Muckamore Abbey Hospital Inquiry

Organisational Module 9 - Trust Board

WITNESS STATEMENT OF MR PETER McNANEY

I, Peter McNaney, former Chair of the Belfast Health and Social Care Trust (Belfast Trust) make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (MAH Inquiry).

1. This statement is made in response to a request for evidence from the MAH Inquiry panel dated 28 March 2024 relating to Organisational Module 9 addressing issues in relation to the Trust Board. The statement is intended to address the 18 questions set out by the MAH Inquiry for Trust Board members.

2. This is my first witness statement to the MAH Inquiry. The documents that I refer to as being exhibited to this statement can be found in the exhibit bundle marked PMcN1. The 28 March 2024 MAH Inquiry request for evidence, with the accompanying questions, can be found at Tab 1 in the exhibit bundle.

3. I have answered the questions to the best of my ability and recollection. My time in the Belfast Trust relates to the period 2014 to 2023. During that time the governance arrangements in the Belfast Trust significantly evolved. I will try as best as I can to reflect, in the course of this statement, the changes made between 2014 and 2023 when I left the Belfast Trust at the end of my final term as Chair.

4. I wish to say at the outset that, in trying to explain the context of the Belfast Trust, how the Trust Board functioned, and how the governance arrangements of the Belfast Trust were intended to work, the explanation is not intended to take away from the overall duty on the Belfast Trust to provide safe care to its patients, and to account for the occasions when it fails to meet that duty.

Qualification, Experience and Position of the Statement Maker

5. In terms of my qualifications and experience, I am a solicitor by profession, qualifying in 1983. I practiced law for around 20 years and ended my legal career as Director of Legal Services in Belfast City Council. I became Chief Executive of Belfast City Council in 2001 and retired in September 2014.

6. I hold a LLB (Honours) in Law from the University of Manchester, which I obtained in 1980. I also hold a Diploma in Management Studies, which I obtained from the University of Ulster in 1998.

7. Belfast City Council is a large organisation with an annual budget of around £220m, and, when I left in 2014, it had a workforce of 2,300. However, it is dwarfed as an organisation by the Belfast Health and Social Care Trust, which has an annual budget of £1.9b, approximately 21,000 staff and 412 property sites spread across the city and elsewhere.

8. Whilst Chief Executive of the Belfast City Council I chaired the Health Inequalities Working Group for the City, but, apart from that, I had never worked in health or social care before I assumed the role as Chair of the Belfast Trust in 2014.

<u>Questions for Trust Board Members</u>

Question 1

Please identify:

i. **The time period in which you were a member of the Trust Board.**
ii. **Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub-committee(s).**

9. When I applied for the role of Chair of the Belfast Trust in 2014, I was aware that Health and Social Care (HSC) in Northern Ireland was facing considerable challenges with increasing demand and diminishing resources. I was also aware that the Belfast Trust had, within the previous two years (2012-14), faced a series of crisis. These included being fined for a serious breach of the Data Protection Act, serious overcrowding in ED with the death of two patients on trolleys, the Dental Inquiry call back, the Pseudomonas Review into the Neonatal Unit investigating the deaths of a number of babies, and being placed in Special Measures by the Minister. However, I am a great believer in public service and the principles of the Health Service and felt that I should try to make a contribution to the issues facing the Belfast Trust and the HSC. It is fair to say, reflecting back, that the role was very challenging, but it was also rewarding. I tried, with many others, to contribute to improving services and patient safety and to make the Belfast Trust's activities more transparent and accessible to the people we served. My experience of working with staff in the Belfast Trust, is that the vast majority are completely committed to the welfare of their patients and clients. They work often in very difficult circumstances and on many occasions do much more than could reasonably be expected of them. They play a vital role in caring for all of us when we can't care for ourselves. They are essential to our society and are dismayed when they hear about failures by individual staff members of the Belfast Trust to provide safe and compassionate care, such as what happened in Muckamore Abbey Hospital. Since we became aware of the issues, the Trust Board and senior staff have tried to improve care at MAH, hold to account staff who have let patients down, learn from what has happened, take whatever steps we can to improve our governance systems to minimise the risk of such things going wrong in the future, and better manage them when they do, recognising that health and social care is a high risk occupation and we must continuously support staff to enter and stay in

our caring professions reassuring them that failures will be learnt from and that they will be treated in a just and fair way.

10. The Belfast Trust is a massive organisation and I have always thought its size and complexity makes its governance very difficult. It operates a number of acute hospitals such as the Royal Victoria Hospital, the Royal Victoria Hospital for Sick Children, the Dental Hospital, the Royal Maternity Hospital, the Belfast City Hospital, the Acute Mental Health Hospital, inpatient Learning Disability (LD) services at MAH, the Mater Hospital and Musgrave Park Hospital. There are also CAHMS services at Forster Green Hospital and inpatient LD services for children at Iveagh and a number of facilities at Knockbracken. The Belfast Trust has 7 wellbeing and treatment centres, 17 health centres, 4 family centres, 29 day centres, 7 elderly people's homes, 9 residential units, a number of community buildings and a range of Trust owned and leased office buildings. In total the Belfast Trust has 412 property sites. As can be seen, the work of the Belfast Trust is not limited to the care and services it provides at hospitals. It also delivers a vast range of social care services across Belfast to support service users to live within their own communities. These social care services include the provision of elderly care, home placements, domiciliary care to over 4,000 service users, 5 supported living facilities together with the provision and operation of 11 children's homes which includes responsibility as a corporate parent for over 950 looked after children.

11. The Belfast Trust provides the principal teaching hospital in Northern Ireland for medical students and nurses, allied health professionals and others. It also provides most of the tertiary regional services for Northern Ireland. In total it provides 1,200 acute beds and serves over 750,000 people in any one year. The scale of the organisation is matched by the complexity of the services it provides, and the consequent risk that it carries as an organisation. Given its size and scale, it is impossible for its Board to proactively monitor and visit all of its sites and services, even on an annual basis, that would just not be realistic. As I discuss further below, visits to different sites by individual members of the Board did happen, including through the likes of Chairman's Award visits, Safety and Quality visits, visits to Children's homes and events. Normally I would have made 30 to

40 visits to various parts of the organisation in a year. However, the governance system was designed to see issues of significance escalated to the Board, particularly when they related to potential significant safety risks or serious adverse incidents involving serious injury or death.

12. This is perhaps difficult to convey, but given the level of risk carried, and the extent of services provided by the Belfast Trust, what can be brought to the Board of an organisation of the size and nature of the Belfast Trust may be considerably different to what could come to a Board of a much smaller organisation carrying much less risk. It is really things that are out of the ordinary, in the context of the size and nature of the services provided, that come to the Board. The nature of the serious issues that did come to the Trust Board, which are reflected in the minutes of the Trust Board meetings, illustrate this. Most of the Trust Board's time is spent considering and seeking assurance about some very serious problems occurring within the Trust and that are ongoing at any one time. To prepare for writing this statement I did read all the Trust Board minutes from 2012 on, which I understand have been disclosed to the MAH Inquiry by the Belfast Trust. As an example of the types of issues that the Trust Board had to deal with at any one time, I exhibit behind Tab 2 the minutes of some confidential Trust Board meetings to try to illustrate the point. If questions are just asked about MAH, understandable though that may be in the context of this inquiry, there is a real danger that the reality of that context will not be properly understood, and an unfair and misleading impression created.

13. It is the case that in November 2017 what was emerging in connection with Muckamore Abbey Hospital was escalated to the Board, including that staff had been suspended because of the abuse of patients at MAH and that a police investigation was underway. The father of one of the affected patients had also made a complaint to the Department of Health, and the Department of Health had then written to the Belfast Trust to express various concerns, including that a SAI had not been reported to the HSCB within 72 hours. The Belfast Trust acknowledged to the DoH, the day following the Trust Board being first briefed on 2 November 2017, that its governance response to the incidents that initially

emerged from MAH was deficient, in terms of breaches in the Serious Adverse Incident and Early Alert procedures.

14. The Board of the Belfast Trust is a unitary Board in the sense that it is made up of Non-Executive and Executive Directors. The Board comprises a Non-Executive Chair and 7 Non-Executive members, one of whom has to have financial experience. The other prescribed Executive members of the Board are the Director of Social Work, the Director of Finance, the Medical Director, the Director of Nursing and the Chief Executive. It was common practice in the Belfast Trust for the Directors of other services to also attend Board meetings.

15. I became the Chair of the Trust Board on 1 March 2014 for what was to be a fixed term of 4 years. My term was extended for a further 4 years in March 2018, and for a further year in March 2022 while the Department of Health tried to identify my successor. My final term expired on 4 April 2023, and so I served a total of 9 years as Chair. Looking back at those 9 years now, it is difficult to believe the extent of some of the difficulties that the Trust, and the wider HSC system, faced. There were many very demanding issues. They included continuous budget and workforce challenges in acute and social care. Significant industrial action by nurses, doctors and social workers. Constant and severe pressure and overcrowding in ED, leading to staff understandably complaining to Regulators and the Department of Health that the position was unsustainable. Waiting lists getting longer and longer. Reporting from public inquiries in relation to Hyponatraemia and Neurology, each of which required a number of significant governance changes. Inquiries are also ongoing in relation to MAH and Infected Blood. We also worked through the remarkable challenge of a global Covid-19 pandemic, which required unprecedented changes in how services were provided and governed. This information is only provided for context in considering the issues the Trust Board was dealing with and is not seeking to evade the Trust's responsibility to provide safe care at MAH.

16. In the Belfast Trust the Chair of the Trust Board also serves as the Chair of the Assurance Committee. I exhibit behind Tab 3, by way of example, the Board Assurance Framework from 2016 to 2017. At page 12 it describes the role of the

Assurance Committee as *"the Assurance Committee is a standing Committee of the Board of Directors and is comprised of Non Executive Directors only. Its role is to assist the Board of Directors in assuring that 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 the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors".*

17. As referred to earlier, the governance system of the Belfast Trust evolved considerably over my time as Chair, due to changing circumstances in the Health and Social Care sector, such as the closure of the HSCB. The Belfast Trust also needed to learn from its experience of failures of care such as MAH, and the Inquiry into Hyponatremia-related Deaths (IHRD), which reported in January 2018, and the Independent Neurology Inquiry, which reported in June 2022. For comparison I also exhibit behind Tab 4 the Assurance Framework for 2022/23 which describes the role of the Assurance Committee on page 49 as *"Trust Board have a responsibility to oversee the effective implementation and management of governance and assurance within the Belfast Trust. Assurance Committee a standing committee of Trust Board supports this by providing oversight of governance, risk management and assurance in a protected space, where risks are considered and sense making is made of assurance information. Its role is to assist Trust Board in ensuring an effective integrated governance and assurance framework is in operation for all aspects of the Trust's undertakings, other than finance".*

18. Further at page 49 it states *"The Committee is informed by intelligent and timely information covering the full range of health and social care information providing a line of sight of all of our business. It is also responsible for the identification of risks and significant gaps in controls/assurance for consideration by Trust Board. It reviews and interrogates information from a variety of sources in order to ensure that the decision is informed by accurate timely and concise data to support the delivery of the Trust's corporate objectives".*

19. It further identifies some key information sources:

a. The Board Assurance Framework risk document articulates each risk, its controls, gaps and assurance provided utilising the "three lines of assurance" model. It enables Trust Board to have an improved ability to understand and confirm that they have assurance over key controls or where control gaps exist and whether actions are in place to address these gaps.
b. Directorate QMS sense making presentations – accountability and assurance is scrutinised through the presentation and critical analysis of key data utilising the 6 QMS metrics establishing individual directorates performance in relation to key assurance areas and the identification and escalation of issues and risks.
c. Steering Group Reports.
d. Infographic Reports
e. Emerging Issues.

20. Page 50 explains that the Assurance Committee provides a second line of assurance within the integrated governance and assurance framework. It has 6 steering groups which are intended to oversee the implementation of robust assurance processes across all the aspects of Belfast Trust business. Appendix F on page 72 provides information on the various steering groups.

21. For the first 2 years of my initial term I was also a member of the Adoption Panel which scrutinises applications for adoption of children in Trust care, and the Organ Donation Committee which assists and supports the programme for organ donation in the Belfast Trust and works closely with the NHS Blood and Transplant Organisation.

Question 2

Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Trust Board level?

22. Up until the latter part of 2017 the structures and processes that were in place at Trust Board level for the oversight of MAH were exactly the same as the structures and processes in place for oversight of the entire organisation.

23. The Department of Health and the Department of Justice jointly published the most recent Adult Safeguarding policy for Northern Ireland on 10 July 2015. Its aim was to prevent harm in the first place and to offer effective protection to the harmed when it does happen. It set up a Northern Ireland Adult Safeguarding partnership and each Trust was to establish a local Adult Safeguarding Partnership (LASP) chaired by its Executive Director of Social Work. The LASP was responsible for ensuring that an effective Adult Safeguarding policy was in place with robust governance arrangements and a commitment to zero harm and ensuring compliance with the agreed delegated statutory functions. The ASG policy recognises on internal page 39 *"that processes and procedures will not protect people and good practice will"* and introduces the concept of a Designated Adult Protection Office (DAPO) who is to be responsible for the management of each referral received by a HSC Trust and, on internal page 40, *"where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated HSC service, the DAPO will engage the RQIA to ascertain whether the provider is in breach of regulation or minimum standards. The RQIA will act on all safeguarding concerns … and where necessary use their powers of improvement or sanction".*

24. The role of the RQIA is described on internal page 30 of the 2015 Policy as follows: *"the RQIA has a key preventative role in adult safeguarding practice. As the independent regulator, RQIA has both a responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services they inspect. The RQIA also has a key role in service improvement with the aim of encouraging improvement on the quality of services they inspect and securing public confidence in the pursuance of those services by keeping the Department of Health informed of their availability and quality".*

25. Cecil Worthington, the then Executive Director of Social Work, reported at the public Trust Board meeting on 4 June 2015 on the Delegated Statutory Functions report. The minutes of the meeting can be found behind Tab 5 in the exhibit bundle. Mr Worthington, along with Mr Growcott, spoke of the social care governance arrangements, including *"the Annual Belfast Local Adult Safeguarding Report … which provided information in respect of the delivery of adult safeguarding*" and *"pointed out the implantation of the draft Revised Adult Safeguarding Policy, which profiled social work as the lead profession in safeguarding would give rise to particular operational and workforce planning challenges … safeguarding adults without capacity or those whose social, emotional and physical limitations give rise to particular vulnerabilities is a key priority for the Trust. The Trust's Adult Safeguarding Committee has been established to strengthen the corporate focus and assurance arrangements with regard to adult safeguarding".*

26. In the period from 2015 through to late 2017, the Board did not receive any warnings of a major safeguarding issue at MAH, whether from the LASP or from any inspection by the RQIA in relation to MAH. I do not mean that there would not have been information in the system as to issues at MAH, as there obviously will have been (as there will be for every service operated by the Belfast Trust), but there was no information coming to the Board, including through the likes of the Social Care Committee, or the presentation of the Delegated Statutory Functions report, that there was something out of the ordinary, or the type of problem that came to the Board in 2017.

