in addressing the housing needs of our most vulnerable service users will have a significant negative impact on individual service users and their families.

The resettlement process is far from complete and the number of people on delayed discharge continues to grow. I am therefore requesting that the DOH and Department for Communities jointly consider how we meet the future housing needs for these vulnerable citizens who should not have a hospital ward as their address.

Yours sincerely

_____

Dr Michael McBride
Chief Executive

Enc

Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100 Fax: 028 9063 7747, www.belfasttrust.hscni.net**

Appendix 1

Table 1.0: Belfast Trust Current funding & Proposed funding from NIHE in relation to SP Schemes

	Scheme definition	Capital Resource at risk	Supporting People Revenue at risk (NIHE)	Care Revenue not at risk (BHSCT)
1a	Pre-Existing Schemes: NIHE Revenue		£ 7.1 m	
1b	Pre-Existing Schemes: BHSCT Revenue			£ 16.48 m
2	Current Schemes under development:	£ 4.7 m	£ 1.39 m	
4	Future Schemes @ 35 places per annum: revenue	£1.75 m to £2.8 m	£ 0.6 m (per annum)	
5	**TOTAL**	**£6.45m to £7.5 m**	**£ 9.09 m +**	**£16.48 m**

Notes:

- **Currently there is £7.1m of SP revenue invested in BHSCT sponsored Supported Housing Schemes and £16.477 m care investment.**
- **There is a £4.7 m capital shortfall and £1.39 m SP revenue shortfall in respect of current plans.**
- **All planned BHSCT schemes have a Strategic Outline Case lodged with the SP unit of the NIHE.**
- **In respect of predicted annual demand for supported housing based on programme of care needs assessment in Belfast an annual shortfall in SP revenue of £0.6 m pa is projected.**