27. In relation to the 2016/17 assurance framework, the document states at page 3 *"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 outlines 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 to deliver appropriate outcomes."*

28. It continues *"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".

29. The document goes on to set out the cascade of planning down through the organisation which includes a corporate plan, directorate annual management plans, services/team annual plans and individual objectives which all form an integral part of the Trust performance management and assurance framework. The framework also makes it clear that the Belfast Trust is responsible in law for the discharge of statutory functions, the majority of these functions relate to services provided by the Belfast Trust's professional social work and social care work force and the scheme for the delegation of statutory functions sets out for each service sector the statutory duties delegated by the HSCB to the Belfast Trust and the accountability arrangements pertaining to those functions. The Belfast Trust was then accountable to the HSCB (now the SPPG within the DoH) for the effective discharge of its statutory functions and HSCB have the authority to monitor and evaluate the services.

30. The framework goes on to describe the Trust's risk management strategy and its policy on risk at Appendix A (internal page 20) of the document. At internal page 10 it states *"controls assurance remains a key process for the Trust and the Trust has identified directors to be accountable for action planning against each standard the results of which are reflected in the Trust's corporate risk register".* The framework also makes clear that the Trust has and continues to develop an open and learning culture that encourages continual quality improvement but with openness when things go wrong. Processes for managing and learning from adverse incidents, complaints and litigation are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust "Being Open" policy.

31. The organisational arrangements for governance and assurance are set out in Appendix B on internal page 21. The Assurance Framework makes it clear that an important element of the Trust arrangements is the need for robust governance within directorates. The organisational arrangements in relation to this are set out at internal pages 11 to 13 of the Assurance Framework and includes the Board of

Directors, the Audit Committee, the Assurance Committee, and the Executive Team which is responsible for assuring that the sequence of performance reports, audits and independent reports required by the Board of Directors as part of the performance management and the assurance process is available.

32. The Executive Team must ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update the principal risk document which will inform the management planning, service development and accountability review process.

33. Page 13 outlines the role of the assurance group, the steering groups that support the assurance group and formal sub committees. The roles of the various elements that make up the governance processes of the Trust are set out on pages 14 to 18. Page 15 makes it clear that *"collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team is responsible for ensuring that the Board as a whole, is kept appraised of progress, changes and any other issues effecting the performance and assurance framework".*

34. The Executive Director of Nursing and User Experience *"is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience and all aspects of service delivery"* and the Director of Social Work *"is responsible for ensuring the effective discharge of statutory functions across all service sectors and the establishment of organisational arrangements and structures that facilitate same. She/he is required to report directly to Trust Board on the discharge of these functions including the presentation of the annual statutory functions report".*

35. Section 8 on Board reporting (internal page 19) makes it clear *"it is important that key information is reported to the Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow the Board to decide on the efficient use of the resources and address the issues identified in order to improve the quality and safety of services".*

36. Finally, the *"Chief Executive, Director of Finance and Estates, Medical Director and Director of Planning, Performance and Informatics will be responsible for providing the monitoring and support for the assurance framework and providing an updated position on performance and governance, the effectiveness of the Trust's system of internal control; providing details of positive assurances on principal risks where controls are effective and objectives are being met; where the organisation's achievement of its objectives is at risk through significant gaps in control and where there are gaps in assurance about the organisation's ability to achieve its corporate objectiveness."*

37. The Assurance sub-committee structure is set out at Appendix B of the document. I would specifically refer to the Social Care steering group. After 18 months as Chair of the Belfast Trust I had realised that the many issues arising from the acute side of the Trust's services were overwhelming the space and time available on the agenda of meetings, leaving insufficient time to interrogate social care issues which accounted for 48% of the Trust budget. After discussion with the then Executive Director of Social Work, Cecil Worthington, and the then Chief Executive, Dr Michael McBride (as he was then), and after consideration by Trust Board members at a development day, it was agreed that we should, from the beginning of 2016, set up a Social Care Committee chaired and populated by non-executive directors. The chair was Anne O'Reilly who herself was a social worker and a previous chief executive of the charity Age Concern. Other non-executives on the Social Care Committee included Martin Bradley a previous Chief Nursing Officer for Northern Ireland, Miriam Karp [redacted] and Nuala McKeagney a management consultant. The Trust Board minutes of 14 January 2016, exhibited behind Tab 6 in the exhibit bundle, refer to the inaugural meeting of the Social Care Committee being held on 7 January 2016 and state *"Ms O'Reilly the Chair of the Social Care Committee had agreed its role was to assure Trust Board that the discharge of delegated statutory functions could be thoroughly scrutinised and reviewed therefore strengthening corporate governance arrangements "* I exhibit behind Tab 7 some representative examples of the minutes of the Social Care Committee from 2016 to 2023. It will be noted from the minutes that as the Committee developed over the years it was

able to create a space for greater interrogation of the Delegated Statutory Functions report and other social care and adult safeguarding issues with a greater engagement with staff than would have been feasible at the Trust Board. It also permitted the social care workforce to feel more valued in having greater time to engage with non-executives and see that the many issues of concern in the social care and safeguarding work of the Belfast Trust was being given visibility at Board level.

38. Before I move on to the Governance and Assurance framework for 2022/23 I do want to indicate that, in my own view, and on the basis of what we knew at the time in 2014 through to late 2017, the assurance framework processes in place at Board level for the oversight of the organisation did appear appropriate, and did appear to be functioning effectively in the context of the many serious events and matters that were escalated to and did receive the attention of the Trust Board.

39. However, the effectiveness of how the processes worked in practice was of course dependant on how staff at various levels of the organisation applied it. In terms of Muckamore Abbey Hospital, there were various levels of staff responsibility starting with health care assistants reporting to registered nurses reporting to assistant ward managers and ward managers at ward level, who in turn would report to the service manager responsible for MAH up through the Co-Director for Learning Disability and on to the Director of Adult Social and Primary Care who in turn would report to the Executive Team and the Chief Executive and ultimately the Board. In addition, as MAH was a designated hospital, it would have dedicated social workers, some assigned to be Designated Adult Protection Officers (or DAPOs) who reported through to the Adult Safeguarding (or ASG) lead and onto the Executive Director of Social Work. In addition, staff also had professional leads eg. for Nursing, Brenda Creaney the Executive Director for Nursing. All of these staff were aware of the values set by the Belfast Trust at that time (because they are constantly promoted), which required patients to be treated with respect and dignity, in an open and trusting environment. There can be no suggestion that abuse or neglect of patients was something which would not have been viewed as utterly inappropriate and totally wrong by the Board of the Trust, or that if the Board had have been aware of abuse that it would have acted to safeguard patients and

hold staff to account. As the minutes of the Trust Board demonstrate, as soon as the matter came to the Board's attention in November 2017, safeguarding and oversight of operations at MAH was a matter constantly on the Board's agenda until I left in 2023.

40. However, it is clear from the evidence of the CCTV, once it began to be reviewed in the later part of 2017 onwards, that staff witnessed other staff at ward level perpetrating neglect and abuse and didn't escalate it. It therefore demonstrated that the processes in place in the Trust were not preventing this abuse and neglect, nor were the ASG arrangements in place at the time sufficient to stop it. Similarly, the at least 61 inspections carried out by the RQIA at MAH in the period 2010 to 2017 also did not result in the suggestion there was a major issue of staff abusing patients. It was only the "game changing" impact of CCTV that allowed the true picture of abuse on at least some MAH wards, and at least in 2017, to be revealed and demonstrate that more effective action needed to be taken.

41. The Board also did have other available systems through which issues could emerge, such as complaints, SAIs and regulatory inspections by the RQIA. These did inform its oversight processes across the organisation, but, to my recollection, in the period 2014 to 2017 no serious complaints, adverse RQIA reports or SAIs suggesting widespread abuse of patients were brought to the attention of the Trust Board in relation to MAH. That changed in November 2017. I note from my examination of Trust Board minutes that a problem in Iveagh (the Trust facility for children with mental health, autism and behaviours which challenge) arising from an RQIA inspection, was brought to Trust Board at its Confidential meeting on 3 July 2014, so it was not the case that problems in Learning Disability services could not or would not come to Trust Board, just as similar issues would and did come to Trust Board from other areas of the Belfast Trust.

42. As I stated earlier the Governance and Assurance Framework of the Belfast Trust evolved in response to issues such as the IHRD public inquiry, the discovery of abuse at MAH, the Neurology call back and other changes learnt from other problems within the Trust and the HSC as a whole. The 2022/23 Integrated Governance and Assurance Framework reflects the move by the organisation to a

collective leadership structure with divisions being established across the organisation. It is exhibited behind Tab 4 in the exhibit bundle. It recognises that priorities and targets should be cascaded through divisional annual management plans, service/team annual plans and individual objectives, as an integral part of the Trust performance management and assurance framework, the Quality Management System (QMS). The directorates and divisions report on a regular basis to the Executive Director Group, using the QMS framework, in order to provide assurance.

43. In relation to Muckamore Abbey Hospital, this approach is demonstrated by the introduction of a weekly Sit-Rep report being prepared for the hospital, and a bimonthly version of the Sit-Rep being reported to Trust Board. By way of example, a copy of the 12 August 2020 Sit-Rep is exhibited behind Tab 8 in the exhibit bundle. It will be noted that it reports on inpatient numbers, admissions and discharges, resettlements, safeguarding referrals for patient on patient and staff on patient incidents, governance reviews on incidents, seclusion, complaints, risk register and ongoing CCTV reporting, reports on the incidents and includes run charts for all of these issues to allow monitoring to be carried out. The Sit-Rep also contains a section on selective CCTV reviewing which happens on a weekly basis to determine if any action is required. The report also has a section on service continuity and staffing issues, training levels, induction of staff, levels of agency, staff engagement and support.

44. The 2022/23 integrated governance and assurance framework also has sections on workforce governance, service user involvement, accountability and a scheme for delegation and direction of social care and children's functions.

45. At paragraph 4.3 on internal page 25 it has a section on accountability for HSC Trust Boards which states *"Trust Boards have an overarching responsibility to provide strong leadership, robust oversight to ensure and be assured that the organisation operates with openness transparency and candour particularly in relation to its dealings with service users and the public."* I would comment here that during my time as Chair, I always tried to ensure that the public were facilitated to speak at Trust Boards and that questions from the public were fully answered in

an honest manner and that the Trust fully co-operated with Inquiries and Reviews into the conduct of its affairs. I also personally met with persons adversely affected by poor care provided by the Trust, including the parents of the children who died as a result of Hyponatremia, parents and carers of those who suffered harm at Muckamore Abbey Hospital and patients who suffered as a result of the failures identified in the Neurology Inquiry. I also advocated that the Trust needed to spend more time learning from complaints and put two Non-Executive Directors on the Review of Complaints Working Group which held workshops with the Northern Ireland Ombudsman's Office to improve complaint handling, one of which took place on 23 January 2017. The Assurance Committee received an annual report and a quarterly update on complaints and learning from experience. A copy of the annual report for 2019/20, and the quarterly report from April to June 2020, are exhibited at Tab 9 in the exhibit bundle. The complaints review group evolved into the service user experience group to undertake a broader remit across the Trust to inform learning and support the progression of corrective improvement actions arising from an analysis of patient, client and carer feedback.

46. I would not want the MAH Inquiry to have the impression that the Trust Board was not interested in the care that was provided to the patients we served. We were. An early example of this was the introduction of service user stories being presented to Trust Board. A consideration of the confidential Trust Board minutes of 3 September 2015, exhibited behind Tab 10, which recorded the first such presentation, will indicate that our focus was not on what the Trust had done well.

47. Ultimately the Board needs to be properly informed of failings and issues which result in harm to patients and clients, so that it can try to do something about it. This requires proper scrutiny of issues raised by bodies such as the RQIA, Ombudsman and the Adult Safeguarding Board as well as issues raised by whistleblowers, and through the SAI and complaints processes. Essentially the Board is also dependent on issues of poor care being reported by staff who witness such care. This is the first line of defence. I must admit that I have been dismayed that so many instances of poor care by staff at MAH were not reported to management by other staff who witnessed such abuse, or by making an anonymous whistleblowing complaint. I am aware that such reporting is often

viewed as a high-risk low benefit action, and the Trust has tried over the years to promote a culture of openness, which in turn promotes quality and learning. The Department of Health conducted a public consultation on the recommendation made by the IHRD Inquiry that a statutory duty of candour for health organisations and individual staff should be introduced. The consultation concluded on 31 August 2021 but DoH has yet to make any decision on whether such a duty should be introduced. In reviewing its Governance Framework the Trust Board determined it was important to indicate to staff that it specifically required staff to report poor care and so added a section at paragraph 4.4 (see internal page 26 of the 22/23 Integrated Governance and Assurance Framework) entitled "accountability for Belfast Trust Employees" which states:

"*As individual staff are accountable for their own behaviours; however everyone has a role in ensuring that the Trust values and code of conduct for HSC employees are followed and to make the care and safety of patients and clients their first concern and to protect them from risk"* and "*Trust Board expects that all staff working within the Belfast Trust familiarise themselves with this code and crucially if any staff member has a concern that an acceptable standard of care is not being adhered to, that they should always raise that concern*".

48. I also understand that it can be very difficult, for those staff who want to and would do the right thing, to detect actions of abuse, especially when service users are very vulnerable and have limited communication skills. Accordingly, the Trust Board added a paragraph at section 1 of the new framework (internal page 7) which recognises this by adding the following "*Our commitment to improve and learn will be underpinned by our values of working together, excellence, openness/honesty and compassion … We accept that greater scrutiny is required especially in services where due to vulnerability, patients are unable to speak for themselves and alert us to poor care".*

49. The Board also recognised that a greater focus was required on complaints and what could be learnt from them. (This is an area that as Chair I had raised early in my first term; see paragraph 19/15 of the confidential Trust Board minutes dated 3 September 2015 exhibited at Tab 10 referred to above, dealing with a patient's story relating to a complaint made about the death of a service user). Therefore,

it is stated on page 4 of the new framework that *"we recognise the powerful contribution that theming and identifying trends in complaints can have and as a learning organisation we prioritise the learning from this across the organisation. It is the Trust's aim that all staff will recognise that a complaint can be an early warning to failing and treatment in care and as such we prioritise that all staff from ward to Board respond positively to any concerns raised, take immediate action to resolve, escalate (where required) and learn".*

50. The O'Hara Report, published on 31 January 2018, arising from the Inquiry into Hyponatremia Related Deaths, has been an issue which the Health and Social Care system in Northern Ireland, and the Belfast Trust Board, have engaged with in detail over the last 5 years.

51. In essence Sir John O'Hara found that at the time of the deaths of a number of children in hospitals the Department *"simply had no system in place for knowing what was going on in its hospitals"* (see the public statement of the Inquiry Chairman dated 31 January 2018 exhibited behind Tab 11).

52. Mr Justice O'Hara therefore recommended that a statutory duty of candour should be introduced both for organisations and for individuals, with accompanying criminal sanction. He stated *"it is time that the medical profession and the Health Service manager stop putting their own reputation and interests first and put the public interest first instead".* The report made over 90 recommendations requiring Trusts to learn from SAI deaths, to learn from complaints, to develop improved leadership skills at Executive and Non-Executive level etc.

53. Following on from the O'Hara report a regional system of working groups was put in place by the Department of Health to look at all its recommendations. A consultation document has been released on the introduction of a statutory duty of candour for organisations and for individuals.

54. The net result of the O'Hara Inquiry is that the Belfast Trust has spent a lot more time trying to ensure that it is open, transparent and candid in responding to complaints and also in investigating serious adverse incidents. Reports of Early

Alerts to the Department of Health and SAIs to the Assurance Committee of the Board has been enhanced, as has the reporting of complaints with a lot more detail being provided. The minutes of the Confidential Trust Board meeting on 4 October 2018, exhibited behind Tab 12, state as follows: *"Mr Dillon referred to the live governance weekly reports considered by the Executive Team. He explained the report provides update information in relation to adverse incidents, SAIs, early alerts, coroners cases, clinical negligence cases, complaints including Ombudsman complaints and corporate risks. These are discussed via a weekly conference call by a group of governance staff and includes representation from the corporate risk and governance team and the deputy medical director alongside directorate governance staff and corporate nursing user experience. The weekly call provides an early opportunity to consider emerging governance issues with sharing of learning ahead of established governance processes and is subsequently considered by Executive Team. Mr Dillon sought views to extending the circulation to Trust Board to provide ongoing and live governance information. He pointed out this would also assist the Trust in meeting IHRD recommendation 81 "Trusts should ensure that all internal reports, various and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of the Board*. *Members welcomed the proposal as this would provide real time information in keeping with the IHRD recommendations*". In addition, Board members both Executive and Non-Executive are encouraged to conduct safety quality visits and a whole programme of visits is organised annually. There is no question that many more things are escalated to the Board in 2021 than in 2014 and the Board and the Trust and HSC are much more candid and transparent in its dealings with its key stakeholders.

55. Returning to the 2022/23 Assurance Framework, page 32 makes it clear "*while the Chief Executive has overall responsibility for the control of management of the Trust's resources and its governance statement, in practice this is achieved through a scheme of delegated responsibility. Trust directors are responsible and accountable to the Chief Executive for the control, management and overall governance from their perspective directorates including the production of specific content".* On page 36 the management of risks are identified and in relation to operational risks it states *"operational risks are by products of the day to day*

running of the Trust and include a broad spectrum of risk including clinical risk, fraud risk, financial risk, legal risks arising from employment law our health and safety regulation and risks of damage to assets or system failure. They are the responsibility of line managers and should be identified and managed by the divisions/directorate and only considered by Trust Board on an exception basis excepting in situations where the Board is checking the effective implementation of Trust policy and procedures".

56. Section 6 of the 2022/23 assurance framework deals with assurance and introduces the 3 lines of assurance approach in relation to risk management and the concept of "trust, demonstrate and check". "Trust" is first line assurance and involves a level of trust by line management that services are being delivering in line with policy and expected standards. Second line assurance necessitates senior management to provide evidence and "demonstrate" that controls and assurance are in place. And "check" involves third line assurance requiring a level of independent verification. The outcome of such verification is considered by both Executive Director Group and Trust Board. Identified gaps in controls and/or assurance will be monitored by the Trust Board until resolved, and in line with risk appetite. When the Board became aware of failings in care at MAH from late 2017 on, it has sought to subject the management of MAH to greater scrutiny ever since.

57. In relation to quality and improvement, page 46 refers to the key component of the Trust's overall system of quality management introduced in September 2020, namely the Quality Management System (QMS). QMS brings different approaches such as performance management, quality improvement, assurance and accountability processes together into a single integrated system. Each QMS report which comes to the Board contains a focus on key management information relating to the Trust's key priorities and associated enablers and gives an overview of the current position. The information is drawn from the QMS framework which comes from care delivery units within their daily safety huddles, sit reps and weekly wider assessments, the monthly review of QMS information at a divisional team level, the weekly review of QMS assessment by the Executive team, the quarterly review by the Assurance Committee of the Board and a bimonthly report to the Trust Board.

58. The QMS report also provides information on the Trust's six quality parameters which are safety, experience, effectiveness, timeliness, efficiency and equity. The development of the QMS has been designed to allow the Trust to make better sense of its operations, measure its achievement of outcomes and its key safety information using real time data from the front line and from patient and staff feedback surveys. To fully explain how QMS works, I enclose at Tab 13 a presentation made by Charlene Stoops, the then Director of Performance and Informatics, to the Trust Board on 3 December 2020, and an extract of the QMS report relating to MAH presented to the Board on the 2 September 2021.
59. Section 8 of the 22/23 framework sets out the role of various parts of the organisation including committees and the Executive Directors Group, Executive Team, Social Care Steering Group, directorate and divisional governance groups, the Chief Executive, individual Executive Directors, Chair and the Trust Board.

60. The introduction of the QMS system has allowed for data sets to be collected and analysed and for summary information to be available to Trust Board. In relation to MAH this finds expression in the Sit-Rep Reports which has given a far greater insight into activities and controls at the hospital. The Sit-Rep reports are regularly considered by the Board at its meetings, and on a weekly basis by management. Whilst incidents of patient-on-patient violence and staff on patient inappropriate behaviour has not ceased, reporting of the incidents are now happening on a consistent basis and can be interrogated by the use of CCTV. There is also a clearer record on the use of seclusion, restraint and the use of medication and run charts are set out in the report allowing progress to be monitored and measured which have demonstrated that over time both interventions have reduced considerably.

Question 3

To your recollection, how often was MAH included on the agenda of:

i. **Meetings of the Trust Board.**
ii. **Meetings of the Executive Team.**

Meetings of the Trust Board

61. Prior to 2017, while there were regular references to MAH as part of the Learning Disability section of the Annual Delegated Statutory Functions (DSF) report and the Interim DSF report (every 6 months) which came to Trust Board each year, MAH was not itself an agenda item (which is similar to other services and hospitals within the Trust without a known significant problem that had been escalated to the Trust Board). From a review of Trust Board minutes from 2014, the only individual mention I can find of MAH was a report from Catherine McNicholl, then Director of Adult, Social and Primary Care, on 2 April 2015, in the context of the Draft Reform and Savings Plan and which included the proposal to withdraw the "financial rewards" system for day centre clients in MAH and the impact on very vulnerable people". The Board indicated that they were not in favour of the proposal and it did not occur. A copy of these minutes can be found at Tab 14 in the exhibit bundle.

62. Following a conversation in 2015 between myself and Dr Michael McBride, the then acting Chief Executive of the Belfast Trust (now Professor Sir Michael McBride, the Chief Medical Officer), that we should take meetings of Trust Board out and about (as in hold meetings in other Trust buildings so as to be more visible to staff) a meeting of the Trust Board Workshop was held at MAH on 2 July 2015. A copy of the agenda can be found at Tab 15 in the exhibit bundle. My recollection is that after the meeting we had lunch with senior staff members of MAH and walked around the wards.

63. Although MAH was only infrequently mentioned on an individual basis, it is important to appreciate that it was treated in a similar way to all other Trust services and facilities in this regard. Having reviewed Trust Board minutes there is mainly only mention of individual services if there was an issue with quality of care or a particularly noteworthy service improvement, alongside regular reports on Finance, feedback from sub committees, Chief Executive report, performance report, safety and quality updates, regular statutory reporting such as DSF, Equality Annual Report, Quality Report, service user stories and updates from the HSCB and Department of Health.

64. Although there was infrequent mention of MAH as an individual facility there was discussion at Trust Board regarding Learning Disability as a service including the twice yearly DSF reports already mentioned, strengthening of Adult Safeguarding arrangements, the setting up of a Social Care committee and budget and reform proposals. There was a proposal brought to Trust Board on 3 September 2015 (Tab 16) seeking permission to proceed to public consultation in relation to the future delivery of learning disability and mental health day services. There was discussion on 5 May 2016 at Trust Board on the results of the public consultation and there was an extraordinary public Trust Board on 21 June 2016 at which there was a large attendance which reflected an overwhelming opposition to proposals to amalgamate day centres by creating more day opportunities. Accordingly, the proposals were amended to keep all day centres open and establish a day services and review forum.

65. Following the reporting of abuse to Trust Board on 2 November 2017, MAH was thereafter regularly on the Trust Board agenda as a specific item on the following dates:

6/12/2018	5/9/2019	1/10/2020
11/1/2018	3/10/2019	5/11/2020
5/7/2018	7/11/2019	3/12/2020
6/9/2018	5/12/2019	14/1/2021
4/10/2018	9/1/2020	4/2/2021
6/12/2018	6/2/2020	1/4/2021
10/1/2019	5/3/2020	6/5/2021
7/2/2019	2/4/2020	10/6/2021
7/3/2019	21/4/2020	2/9/2021
4/4/2019	7/5/2020	7/10/2021
2/5/2019	11/6/2020	4/11/2021
6/6/2019	2/7/2020	2/12/2021
4/7/2019	21/9/2020	13/1/2022
		3/2/2022

66. I am not in a position to advise how often MAH was on the agenda on the Executive Team prior to September 2017, when I understand the then Director of Adult Social and Primary Care, Marie Heaney, informed them of what was coming to light, but I have been informed that the Executive Team met in MAH in 2015 and 2016, and that individual Executive Team members were regularly on site for management duties, safety quality visits and other activities. For example, Brenda Creaney, the Executive Director of Nursing and Trust Board member, informed me she was on site 17 times between 2010 and 2017, and Cecil Worthington, a former Executive Director of Social Work and Trust Board member informed the leadership and governance review that he did regular walkarounds at MAH.

Question 4

Did you have occasion to visit MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

67. I visited MAH on approximately 7 occasions that I can identify during my time on the Trust Board, which was between March 2014 and April 2023. They were as follows:

    a. Trust Board Workshop on 2 July 2015 held in the administration building at Muckamore Abbey Hospital. My memory is that we had lunch after the meeting with members of the MAH management team including Mairead Mitchell and Dr Colin Milliken, and, after that, had a tour of the wards.

    b. 9 August 2017. Chairman's Award inspection to PICU to speak to staff, and patients regarding their submission for a Chairman's Award for a "Captain Safety" health improvement initiative which involved a member of staff dressing up as a "superhero" and appearing on the ward to point out safety concerns and fix them. I was accompanied by another Non-Executive Director, Nuala McKeagney, and we spent 2 hours visiting Cranfield 1 and 2 and the intensive care unit. We spoke to staff who were very enthusiastic

about the patients and the care they were receiving. We spoke to the ward manager and the assistant ward manager who showed us examples of anonymised patient plans and the various interventions patients were involved in including day opportunities. The ward was clean, well organised and appeared to be very well staffed. The staff were very knowledgeable about their patients and the interactions that I observed were compassionate and professional. I have reflected afterwards that this was just 3 days before the reported assault on P96 by a staff member in the same ward. From my time as a senior manager and subsequently as a Board member I would usually be quite confident that I would be able to pick up on a workplace which was not well run in terms of being badly organised with poorly motivated staff and no real plan on how they would manage those in their care. I can honestly say this was not my experience of the PICU ward on that visit. I also recollect the patients' delight when Captain Safety appeared on the ward.

c. Safety Quality Visit with Miriam Karp, another Non-Executive Director, on 20 February 2018. This visit was organised after we had been informed by Marie Heaney, the Director then responsible for MAH, of abuse having been discovered at MAH. Miriam and I spoke to staff, patients and visited a number of wards. There was concern from staff about the ongoing viewing of historical CCTV, in the sense they felt it was hanging over staff, which they wanted quickly resolved.

d. I was due to visit MAH on 18 February 2019, when Margaret Flynn was due to meet families about the Level 3 SAI investigation that resulted in the "A Way to Go" report. The location of the evening event was changed shortly before to a venue at Antrim Area Hospital. Margaret Flynn addressed families and carers of patients of MAH. I attended with the then Belfast Trust Chief Executive, Martin Dillon, to meet the families informally, but to formally state in person the apology of the Belfast Trust for the unacceptable behaviour of some staff in MAH and to discuss the proposals to respond to the recommendations in Margaret Flynn's report. At the meeting, for instance, I remember I spoke to Mother of P77 and her sister, and to Father of P96

Father of P96, as well as a number of other family members of patients.

e. On 19 July 2019 I did a leadership walk round with Dr Cathy Jack, the then Belfast Trust Medical Director. We visited Cranfield Ward and spoke to patients, management, ward managers, doctors and nurses and observed the work in the wards. During the visit I recall talking to a medical consultant from England who advised that people with severe autism, some of whom were housed in MAH, would never be housed in such an institution in England, and we had a discussion on the need for more community provision in Northern Ireland.

f. During the height of the Covid-19 pandemic in 2020 and 2021 it was difficult to do in person visits in any hospital, including MAH. I did however arrange a series of virtual visits on Microsoft Teams across the organisation, and, on 14 October 2020, I did such a visit with the day opportunities team at MAH who ran the day centre and organised activities. They took me through the activities and how they were welcomed by patients. They regretted that they weren't able to do as many external visits as they used to because of Covid-19 but they explained how they compensated for this with a greater range of internal activities.

g. Peter May took over as Permanent Secretary of the Department of Health on 4 April 2022. Dr Jack, who was by then the Belfast Trust Chief Executive, and I arranged for him to come and visit MAH with his team, and this visit took place on 14 July 2022. On my way to the visit I met Mother of P77, a mother of a patient, in the MAH car park and had a long conversation with her about her son and his care. She expressed concern at not being able to get access to documentation regarding her son and I said if she emailed me I would follow up on it, and I gave her my card. I then went in and met Peter May and his team in the MAH Conference Room and discussed the hospital, its issues, the need for a regional approach, and how it was important to put a greater resource around resettlement. I stressed the need for an early resolution on MAH's future. We then had a tour of the facility

and broke up into 2 groups and visited wards. I met Peter May at the end of the visit and discussed his impressions. I also arranged in the Belfast Trust for the documentation sought by Mother of P77 to be sent to her, although it took a little time because a redaction process had to be completed.

Question 5

Did the Trust Board receive reports on the following (and if so please indicate how often) on:

i. **Safeguarding of patients in MAH**
ii. **Seclusion rates at MAH**
iii. **Complaints relating MAH**
iv. **Resettlement of patients from MAH**
v. **Staffing (both establishment and vacancies) at MAH**

68. Prior to late 2017 the Trust Board did not receive detailed MAH specific reports, just as it did not receive detailed reports (covering the types of issues referred to above) about other facilities that may have some or all of the same issues occurring. The annual DSF reports which did come to Trust Board, within their Learning Disability section, did mention Muckamore Abbey Hospital and the social workers who worked within it as a designated hospital, but not in the detail I assume the question envisages.

69. I have outlined above in answer to question 3, the regular reports that the Trust Board received after the safeguarding incident was reported to it in November 2017 and it became apparent there was a significant and ongoing difficulty. I have also indicated above that much of the type of information referred to above was contained within the MAH Sit-Rep reports that were developed and which were then regularly presented to the Trust Board from 7 November 2019. These Sit-Reps contained information on safeguarding, seclusion, complaints, resettlement and staffing. I have already exhibited an example copy of the Sit-Rep report behind Tab 8, and some representative examples of the reports made to Trust Board in

relation to MAH between 2017 to 2023 are attached behind Tab 17. I understand that copies of the minutes of Trust Board, both the confidential and public meetings, between 2014 to 2022 have been provided to the MAH Inquiry. In relation to the information contained therein I would be happy to answer any further questions the MAH Inquiry may have in relation to this information.

Question 6

If the Trust Board did receive reports on the matters set out in paragraph 5 (i)-(v) above, please explain:

- **i. Who prepared these reports?**
- **ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?**
- **ii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?**

70. As I have indicated above, copies of the reports to the Trust Board, and the Trust Board confidential and public minutes from 2014 to 2022 have been provided to the MAH Inquiry. I understand copies of the Assurance Committee Minutes have also been provided to the MAH Inquiry. A consideration of that voluminous material is necessary in respect of this question. The authors of the individual reports exhibited are indicated, but, in general, Marie Heaney, then Director of Adult Social and Primary Care, led the reporting from 2017 until her retirement in 2019, when the reporting was taken over by Bernie Owens and later Gillian Traub. Carol Diffin, then Director of Social Work, reported in relation to CCTV viewing and Adult Safeguarding, and Jacqui Kennedy, the then Director of Human Resources, reported in relation to disciplinary investigations and hearings against staff said to be involved in abuse/neglect. The Trust Board consistently engaged with the reports and questioned directors about the issues they contained, as well as encouraging engagement with families, and through the appointment of a carer's co-ordinator, the appointment of a NED as a Learning Disability Champion and the appointment of 3 social workers as Family Liaison Officers.

71. The issues presented in the reports were interrogated by the Trust Board in an open and constructive manner, which is demonstrated through a reading of the minutes provided. The information did appear to be sufficient to allow effective engagement with the issues by Trust Board. Information received was monitored over time by the Trust Board by reference to the run charts and other data provided in the reports. This allowed the Trust Board to measure progress and identify issues.

Question 7

Please provide details of any occasions in which you became aware of concerns relating to the matter set out in question 5 (i)-(iv) above and describe your recollection of action taken at Trust Board level to address any such concerns.

72. During my tenure as Chair, the first time the Trust Board became aware of serious concerns about safeguarding was on 2 November 2017 when the Trust Board was advised of 2 members of nursing staff from MAH being suspended and a PSNI investigation being underway. The Trust Board was informed that a Director led oversight group had been established to review progress on action plans for the site on a weekly basis. The Trust Board then received regular updates which covered the issues outlined in question 5. The actions taken in relation to the items outlined are set out in the minutes. This included the Trust Board commissioning an independently chaired level 3 SAI. It was chaired by Margaret Flynn, who had led a Serious Case Review into the Winterbourne View hospital that reported in 2012. The final SAI report entitled “A Way to Go” a review of safeguarding was presented to Trust Board, shared with MAH patients and families, and was submitted to HSCB with a covering letter from Mrs Flynn. The report was also shared with the Department of Health and an Action Plan was agreed with the Muckamore Departmental Assurance Group (MDAG) that had been set up by the Department of Health.

73. There were consistent concerns expressed to the Trust Board regarding safe staffing of MAH between 2017 and 2023, given the level of suspensions of staff due to adult safeguarding concerns and involvement in the police investigation or the Trust disciplinary investigations. The Trust Board was consistently informed of the difficulties in relation to recruitment and the steps that were being taken to try and ensure that sufficient staffing was available. A full line of sight in relation to these matters was also given to the HSCB and the Department of Health.

74. On a number of occasions new leadership teams were put into MAH as part of the effort to improve. First, Marie Heaney, then Director of Adult Social and Primary Care was freed up from other duties to concentrate on managing the issues arising from Margaret Flynn's report. Then, in 2019, in response to the service of three RQIA Improvement Notices, Bernie Owens, who had been the Director of Emergency Care, was asked to manage hospital operations, while other directors addressed other aspects (principally the CCTV investigation and resettlement). Ms Owens, together with Gillian Traub as Co Director for MAH, continued to develop the weekly safety report detailing performance against key safety quality measures including seclusion, complaints, resettlement and staffing. Work was undertaken to address the areas of concern identified by RQIA, which ultimately resulted in the improvement notices issued by the RQIA being lifted.

75. I have referred to the regular reporting received by Trust Board. The Trust Board consistently applied constructive challenge to the management of the issues which included, amongst others, staffing changes, the development of the Sit-Rep with focussed information on key metrics, and the commissioning of East London NHS Foundation Trust as a Critical Friend to advise on the operation of MAH and to share learning of best practice in the management of Learning Disability.

Question 8

What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also describe your

recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

76. Staffing issues in MAH were operationally managed by the Service Manager, Co-Director, Director in charge of the hospital, and with the assistance of the Directors of HR, Nursing and Social Work. Issues were escalated to the Trust Board in relation to difficulties in obtaining appropriate staff who were trained in learning disability and other relevant disciplines. The Trust Board sought assurances that staffing was safe, supported arrangements being made to recruit agency staff, and an approach to the Department of Health which resulted in a 15% premium for staff who were prepared to work at MAH. The Trust Board consistently offered advice in relation to training and support for staff and also sought assurance that the right nursing models had been applied in determining the appropriate staff levels.

Question 9

Did the Trust Board approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

77. I will give way to the Executive Directors, particularly the Director of Finance, on this issue, but it is not my recollection that cost savings and efficiencies in relation to MAH differed from the approach required of the Belfast Trust and taken to other services across the Trust during the relevant period. It is right to note that there was a great challenge between 2014, and right up to the present, in terms of available budgets for health and social care, but the Belfast Trust applied the same principles across its various programmes of care. For the detail in relation to this the MAH Inquiry may obtain most assistance from Ms Edwards, the Executive Director of Finance at the Belfast Trust.

Question 10

From 2010 onwards, following bed closures at MAH:

- **i. How did the Trust Board assure itself that the reorganisation of wards was safe?**
- **ii. Were concerns about ward staffing (both established and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection and any actions taken by the Trust Board to address these concerns.**

78. I did not join the Trust Board until 2014, so am not in a position to comment on issues from 2010 until 2014. However, it is the case that the reorganisation of wards in any part of the Belfast Trust would not normally be a matter that would be specifically addressed at Trust Board, unless there was some specific issue a relevant Director wanted to raise. It is an issue that would be managed within the Directorates within which it was occurring, overseen as necessary by the Chief Executive and the Executive Management Team, on the basis of the application of the standards expected in the Belfast Trust that has patient safety at its core. From November 2017, not so much bed closures or reorganising of wards, but issues about the difficulty in staffing wards safely was raised with the Trust Board on numerous occasions and the Trust Board were supportive of operational actions taken by management to try to ensure safe staffing, recognising that it was a constant challenge.

Question 11

Were any issues relating to Muckamore ever included in:

- **i. The Delegated Statutory Functions Report?**
- **ii. the Corporate Risk Register?**

The delegated statutory functions report

79. The Delegated Statutory Functions report (or DSF report) is in a prescribed form created by the then Health and Social Care Board (HSCB). As I learned as my time progressed in the Belfast Trust, the DSF report is essentially a social work document designed to create an unbroken line of accountability for the discharge of statutory functions by the social care workforce, running from the individual practitioner through the service area line management and professional structures to the Executive Director of Social Work who then presents it to the Trust Board and onwards to the Health and Social Care Board for discussion and sign off. In each DSF report, as well as the required statistical returns, there is a narrative section dealing with the Learning Disability service of which MAH was part. I understand all of the Delegated Statutory Functions reports have been provided by the Belfast Trust to the MAH Inquiry.

80. By way of example, I enclose behind Tab 18 a copy of the statutory functions return for the year ended March 2016 in which the learning disability section of the report is prepared by Aine Morrison, and, behind Tab 19, a copy of the DSF report for March 2019 which was prepared by H425 [redacted]. There is a greater mention of MAH and issues relating to MAH in the 2019 report, which specifically refers to the services' participation in the UK wide Learning Disability Services benchmark network, the weekly situation report as being used as an Executive reporting tool that summaries key aspects of care delivery, experience, safety and quality also providing a high level overview of weekly patient numbers, admissions, discharges and occupancy. Patient care pathway, safeguarding complaints incidents, seclusion, patient feedback, staffing and staff support is also included.

81. Paragraph 3.10 of both the reports deal with social workers that work within designated hospitals which includes MAH. The reports make it clear that the Social Work department continues to lead in relation to safeguarding incidents in the hospital with a Band 7 lead DAPO who processes the hospital adult safeguarding referrals under the adult safeguarding policy. The DAPO has the lead role in investigations for patients.

The corporate risk register

82. I do not believe there was any mention, on my taking up my post as Chair of the Trust Board of the Belfast Trust in 2014, of MAH, or adult safeguarding at MAH, being a corporate risk. When issues came to the Board's attention in late 2017 my recollection is that reference was then made in the Corporate Risk Register to MAH thereafter. I understand the Corporate Risk Register has been provided to the MAH Inquiry by the Belfast Trust. The items were discussed by the Trust Board as is set out in the copies of the Trust Board and Assurance Committee minutes that I have already referred to.

Question 12

Were SAIs which occurred at MAH always reported to the Trust Board if so

- **i. What information did Trust Board receive in respect of SAIs?**
- **ii. Were SAIs discussed at Trust Board meetings?**
- **iii. What actions did the Trust Board take in response to SAIs?**

83. There is general reporting about the level of SAIs in the Belfast Trust, and only when a specific problem (that the SAI process may be part of addressing) is brought to the attention of the Trust Board will there be specific discussion of a particular incident or issue. The only specific SAI that I recollect coming to the Trust Board regarding MAH was the one relating to Adult Safeguarding carried out by Margaret Flynn entitled "A Way to Go". The Trust Board insisted that the SAI had an independent Chair. The Report was shared with Trust Board at its meeting on 4 October 2018 and was discussed at the Board workshop on 1 November 2018. Margaret Flynn, the principal author of the Report, attended Trust Board on 5 September 2019 to discuss the Report and to update the Board on changes at MAH since the review was completed. A copy of the Report was provided to the HSCB and the Department of Health. An action plan was prepared by officers to take forward the recommendations made in the SAI report and this was agreed

with the Department of Health. Due to the nature and extent of the Belfast Trust there are many SAIs in the Belfast Trust each year. Unless they relate to a loss of life (post IHRD), they do not, as a matter of routine, come to the Trust Board. The reason why Margaret Flynn's report came to the Board was because it was requested when commissioned that the report came back to the Board to inform the response to the abuse issues which had come to light at MAH. An annual report on SAIs came to Assurance Committee and a quarterly update was also given to the Committee. While I understand this material has been provided to the MAH Inquiry, I exhibit behind Tab 20, by way of example, an agenda of the Assurance Committee and a copy of the annual report that I am referring to.

Question 13

How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

84. The Trust Board valued the regular inspections by RQIA and their feedback. It was an important independent check specifically focused on considering whether the relevant hospital or service was operating properly. The Trust Board was fully sighted on the decision of the RQIA to serve 3 Improvement Notices on MAH on 16 August 2019. These were in respect of failures to comply with minimum standards across three areas; staffing, adult safeguarding and financial governance. The date given for the Belfast Trust to demonstrate compliance was 15 November 2019. The service of the notices was quickly brought to the Trust Board's attention, together with an improvement plan to address the RQIA concerns. The Trust Board consistently sought assurances on progress and received a detailed report at its extraordinary meeting in September 2020 detailing the work which had been done to comply with the notices resulting in the RQIA writing to Dr Jack, then Chief Executive, on 22 April 2020 to confirm that the notice for adult safeguarding had been lifted. A copy of the report of Gillian Traub to the

Trust Board meeting on 21 September 2020 is exhibited at Tab 21. It sets out the action taken by the Belfast Trust to have the notices lifted.

Question 14

Did the Trust Board ever escalate issues related to MAH, or formally correspond with DOH, in relation to problems such as staffing shortages or challenges round resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

85. The Trust Board would not normally formally correspond with the DoH unless it was in response to a letter directed to the Chair. The Chief Executive would normally correspond with the Permanent Secretary at DoH on behalf of the Belfast Trust. The Director of Nursing would liaise with the Chief Nursing Officer, and the Director of Social Work with the Chief Social Worker. The Chair of the Trust Board also has a direct link to the Minister for Health, however it should be noted that no Minister was in place between January 2017 and January 2020 as there was no Northern Ireland Executive and the Assembly was not sitting. So there are a number of communication and engagement mechanisms between the Belfast Trust and the Department of Health, in addition to the likes of Early Alerts. Following the “Way to Go” SAI report, Richard Pengelly, then the Permanent Secretary of the Department of Health, set up a Muckamore Departmental Assurance Group (MDAG). It was jointly chaired by Sean Holland, then the Chief Social Worker, and Charlotte McArdle, the Chief Nursing Officer. The Belfast Trust participated in this group and worked to inform its proceedings. At the request of the Trust Board a risk summit with all statutory stakeholders was held on 29 April 2021 at which the Trust was represented by the Chief Executive, Cathy Jack, and Gillian Traub, Director. The Chief Executive will be able to inform the MAH Inquiry about her correspondence with the Permanent Secretary and how she shared the Trust’s view that MAH was providing the wrong type of care in the wrong place and should be closed.

Question 15

Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details

86. Prior to November 2017 I am not aware of there having been any discussion at Trust Board about CCTV in any Belfast Trust facility. The Trust Board regularly discussed CCTV at MAH after November 2017, in the context of what had emerged at MAH. It received assurances that CCTV was operational in almost all of MAH over a period of time from 2017 to 2018.

Question 16

Other than as addressed in responses to the questions above, please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Trust Board level to address such concerns?

87. The first time I became aware of abuse at MAH was, as I have stated previously, in the later part of 2017. As a result of the emerging issues, the Trust Board exercised regular oversight of issues pertaining to MAH as set out in the extensive Board minutes already referred to. I was not aware of any incident of abuse prior to this.

Question 17

Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

88. I understand that the Winterbourne review occurred in 2011, which was a considerable time before I joined the Trust Board of the Belfast Trust in 2014. I became aware of the Winterbourne review in late 2017 when we appointed its author as the independent chair of the Level 3 SAI at MAH. I have since read the Winterbourne review report, and the recommendations coming from the Department of Health in England, but I have never heard of the STOMP initiative which I understand wasn't promoted in England until 2016. I am also aware of further reviews of abuse at institutions in England such as Whorlton Hall in 2019.

Question 18

Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

89. In relation to the Family Liaison Officers (FLOs), the Trust had created these roles to support parents/family members/carers as they dealt with the trauma of being advised that their loved ones had been mistreated at MAH whilst in the Trust's care. Martin Bradley the Deputy Chair and I met the FLOs on the 9 February 2023 and received a paper from them in respect of issues they wanted to raise. I sent a note of the meeting and a memo to the Chief Executive and Executive Director of Social Work, Tracey Reid, from whom I received a reply. I exhibit this material behind Tab 22 in the exhibit bundle. I understand that work in this regard is ongoing in the Belfast Trust.

90. I am obviously deeply sorry that patients at MAH in the care of Belfast Trust were abused and neglected, and that staff who witnessed such events did not report matters as they should have. I do not believe that behaviour reflects the approach of the vast majority of staff of the Belfast Trust. It is certainly not something acceptable to the Trust Board I was part of, or the Executive Team with whom we closely worked. We always intended to have, and were doing our best to have, the best governance system in place that we could to help provide the best services

we could to the patients who required the help of the Belfast Trust. Where the governance system didn't work sufficiently, whether because of how it was designed, or how it was operated by staff, then I apologise for that as well.

91. I will be happy to respond to any further questions raised by the MAH Inquiry.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have, to the best of my ability, either exhibited or referred to the documents which, collectively, I believe are necessary to address the matters on which the MAH Inquiry Panel has requested me to give evidence.

Signed: **Peter McNaney**

Dated: **03 July 2024**

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MAHI Muckamore Abbey Hospital Inquiry

MAHI Team
1st Floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

28 March 2024

By Post
Mr Peter McNaney
Former Chair BHSCT
29A Tweskard Park
Belfast
BT4 2JZ

Dear Mr McNaney

Re MAHI Organisational Modules 2024: Request for Witness Statement

The Inquiry is currently preparing for the final phase of evidence. Please see enclosed a document summarising the ten organisational modules to be heard in this phase: Organisational Modules 2024.pdf (mahinquiry.org.uk).

It is anticipated that the Inquiry will hear evidence in respect of these modules in September and October 2024.

The purpose of this correspondence is to issue a request, in the first instance, for a statement from you that will assist the Inquiry in this phase of evidence. It should be regarded as a request by the Inquiry Panel for the purposes of Rule 9 of the Inquiry Rules 2006.

The Inquiry understands that you were Chair of the BHSCT Trust Board between 2014 and 2023.

You are asked to make a statement for the following module:

M9: Trust Board

I have also enclosed for your attention a copy of the Inquiry's Terms of Reference. You will note that the module in respect of which you are asked to make a statement is primarily concerned with the evidence of those in key positions of responsibility for MAH, past and present, at Trust Board level.

Please find enclosed a set of questions for Trust Board members that the Panel wish to be addressed in your statement ("Questions for Trust Board Members"). It would be helpful if you could address those questions in sequence in your statement. If you do not feel that you are in a position to assist with a particular question, you should indicate accordingly and explain why that is so.

Please note that, while the Inquiry has received and heard a considerable body of evidence about the relevant systems and processes that were in place during the timeframe of the Terms of Reference, the Inquiry will now be focusing primarily on the *adequacy and effectiveness* of those systems and processes.

Please see enclosed a Statement Format Guide that will assist with the presentation of your statement. It is important that statements made for Inquiry purposes should be consistent in format. It is appreciated that the number of required sections will depend on the range and breadth of issues to be covered and that some flexibility will be needed to ensure the most effective presentation, but you are asked to adhere to the Guide to the extent that is possible.

You are requested to furnish the Inquiry with your completed statement by 10 May 2024. Your statement should be uploaded to the Inquiry's document management platform BOX via the following link:

https://mahinquiry.box.com/s/rn62nby13v2fie92qm0iecxgldv21lit

Should you have any issues accessing BOX please email info@mahinquiry.org.uk and a member of the team will assist you.

Statements made for the purpose of the organisational modules will be published on the Inquiry's website.

As noted above, it is anticipated that evidence in these modules will be heard by the Inquiry in September and October 2024. If there are any dates in those months on which you will be unavailable to attend the Inquiry to give evidence, please inform the Inquiry as soon as possible by emailing the Inquiry Secretary jaclyn.richardson@mahinquiry.org.uk.

If you have any queries about this correspondence, please do not hesitate to contact me.

Yours faithfully,

Lorraine Keown
Solicitor to the Inquiry

Encs:

1. Outline of Organisational Modules April – June 2024: Organisational Modules 2024.pdf (mahinquiry.org.uk)
2. MAHI Terms of Reference.
3. OM2024 Statement Format Guide.
4. Questions for Trust Board Members.

MAHI Muckamore Abbey Hospital Inquiry

M9: Trust Board
Questions to be Addressed in Witness Statement

Questions for Trust Board members

1. Please identify:

   i. The time period in which you were a member of the Trust Board.
   ii. Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub-committee(s).

2. Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Trust Board level?

3. To your recollection, how often was MAH included on the agenda of:

   i. Meetings of the Trust Board.
   ii. Meetings of the Executive Team.

4. Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

5. Did the Trust Board receive reports on the following (and if so, please indicate how often):

   i. Safeguarding of patients at MAH.
   ii. Seclusion rates at MAH.
   iii. Complaints relating to MAH.
   iv. Resettlement of patients from MAH.
   v. Staffing (both establishments and vacancies) at MAH.

6. If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:

   i. Who prepared those reports?
   ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?
   iii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?

7. Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.

8. What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also describe your recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

9. Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

10. From 2010 onwards, following bed closures at MAH:

    i. How did the Trust Board assure itself that the reorganisation of wards was safe?
    ii. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.

11. Were any issues relating to MAH ever included in:

    i. The Delegated Statutory Functions Report?
    ii. The Corporate Risk Register?

    If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.

12. Were SAIs which occurred at MAH always reported to the Trust Board? If so:

    i. What information did the Trust Board receive in respect of SAIs?
    ii. Were SAIs discussed at Trust Board meetings?
    iii. What actions did the Trust Board take in response to SAIs?

13. How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

14. Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

15. Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.

16. Other than as addressed in responses to the questions above, please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Trust Board level to address such concerns?

17. Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

18. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

2.011

Belfast Health and Social Care Trust
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Minutes of the Confidential Trust Board Meeting
Held on 5 July 2018 at 9 am
in the Boardroom, Belfast City Hospital

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr John Growcott	Director Social Work/Children's Community Services (Interim)

IN ATTENDANCE:

Dr Steve Austin	Deputy Medical Director (on behalf of Dr Jack)
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development (Interim)
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

Apologies

Mrs Nuala McKeagney	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Maureen Edwards	Director of Finance
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health

1. Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest reported.

b. Executive Director of Social Work/Director of Children's Community Services

Mr McNaney advised a recent interview process had resulted in a successful appointment to the Director of Social Work post and he wished to record Trust

Boards congratulations to Mrs Carol Diffin as the successful candidate who would be taking up post on 1 September 2018.

c. Dr Jack and Family

Mr McNaney wished to reflect that members' thoughts were with Dr Jack and her family at this difficult time.

2. Report of the Chief Executive

a. Neurology Review

Mr Dillon advised that the RQIA had written to the Trust regarding the Review of Governance of Outpatient Services in the Trust, with a particular focus on Neurology and other High Volume Specialties. The RQIA intended to complete the review in six months with the report submitted to DoH by mid-December, 2018.

Highlighting key areas Mr Dillon advised that Mrs Caroline Leonard had agreed to be the lead contact for this process.

Mr Dillon advised it was anticipated the panel referenced in the letter would visit the Trust for a week in September and preparations were now underway with a meeting to discuss scheduled with RQIA .

Mr Dillon briefed members on recent discussions regarding the impact of this issue, which had taken place with Neurologists, Dr Jack and Mrs Owens and advised of plans to facilitate a further meeting with the Permanent Secretary, CMO and the team.

Mr Dillon advised the Coordinating Group was due to meet 6 July. Due to annual leave Mr Brian Armstrong would be attending on behalf of Mrs Owens.

Mrs Owens presented the data report in respect of the Patient Call Back involving a total of 2529 patients. She advised the Trust was on track to deliver the review programme within the agreed 12-week period. Mrs Owens pointed out that some patients had declined an appointment and others had requested a date out with the 12-week period and these arrangements were being put in place.

In response to assurances sought by Mr McNaney, Mrs Owens advised the minimum duration of appointments was 30mins with a number longer, explaining further the nature of conversations with patients regarding their diagnosis depending on test results etc.

Highlighting how traumatic this could be some patients, Professor Bradley queried arrangements for psychology input.

Remaining concerned, following assurance from Mrs Owens Prof Bradley sought further clarity.

Mr Dillon advised he would commit to provision of more detailed explanation/description of arrangements for Trust Board if helpful.

Professor Jones joined the meeting.

Mr Dillon continued to explain the set up at clinics and the role of the Senior Managers on duty meeting and greeting patients and referring for counselling services as required.

Mr Dillon highlighted ongoing work with charities, explaining this support option was also signposted to patients at clinics and identified on the website. He also advised that Mrs Patricia Donnelly had developed a service user survey for the DoH in relation to the patient call back.

In responding to a further request for assurances from both Prof Bradley and Mr McNaney, Mrs Owens advised she could provide absolute assurance regarding the immediate support available at clinics with follow up telephone calls from a psychologist.

Mr McNaney commented a lot of information provided was immediate feedback and suggested the need for this to be triangulated with longer-term feedback.

Following a comment from Ms O'Reilly endorsing the need for more information the discussion continued. It was agreed Trust Board would be provided with detailed information from a number of sources to allow triangulation of information for assurance, including the outcome of a patient survey, feedback from charities involved, a copy of an information leaflet discussed and if possible a patient story to Trust Board as soon as possible.

Mr Dillon provided assurance that a lot of diligent work was being undertaken by Trust staff and an outcome report will be prepared in due course. He further advised that an exercise would be undertaken by the PHA to grade if any patient harm had occurred.

Dr Loughran confirmed he was content with the commentary but sought an update on the 100 patients who had initially not responded to attempts to contact.

Mrs Owens advised the latest figures were 38 remain still to be contacted and explained ongoing actions advising next step would be to visit addresses.

Trust Board agreed to note progress and sought future triangulated information and assurance around support being provided to patients.

Trust Board also acknowledged the importance of appropriately acknowledging the work of staff and agreed an opportunity to do so might present itself during a learning lunch in September proposed by Mrs Owens.

Mr McNaney drew attention to correspondence from Miss Christine Lynch, on behalf of the "We Support Dr Watt" group, outlining concerns regarding the review process and asking that Dr Watt be permitted to return to work.

Following discussion Mr McNaney asked Mrs Owens to follow-up on the issues raised in Miss Lynch's correspondence.

Prof Bradley asked that a copy of the Trust response be provided to members.

Mr Dillon advised that TIG was prioritising a regional review of Neurology Services.

b. IHRD Report Update

Mr Dillon provided an overview of progress in relation to Department of Health Work streams, referencing ongoing work at Trust level to understand gaps against the recommendations in the IHRD report.

Mr Dillon updated in relation to ongoing action regarding staff named and criticised in the report. Referencing a previous meeting Mr Dillon confirmed staff named did not present a current safety risk and referenced MHPS processes completed previously. Mr Dillon continued to explain the current process, describing the work of DDRC Group which manages all Health, conduct & performance concerns regarding Doctors and Dentists operates within the Department MHPS DHSSPS framework and is overseeing these cases. He advised this approach had been shared with NCAS. He also advised that in addition Verita, (independent expert company) had also agreed to carry out any formal investigation required.

Mr McNaney provided a summary of the recent meeting with the families of the children involved.

Mr McNaney explained families were offered a personal apology and provided with an outline of steps taken however, families continued to seek answers as to why Doctors had not been excluded.

In response to a query from Professor Bradley, Mr Dillon advised of the Trusts responsibilities as an employer. Mr Dillon advised staff also had rights and the MHPS process ensured appropriate management, some staff may need to proceed to formal investigation stage and if disciplinary action is required then it will follow.

Mrs Kennedy confirmed Doctors are subject to Trust disciplinary processes and the correct route is via MHPS. The steps are clearly laid out and any decision to exclude was very clearly defined criteria. Mrs Kennedy provided assurance of the Trust complete adherence to these processes.

In responding to a query from Professor Bradley regarding how Doctors gave evidence, Mrs Kennedy confirmed this fell under the conduct element of these processes.

Professor Bradley commented on the importance of now giving NCAS space to complete their work.

Further to a suggestion from Mrs Karp regarding the potential for all those identified, to proceed automatically to formal investigation given potential criticism about transparency, discussion followed regarding the balance required around retaining public confidence, satisfying families and ensuring fair processes.

Mr McNaney stated the Medical Director is responsible for the safety of practice, recommending members reflect to her concern regarding the issue of probity and seek assurance that it is taken into account.

In response to further concerns from Ms O'Reilly, Mr Dillon stated there should be no doubt that all those identified were being taken through a process of MHPS, all had been written to and all had self-referred to the GMC.

Mr Dillon continued that within MHPS DHSSPS framework each individual case had a nominated Non Executive Director and for these cases it had been agreed this would be Mrs Miriam Karp.

Dr Austin reminded members of the time elapsed between the incidents and the Inquiry. Acknowledging the importance of public confidence, he also highlighted the importance of staff confidence, emphasising the need to remember individuals were involved and therefore actions needed to be balanced and proportionate.

Dr Loughran confirmed his confidence in the process, stating twelve Doctors each was subject to internal processes; subject to external review and this needs to be allowed to run. He pointed out the Trust Board cannot interfere and cautioned of the potential to bring process to a standstill.

Responding to a query from Professor Bradley, Mr McNaney advised he understood Verita had already indicated possibly receiving evidence from families.

Mr McNaney summed up the discussion reiterating the Trust approach had been confirmed as appropriate by NCAS and Verita had been engaged to complete the external element. Mr McNaney suggested as a way forward, Trust Board should receive regular updates on progress to include the issue of probity and would not wish to interfere in process but rather receive assurances.

Professor Bradley commented he believed the Trust was following appropriate processes.

Responding to a query from Professor Jones, Mr Dillon confirmed he was confident in the event of being challenged the DDRC Group consisted of the correct people.

Mrs Karp explained her role and responsibilities within the framework further to a query from Ms O'Reilly.

c. Muckamore Abbey Hospital – Update

Mrs Heaney provided an update regarding ongoing investigations and oversight arrangements at Muckamore Abbey Hospital, summarised in a table paper.

Mrs Karp commented that she was very pleased to note that the additional staff recruited were now being phased in with eight healthcare workers commencing in June with a further 10 min July . This will be followed by the phasing in of staff nurses from August onwards. Mrs Heaney confirmed for Mrs Karp that the healthcare support nurses were being supervised and supported by clinical psychology. Mrs Heaney also clarified for Mrs Karp that a comprehensive induction and support programme was being developed for the new staff to ensure they had the appropriate guidance and support.

In response to clarification sought by Prof Bradley, Mrs Heaney confirmed of the three staff no longer working one had been dismissed with the remaining two currently suspended whilst disciplinary processes remain ongoing.

d. Commissioner for Older People NI – Investigation into Dunmurry Manor Nursing Home

Mrs Heaney referred to the Commissioner for Older People NI (COPNI) Dunmurry Manor (DM) report issued on 13 June, 2018 and advised that the Trust was considering the recommendations within the report. She explained that SEHSC Trust is the host Trust with the lead role in the management and co-ordination of the Adult Safeguarding investigation. In this context BHSCT, as one of the placing Trusts, will be working closely with all Trusts regarding agreed action plans to address the recommendations.

Mrs Heaney advised the Trust had written to all next of kin of residents currently in DM to offer reassurance and support this was also being followed up with a telephone call. In addition a similar letter was issued to all next of kin for all residents BHSCT has responsibility for in care homes.

Mrs Heaney reported that DM was owned by Runwood Homes Ltd., and has a care home in the BHSCT geographical area, Clifton House. The Trust is undertaking weekly monitoring visits to this facility and a number of issues are being followed up.

Members were advised that since opening BHSCT had placed 63 residents in DM in the first two years, currently there are 25 BHSCT residents in DM. Mrs Heaney advised during the COPNI investigation period the Trust had

responded to a total of seven incidents, which had met the threshold of an adult protection investigation. These included five incidents deemed to be of a sexual nature, involving resident with a diagnosis of dementia. One incident was of a physical nature and again involved residents deemed to lack capacity. A further serious incident in relation to pressure damage was also investigated and forms part of the COPNI report.

Mrs Heaney advised as part of the adult protection investigation, a wider screening in relation to Trust residents was undertaken and through this three individuals care had issues of concern and were reviewed. None of the records reviewed required investigation under the Adult Safeguarding Policy or referral to the PSNI. From September 2014 to June 2018 a number of incidents had been reported to the Adult Protection Gateway Team. However, these did not meet the threshold for investigation and were referred to the community social work teams for safeguarding investigation and follow up.

Mrs Heaney advised that in response to serious concerns in 2014/15 the Trust had carried out care reviews in relation to all Belfast residents in DM. Enhanced monitoring was introduced in DM by keyworkers, initially on a fortnightly basis. Inter-Trust meetings had agreed a more co-ordinated approach with weekly monitoring undertaken. Where safeguarding concerns were identified discussion took place between BHSCT ASGT and SEHCT ASGT. Inter-Trust meetings were held to discuss concerns and agree an action plan between SEHSCT and DM.

In relation to current arrangements in DM, Mrs Heaney advised that a Care Review and Support Team (CReST) practitioner was appointed to DM in April 2018. The practitioner is currently responsible for a number of Trust permanent residents. The CReST Service Manager undertook a monitoring visit on 25 June 2018 using the "Early Indictors of Risk Assessment Tool" with no issues identified and overall feedback had been positive.

In response to Professor Bradley, Mrs Heaney provided further assurance regarding remaining patients.

Ms O'Reilly advised oversight would be provided to the Social Care Committee and commended the CReST model in providing assurance there were no issues in respect of current residents.

In response to a query regarding moving forward and preparing for the future Mrs Heaney reinforced the need to develop this sector through partnership and Quality Improvement, flagging the need for future investment in the long-term care environment.

e. Dementia Ward – Knockbracken

Mrs Heaney provided a briefing in respect of workforce issues in a dementia ward on the Knockbracken site and arrangements being put in place to manage the situation.

In response to a question from Mrs Karp, Mrs Heaney advised that there were very strict monitoring arrangements in place to safeguard the patients.

Members noted the position.

f. Audiology

Mr Dillon outlined an emerging issue involving concerns raised by the Health Service Executive (HSE) regarding Paediatric Audiology services provided to Mayo and Roscommon by BHSCT. In addition to these concerns, Mr Dillon informed the Board of delays in responding to communication from HSE received by the Trust and apologised for the handling of this aspect by the CEO's office. Mr Dillon advised Mrs Caroline Leonard was currently leading on follow up of the issue regarding the provision of this service in Mr Dawson's absence and invited Mrs Leonard to provide a briefing.

Mrs Leonard provided assurance that the current BHSCT service was secure and the individual at the centre of concerns no longer had a clinical portfolio and at present was absent from the Trust.

Mrs Leonard explained some of the difficulties encountered in initially assessing the extent of the potential impact of the issue, outlining areas of risk such as Audiologists not required to register with a professional governing body as with other professions, making it less clear-cut to routinely assure competence.

Mrs Leonard explained this service is overseen as a diagnostic service and there had been initial difficulty in defining patient groups who could potentially be affected, which was compounded by current ill health of a key member of clinical staff. However, a risk assessment was underway and Mrs Leonard explained the methodology used which included identifying the cohort of potentially affected patients and chart review by a retired audiologist to determine if there had been risk exposure. Mrs Leonard confirmed the Public Health Agency was also fully engaged.

In response to a request for assurance regarding ensuring communications would be acted on appropriately, Trust Board were advised of work commenced to progress a document management system, which included an audit trail and supported robust monitoring of documents and associated responses.

g. Medicinal Cannabis Oil Licence

Mr Dillon briefed members the Trust had been notified this morning that a mother and her 12 year son (who has severe epilepsy and had been the centre of a campaign to see cannabis oil licensed for medicinal use in the UK) were travelling back to Northern Ireland from London this afternoon.

Mr Dillon outlined the young boy's circumstances relating to the issuing of an emergency licence from the DoH in order that he could receive the medicinal

cannabis oil. The DoH and Trust staff were working to co-ordinate the application and licence issue to BHSCT to allow the young boy to receive the medication in the RBHSC.

Members noted the position.

3.007

Belfast Health and Social Care Trust
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Minutes of the Confidential Trust Board Meeting held on 3 December 2020 at 9.00 am via Microsoft TEAMS (due to COVID-19 guidance)

Present

Mr Peter McNaney	Chairman
Dr Cathy Jack	Chief Executive
Professor Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr Chris Hagan	Medical Director

In Attendance:

Dr Brian Armstrong	Interim Director Unscheduled and Acute Care
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development
Mrs Bernie Owens	Director Neurosciences, Radiology
Mrs Charlene Stoops	Director Performance, Planning and Informatics
Ms Gillian Traub	Interim Director Adult and Primary Care
Dr Clodagh Loughrey	Interim Director Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Ms Paula Forrest	Co-Director Nursing – For Min.
Mr Wesley Emmett	Management Consultant - Observing
Miss Marion Moffett	Minute Taker

Apologies

Mrs Caroline Leonard	Director Surgery and Specialist Services
Mrs Bronagh Dalzell	Head of Communications

51/20 Minutes of Previous Meeting

The minutes of the confidential Trust Board meeting held on 1 October 2020 were considered subject to minor amendments.

51/20 Matters Arising

No items raised

52/20 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest reported.

53/20 Chief Executive's Report

a. Emerging Issues

i. Family Planning Services

Dr Jack advised on a concern which had arisen in the Family Planning Service relating to the management of women treated by Dr A. Dr A has been fully clinically restricted since August 2020. In October 2019 an SAI was notified about a unplanned pregnancy in a lady who should have had a long term contraceptive device implant. Then in December 2019 there was a further SAI notification about a woman having 2 implants (one not being removed). On the basis of an SAI Action Plan Dr A was identified as needing remedial training. Dr A was met with in March 2020 and underwent the required training.

In August 2020 a nurse colleague raised concerns around Dr A's practice. It also came to light another women had a second implant linked to Dr A and another woman had an unplanned pregnancy.

Dr Jack apologised that Trust Board had not been advised of the restriction in September.

Mr Dawson advised the Trust is working with PHA, DoH and SEHSCT (Dr A had clinics in Bangor) and are putting in place arrangements to review 667 patients seen by Dr A during the period October 2017 and August 2020.

Members noted Dr A is presently being investigated under the Maintaining High Professional Standards process.

Dr Jack advised there was a delay in the SAI reporting and a review of the process is being undertaken, led by Mr Dawson. In addition all Directorates are undertaking a review to identify peripheral clinics where there could be vulnerabilities if clinicians are working in isolation.

Mrs Karp sought clarification in relation to Dr A's restriction. Dr Jack advised Dr A is not off sick they are suspended with no patient facing duties.

In response to a comment from Professor Bradley, Mr Dawson advised a communication strategy is being developed and would include a briefing with political parties' health representatives.

Mr McNaney reflected on learning for the Neurology and Muckamore Abbey Hospital inquiries and stated that Trust Board should be advised at the time a doctor is restricted. He also expressed his disappointment that the review of lone workers has not been completed and sought assurance that this work would be completed as soon as possible.

Dr Jack advised that the Chairs of Division have been asked to review their areas in relation to lone working. She stated that discussions are ongoing with the Royal College to introduce Peer Review. Mr Hagan is developing a protocol that twice a year 10 randomly selected notes from two clinics will be pulled for all doctors across the organisation to ascertain if there ae any concerns.

ii. EU Exit

Mrs Kennedy presented a paper highlighting key issues for the Trust in relation the end of the transition period (EOTP) on 31 December 2020 following the UK's withdrawal from the European Union.

Members noted the Trust's contingency planning in respect of healthcare supply chain, access to healthcare/movement of people and data transfer.

iii. Health Committee

Dr Jack advised that she, together with Chief Executive colleagues had been invited to the Health Committee on 17 December to talk about Covid-19 response and waiting lists.

b. Covid-19 Update

Mr Hagan paid tribute to Mr Tony Doherty who had sadly died from Covid on 3 November, Mr Doherty had worked in Patient and Client Services for many years and will be greatly missed his colleagues and friends in the Trust.

Mr McNaney advised he and Dr Jack had written to Tony's wife and wished to formally express members condolences to the Doherty family.

Mr Hagan presented a report on the current Covid position. The number of cases had fallen since his previous report. The maximum number of cases had been 183 on 12 November, there were currently 119 in hospital (11 ventilated). There have been a total of 31 healthcare workers admitted with Covid since the beginning of the pandemic.

Mr Hagan advised plans are being put in place to open up the old Critical Care unit on the RVH site as a Covid Intensive Care Unit with 28 beds. This would free the BCH site to restart elective surgery.

In relation to Nosocomial Covid-19 Infections, Mr Hagan advised since April to end of November 2020 there had been a total of 40 outbreaks declared across Trust facilities in both primary and secondary care settings. This is a significant increase in the number of outbreaks declared during the second Covid-19 surge, when compared to the first surge, i.e. 8 between April and July 2020; and 32 between September and November 2020. The Infection Control Team carried out a review of these areas and identified some non-compliance around hand hygiene and use of PPE. Mr Hagan and Miss Creaney have discussed the findings with the IPC team and agreed actions to address the non-compliance.

- **Covid-19 Vaccination Programme**

Dr Jack advised that Mrs Owens was the lead Director for the Covid Vaccination Programme.

Mrs Owens explained the Covid-19 *Pfizer* vaccine is expected to be delivered to Northern Ireland this week. Each Trust is required to start vaccinating staff on 14 December and have all staff vaccinated with the first dose of vaccine by 7 January 2021. The second dose of the vaccine must be given 28 days later.

The Trusts Vaccination Centre will be the vacant ground floor of the Non-Clinical Support Building (NCS). The vaccinations will be given by trained peer vaccinators and senior nursing staff who will complete 3 hours of specific Covid vaccine training, having had 17 hours training before becoming peer vaccinators. A pharmacist is required to be in the Vaccination Centre at all times to ensure the appropriate management of the drug. Standard operating procedures have been developed in line with PHE guidance.

Trust staff from hospital and community settings will be vaccinated in the NCS. The plan is to have regular transport to and from hospital and community settings to facilitate access. Staff from the Independent sector, primary care and other Trusts can also have their vaccine in the Trust's centre.

The centre will operate 12 hours per day, 8am to 8pm, 7 days per week, with the exception of Christmas Day and Boxing Day. This will provide capacity to deliver 1,080 vaccines per day.

Mrs Owens advised the DoH is adopting a four nations approach to the vaccination programme. The DoH had recently been advised that the expected number of vaccines may not be received in Northern Ireland in January, which will have an impact on delivering the programme. Due to a change in the Joint Committee on Vaccination and Immunisation (JCVI) guidance clarification is awaited from the DoH regarding administering second dose i.e. in 21 or 28 days. The regional booking system automatically issues an appointment for second dose 21 days after the date of the first dose, this will have to be revised if changes to 28.

In relation to the Oxford vaccination, due in December, JCVI guidance for this vaccine is 28 days for second dose. As the Oxford vaccine is more mobile DoH plan that Primary Care will be able to administer the vaccine to nursing homes from 4 January 2021. However, clarification is awaited from the DoH in relation to this.

Dr Jack briefed members on a data breach relating to a vaccination trial, instead of issuing an email to individual people the email had been circulated to a number of people, Information Governance have been notified.

Mr McNaney acknowledged the enormous amount or work undertaken in a short amount of time and thanked Mrs Owens and the Covid Vaccination Team.

c. Valencia, Knockbracken Healthcare Park

Miss Traub presented an update report in relation to Valencia, Knockbracken Healthcare Park.

Members noted the report.

d. Meadowland, Musgrave Park Hospital

Dr Armstrong presented an update report in respect of actions being taken to address issues in Meadowlands, Musgrave Park Hospital

Members noted the report.

e. Learning Disability Services including Muckamore Abbey Hospital

Miss Traub presented the Patient Safety Report in respect of Muckamore Abbey Hospital. She referred to the RQIA unannounced inspection on 27-29 October 2020, and advised a feedback meeting has been scheduled with RQIA on 11 December 2020.

Ms O'Reilly advised she was meeting with Ms Creaney and Mrs Karp to discuss her new role as Lead Non Executive Director for Learning Disability was looking forward to supporting and working with families in developing the role.

Ms Traub advised a meeting is being scheduled with families and Ms O'Reilly.

Members noted the Historical CCTV and Disciplinary Process reports.

Mr McNaney welcomed the progress being made in respect of the disciplinary procedures.

f. Neurology

Mrs Owens advised that as yet the DoH have not agreed a date to publish the Outcomes 2 report. In relation to patient recall the HSCB and PHA have completed the review of records which identified 4,046 patients who had been prescribed the drugs listed. The Trust is in the process of validating this information. It is proposed these will be telephone reviews in the first instance followed by a face to face review if required. It is anticipated it will take 6 to 8 weeks for the Trust to complete the case note review.

In relation to Blood Patch procedure, the 22 records have been forwarded to the Royal College.

The DoH had indicated to Dr Watts solicitor they intended to provide the Verita Report in draft form to the Inquiry. Dr Watts solicitor has made an application for an injunction to the High Court. The Hearing has been listed for 7 January 2021, Counsel has been engaged through DLS to represent the Trust.

Members noted the Minister had announced on 24 November the Neurology Inquiry will complete as a Statutory Public Inquiry (SPI). The Trust is seeking clarification as to the process that will apply as the Inquiry moves to an SPI.

g. RCS Invited Review of Cardiothoracic Surgery Services

Mr Hagan presented an update in relation to action being taken to address the issues raised by the RCS following the Cardiothoracic Surgery Review.

Dr Jack advised the out-of-hours protocols for trainees have now been developed providing clear escalation procedures. Mr Hagan advised that he had a further meeting with the trainees recently which had been very positive.

Members noted the report.

h. IHRD

Mr. Dawson presented recent correspondence from the DoH in respect of changes to the IHRD programme structure and providing an update on the current and future work of the programme.

Ms O'Reilly advised she had recently attended a meeting of the Being Open Group at which the consultation process had been discussed, including a stakeholder engagement plan and public survey.

Mrs Kennedy advised there is regional training programme being developed in relation to Just Culture.

In noting the position Mr McNaney referenced the need for the Just Culture Agenda workstream to be taken forward alongside the Duty of Candour.

54/20 Director of Nursing and User Experience

a. Nursing Workforce

Mr McNaney welcomed Ms Forrest to the meeting.

Miss Creaney gave a detailed presentation on the Nursing and Midwifery Workforce Strategic Plan and explained the plan was a work in progress. She wished to thank Professor Bradley and Mrs McKeagney for their support to date. She explained the purpose of the presentation was to update Trust Board on the current issues and actions being undertaken and proposed future actions with regard to improving the overall Nursing and Midwifery workface position with the aim to make Belfast the employer of choice for Nurses and Midwives

Miss Creaney highlighted that the nursing and midwifery workforce across the Trust has experienced challenges in recruitment and retention over the last 10 years, in spite of a number of strategies, increase in postgraduate places and international recruitment. The current Trust vacancy level is 17.2 %. The current workforce availability does not meet the pace of service development and demand for nurses and midwives across the province. This is also replicated across the UK and globally.

Miss Creaney advised that Divisional teams have developed action plans specific to their areas. The Trust is working with commissioners, the DOH, Belfast City Council, trade union colleagues and the three universities who provide post graduate Nursing and Midwifery education across NI.

Mrs Kennedy referred to the workforce capacity and pointed out that if the Trust was successful in recruiting all nurse graduates it would not have any significant impact on the nurse vacancy position. The Trust needs to be innovative and creative in attracting nurses from other countries. The Trust is part of the regional international recruitment campaign with 23 successful candidates due to take up employment in the Trust in November/December. The DoH is planning a further international recruitment campaign.

Mr McNaney emphasised the need for Trust Board members to work together to improve and develop coherent solutions in relation to nurse recruitment.

Professor Jones reflected on the need to clarify what the targets are in relation to addressing the issues. He emphasised the need to find solutions and partnership working with education providers to develop appropriate training programmes to ensure people have the skills required. Professor Jones stated that he was committed to working with Directors to bring forward a plan to address the nursing workforce issues.

Mrs Edwards explained that a workforce strategy will require a full business case to be developed, including a full financial analysis and various funding methodologies for submission to the DoH.

Mrs Karp referenced the risk to the organisation and the need to be innovative in creating a skill mix of roles to meet service need i.e. an apprenticeship scheme. She referenced the need to learn from good practice in other countries and the role of Nurse Practitioners in England.

Professor Bradley commented on the need to increase student graduate programmes and develop appropriate skill sets across professions. The Trust needs to bring forward proposals to assist the DoH in addressing the regional workforce issue.

Mr Smyth commented on the high cost and reliance on agency staff which is not sustainable. He also highlighted the need for a retention strategy to encourage staff to remain in the Trust.

Mrs McKeagney acknowledged the need for further development of the workforce plan and strategy and said she would be supported members comments and the need for further development of the nursing strategy.

Ms O'Reilly commented on the need for health and social care roles to clearly be defined. She advised the Northern Ireland Social Care Committee are currently considering the needs of a workforce for health and social care.

Mrs Diffin advised that a social work/social care workforce strategy is in the early stages of development and reflected on similar issues as nursing.

Dr Jack stated the need to look at competence based models, based on population needs. She advised the Trust was linking with Northumbria Trust to learn from their theatre workforce model.

Members reflected on learning from Covid and how staff had been trained to be redeployed in ICU.

Miss Creaney referred to exploring non nursing roles

Dr Jack undertook to discuss with the Chairman the establishment of an Oversight role for Non Executive Directors to contribute to the development of a nursing workforce strategy which would be presented for further discussion by Trust Board in early 2021.

Following a lengthy discussion Mr McNaney stressed the need for Trust Board to ensure the nursing workforce issues are addressed in the interests of the safety and effectiveness of the organisation. He wished to record his appreciation to Professor Jones, Professor Bradley and Mrs McKeagney for their offer to collaborate with Director Colleagues to develop the strategy.

BOARD ASSURANCE FRAMEWORK

2016-2017

Index

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, young people, 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 Trust Corporate Management Plan 2016-2017.

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 outlines 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.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives[1];
- Identified principal risks that may threaten the achievement of those objectives;
- Controls in place to manage these risks, underpinned by core Controls Assurance Standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast Health and Social Care Trust – Trust Vision & Corporate Plan 2013/4-2015/6; Corporate Management Plan 2015/6 & Trust Delivery Plan 2015/16

On an ongoing basis the Board will:

- Assess the assurances given;
- Identify where there are gaps in controls and/or assurances;
- Take corrective action where gaps have been identified; and
- Maintain dynamic risk management arrangements including, crucially, a regularly reviewed Principal Risk Document.

2. Strategic Context

In order to produce the outcomes for which the Department of Health (the Department) is ultimately responsible, a strong partnership is required between the Department and those HSC organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

The Minister's Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

New Directions 'A blueprint for future health and social care delivery in Belfast Trust' , which will determine the future shape of services within Belfast Trust, is currently under development. The existent 3-year Trust Vision & Corporate Plan affirms the Trust Vision and Values, and sets out the three-year commitment for Trust services with identified outcomes. The Trust Vision is to:

'continuously improve health and social care delivery and foster innovation in pursuit of this goal. We will seek to achieve the right balance between providing more health and social care in, or closer to, people's homes and supporting the specialist delivery of acute care, thereby delivering positive outcomes for the people who use our services.'

The Trust Delivery Plan (TDP) describes how the Belfast Trust plans to use its resources to deliver health and social care services to patients, clients, children and young people, carers and families, and presents the Trust's proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets.

3. Objective Setting

The Trust's Annual Corporate Management Plan, supported by Directorate Management Plans, identifies the annual objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan.

The Trust has identified six Key cross-Directorate Themes this year, each led by a Lead Director, working across Directorates. These 'Big 6' themes are:

- Build the will and the capacity to ensure that continuous quality improvement and the relentless reduction of patient harm becomes our greatest focus.
- Improving care to support more people to live well at home.
- Improving Elective Care with an emphasis on Cancer Care improvement. Develop and deliver an Improvement Plan for Elective Care including Cancer performance.
- Improving Unscheduled Care – Identify, resource and deliver the Unscheduled Care Plan for 2016/17 including Escalation Arrangements.
- Implement the Organisational Development Framework to realise our ambition of being recognised as a world leader in the provision of health and social care.
- Develop an integrated plan for the people of Belfast with a range of partners and agencies.

Each Key theme links to the Trust's five strategic objectives, which remain as:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.
- Continuous Improvement - Our commitment: to work in partnership across the community, voluntary, statutory, public and private sections to deliver improvements in service, quality and experience to the people who use our services

- Partnerships -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion

- Our People - we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce

- Resources - we will work to optimise the resources available to us to achieve shared goals.

Directorate Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

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[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Directions and the HSCB/PHA Commissioning Plan.

While the Corporate Management 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 Management Plans;
- Service/Team annual plans;
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

4. What Assurance Means

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).

This 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. Accountability

5.1 Accountability to Minister and the DHSSPS

Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, efficiency savings and service improvements will be delivered. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements. The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social services to the people of Northern Ireland and for good governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

5.2 Accountability with the Health & Social Care Board

The Health and Social Care Board and Health and Social Care Trusts are accountable to the public for the services that they commission and provide.

The basis for HSC accountability is the Health and Personal Social Services (Northern Ireland) Order 1972[2] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department the duty to:

- provide or secure the provision of integrated health services in Northern Ireland designed to promote the physical and mental health of the people of Northern Ireland through the prevention, diagnosis and treatment of illness;

- provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland; and

- secure the efficient coordination of health and personal social services.

Under Article 16 of the 1972 HPSS Order, the HSS Boards were established for the purpose of administering and providing health and personal social services within their respective areas. This broad remit changed in the early 1990s when the HPSS (NI) Order 1991[3] (augmented by the HPSS (NI) Order 1994[4]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards' planning and commissioning of services for their resident populations, and the Trusts' provision of those services, remains but the HSS Boards functions have now been subsumed into those of the single regional Health & Social Care Board (HSCB). The Board was established in April 2009 by the Health and Social Care (Reform) Act (Northern Ireland) 2009 and includes five Local Commissioning Groups (LCGs) coterminous with the Trusts, Public Health Agency (PHA), a Business Services Organisation (BSO) and a Patient and Client Council (PCC).

Regarded from the accountability perspective, there are two broad categories of HPSS activity:

- Category one: those services identified as being needed and commissioned by the HSC Board from Trusts. The volume and quality of which are detailed in Service and Budget Agreements between the commissioner and the providers. This category also includes statutory obligations of Trusts including delegated statutory functions.

- Category two: certain duties to be performed by HSC organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

[2] S.I.1972/1265 (N.I.14)
[3] S.I. 1991/194 (N.I. 1)
[4] S.I. 1994/429 (N.I. 2)

In accountability terms, there are differences between the two categories. In category one, Trusts are, initially answerable to the HSCB, via their Service and Budget Agreements, for the quantity, quality and efficiency of services. This relationship has been strengthened by the introduction of the statutory duty for the quality of services commissioned for, and provided to, the population which applies to both the HSCB and Trusts [5]. In this category, therefore, Trusts are responsible to the HSCB for the delivery of services to the quantity, cost and quality specified in Service and Budget Agreements.

Trusts, as corporate entities, are responsible in law for the discharge of statutory functions. The Trust is accountable to the HSCB for the discharge of those statutory functions delegated by the HSCB (relevant functions) and those conferred directly on Trusts by primary legislation. It is obliged to establish sound organisational arrangements to discharge such functions effectively. The majority of these functions relate to services provided by the Trust's professional Social Work and Social Care workforce.

The Scheme for the Delegation of Statutory Functions (the Scheme) sets out for each Service Sector the statutory duties delegated by the HSCB to the Trust and the accountability arrangements pertaining to these functions.

The Scheme specifies the organisational control and assurance processes informing the Trust's discharge of its statutory functions.

The nature and scope of the statutory functions and related services discharged by the Trust give rise to enhanced levels of public scrutiny. These include interventions in matters of personal liberty, the protection of vulnerable children and adults, the Trust's corporate parenting responsibilities, the provision of vital services and the exercise by the Trust of regulatory functions. Their effective discharge is central to organisational integrity. As a consequence, they have a heightened organisational and corporate significance and related assurance profile. The Trust is required to have in place systems that are robust and capable of balancing appropriately the complex issues of protection and care.

The Trust is accountable to the HSCB for the effective discharge of its statutory functions as well as the quantity, quality and efficiency of the related services it provides. The HSCB has the authority to monitor and evaluate such services and requires the Trust to produce an annual report on how it has discharged its relevant functions.

In category two (financial control, governance, and for overall organisational performance etc) the HSCB is accountable directly to the Department. The HSCB may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc on

[5] Paragraph 5 of HSS(PPM) 10/2002

governance or financial control. The Trust has been identified as a designated body by the General Medical Council and the Nursing and Midwifery Council and will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

6. The Assurance Framework

This Assurance Framework provides a comprehensive and systematic approach to effectively managing the risks to meeting our objectives. The framework illustrates the wide range of assurances from internal and external sources. The most objective assurances are those derived from independent reviewers – which will include the Regulation and Quality Improvement Authority, Departmental special inquiries or reviews and Internal and External audit. These are supplemented from non-independent sources such as performance management, multi-disciplinary audit, self-assessment reports and professional monitoring and review processes within legislative and professional regulatory guidance.

The role of the Courts in the 'regulation' and the holding of the Trust to account with regard to the discharge of its statutory functions is of key importance, for example when applying for a child care order.

It is important that as information is collated and evaluated across the Trust that this is done in a consistent and efficient way, is proportionate and minimises duplication of work by different reviewers.

This framework provides a structure for acquiring and examining the evidence to support the Statement of Internal Control.

Risk Management

The Belfast Trust has a risk management strategy that underpins its policy on risk (see Appendix A) and explains its approach to acceptable risk.

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the principal risks to achieving these objectives. These are encapsulated as the Principal Risk Document. There are systems in place to monitor and review risks which are delegated below Corporate level.

Controls Assurance remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard. The results will be reflected in the Trust's Corporate Risk Register.

The Belfast Trust has and continues to develop an open and learning culture that encourages continual quality improvement, but with openness when things go wrong. Processes for managing and learning from adverse incidents, complaints and litigation are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust's Being Open Policy.

Quality Improvement

The Trust is continually aiming to improve the quality of services we deliver to our patients and clients and to improve the working environment for our staff. We recognise that we cannot provide high-quality care consistently across all our services without having a fundamental all-embracing approach to quality improvement (QI) that runs throughout the organisation. The three landmark reports in 2013 on quality and safety in the NHS (Francis Report, Keogh Review and the Berwick Report) all recommended the development of an organisational culture which prioritises patients and quality care above all else with clear values embedded throughout all aspects of organisational behaviour and a relentless pursuit of high-quality care through continuous improvement. The Trust is developing a new five-year Quality Improvement Strategy to build QI capacity throughout the organisation and to ensure integration with the Assurance Framework.

Organisational Arrangements

Proposed organisational arrangements for governance and assurance are set out in Appendix B. An important element of the Trust's arrangements is the need for robust governance within Directorates. This will be tested through the accountability review process. There are a number of internal and external mechanisms that support this.

The **Board of Directors** is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team;
- Ensuring accountability to the public for the organisation's performance;
- Assuring that the organisation is managed with probity and integrity.

The membership of the Board of the Trust is defined in the Establishment Order to include the Directors of Social Work, Medicine, Nursing and Finance.

The Audit Committee

The Audit Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors. Its role is to assist the Board in ensuring an effective control system is in operation. This includes the effectiveness of internal financial controls, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance in the Belfast Trust.

The Assurance Committee

The Assurance Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors only. Its 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 the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

The Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the Remuneration Committee is to provide 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 Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

The Executive Team

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by the Board of Directors as part of the performance management and assurance processes, is available.

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update the Principal Risk Document, which will inform the management planning, service development and accountability review process.

The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny committees. The Assurance Group will be responsible on behalf of the Executive Team for developing and maintaining the Assurance Framework, including the Principal Risk Document. It will be responsible for maintaining a programme of self-assessment and independent audit/verification against required standards, other than finance.

Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice across the Trust.

7. Accountabilities and Responsibilities for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be clear about the functions of governance and their roles and responsibilities. Good governance means promoting organisational values at all levels, taking informed and transparent decisions, managing risk, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

The Role of the Board

The role of the Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of timely information to Board members and effective communication with staff, patients and the public.

The Role of the Non-Executive Directors

Non-Executive Directors will assure themselves and the Trust Board that the Audit Committee and Assurance Committee and related committees are addressing key governance issues within the organisation. Their responsibilities include:

Strategy: by constructively challenging and contributing to the development of strategy;

Performance: through scrutiny of the performance of management in meeting agreed goals and objectives;

Risk: by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible.

Non-Executive Directors are responsible for ensuring the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

The Role of the Chief Executive

The Chief Executive through his/her leadership creates the vision for the Board and the Trust to modernise and improve services. He/she is responsible for the Statutory Duty of Quality. He/she is responsible for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. His/her responsibilities include leadership, delivery, performance management, governance and accountability to the Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

The Role of the Executive Team

The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team is responsible for ensuring that the Board, as a whole, is kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

The Role of the Deputy Chief Executive/Director of Finance & Estates

As Deputy he/she both deputises for the Chief Executive and undertakes duties beyond the scope of Finance and Estates in line with service needs and organisational objectives.

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. He/she is, with the Chief Executive, responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with the Department of Health and Treasury requirements.

The Director of Finance and Estates ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meets it statutory and legal responsibilities relating to finance, financial management and financial controls. He/she ensures that the Trust has in place Standing Orders and Standing Financial Instructions, including Reservation of Powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

The Director of Finance and Estates is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to the Board of Directors.

The Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development is accountable to the Chief Executive for ensuring the Trust has in place systems of staff management which meet legal and statutory requirements and are based on best practice and guidance from the Department of Health and other external advisory bodies. Working closely with other Directors he/she maintains a system of monitoring the application of the Trust's Human Resources Strategy, policies and procedures and, on behalf of the Board, ensures it receives the relevant information/annual reports according to the Board's information schedule.

The Trust's Learning and Development function falls within the remit of the Director of Human Resources. As such he/she works with relevant Directors to ensure the system of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

The Medical Director – Lead Director responsible for Integrated Governance and Risk Management, including Clinical Governance, and Quality Improvement

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management and excluding finance. This responsibility is shared with the Director of Nursing & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet its statutory and legal responsibilities relating to their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on the Board's ability to fulfil its governance responsibilities.

As part of the Trust's performance and assurance process, the Director of Performance Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and

User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services

The Director of Social Work/Children's Community Services is responsible for ensuring the effective discharge of statutory functions across all Service Sectors and the establishment of organisational arrangements and structures to facilitate same. She/he is required to report directly to Trust Board on the discharge of these functions, including the presentation of the annual Statutory Functions Report and six-monthly Corporate Parenting reports.

The Director of Social Work/Children's Community Services provides professional leadership to and is responsible for the maintenance of professional standards and all regulatory issues pertaining to the Trust's social work and social care workforce.

The Director of Performance, Planning and Informatics

The Director of Performance, Planning and Informatics is accountable to the Chief Executive for ensuring that a performance and accountability framework suitable for the delivery of the Trust Delivery Plan and Corporate Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

Service Directors

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social & Primary Care;
- Director of Unscheduled & Acute Care

The Service Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance. Each Directorate will establish a Directorate Assurance Committee and develop systems and structures to support the various governance strategies, policies and procedures and ensure these are audited and monitored.

Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management and the assurance framework, the Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, the objectives and targets for their Directorate, based upon the management plan agreed by the Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Directorate performance reviews.

The Directorates are supported and facilitated to meet their governance requirements by their dedicated governance leads and the risk and governance staff of the Medical Director's office.

8. Board Reporting

It is important that key information is reported to the Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow the Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Chief Executive, Director of Finance and Estates, Medical Director, and Director of Planning, Performance and Informatics will be responsible for providing the monitoring and support for the Assurance Framework and providing an updated position on performance and governance, the effectiveness of the Trust's system of internal control; providing details of positive assurances on principal risks where controls are effective and objectives are being met; where the organisation's achievement of its objectives is at risk through significant gaps in control; and where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It is important for the quality and robustness of this Assurance Framework that it is evaluated by the Board annually.

Appendix A

RISK MANAGEMENT POLICY STATEMENT (INCORPORATING A DEFINITION OF ACCEPTABLE RISK)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

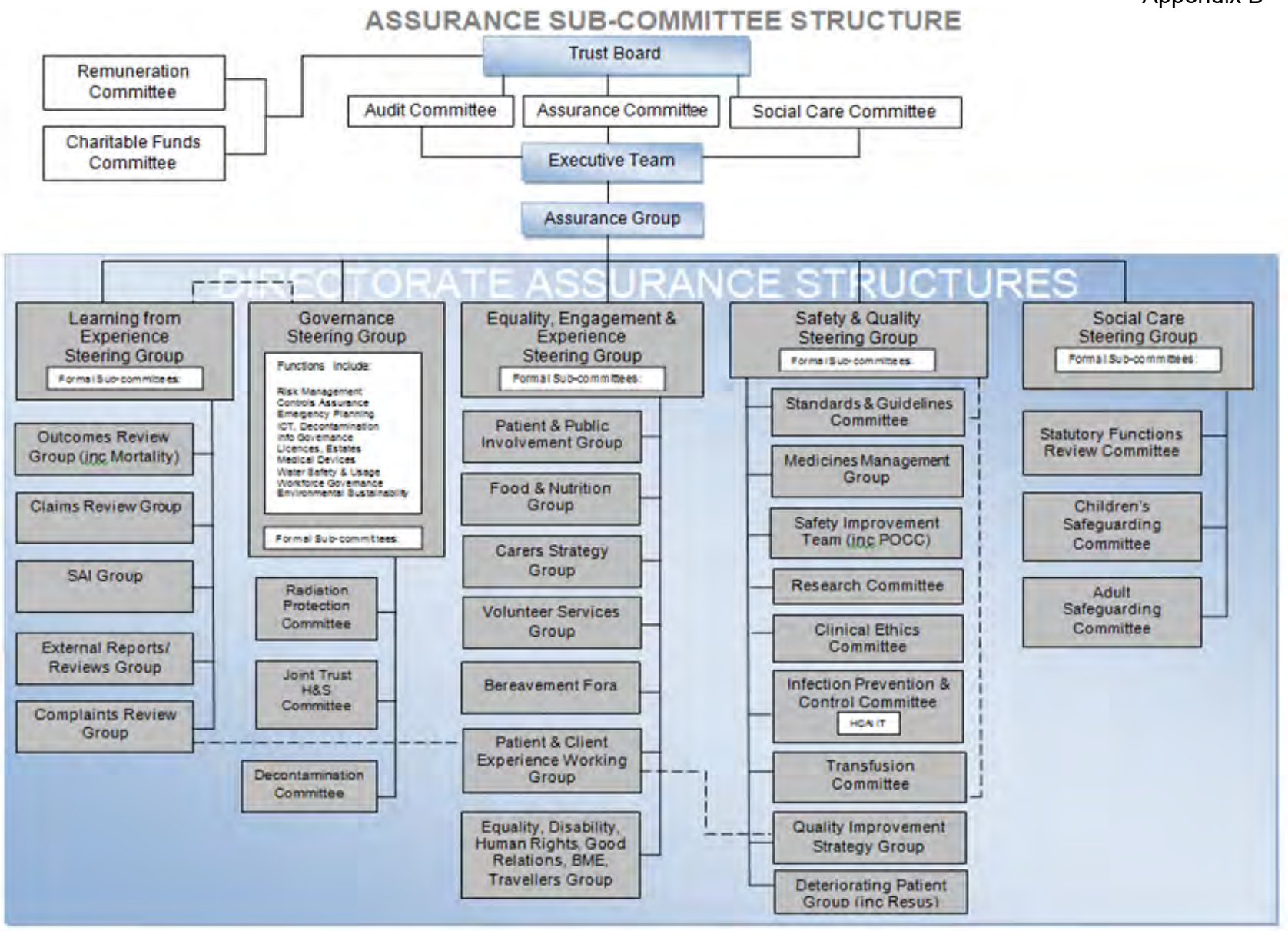
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

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. It will identify acceptable risks through a systematic and objective process. 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 involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

Appendix B


ASSURANCE SUB-COMMITTEE STRUCTURE
Trust Board
Remuneration Committee
Charitable Funds Committee
Audit Committee
Assurance Committee
Social Care Committee
Executive Team
Assurance Group
DIRECTORATE ASSURANCE STRUCTURES
Learning from Experience Steering Group
Formal Sub-committees:
Outcomes Review Group (inc Mortality)
Claims Review Group
SAI Group
External Reports/ Reviews Group
Complaints Review Group
Governance Steering Group
Functions include:
Risk Management
Controls Assurance
Emergency Planning
IGT, Decontamination
Info Governance
Licences, Estates
Medical Devices
Water Safety & Usage
Workforce Governance
Environmental Sustainability
Formal Sub-committees:
Radiation Protection Committee
Joint Trust H&S Committee
Decontamination Committee
Equality, Engagement & Experience Steering Group
Formal Sub-committees:
Patient & Public Involvement Group
Food & Nutrition Group
Carers Strategy Group
Volunteer Services Group
Bereavement Fora
Patient & Client Experience Working Group
Equality, Disability, Human Rights, Good Relations, BME, Travellers Group
Safety & Quality Steering Group
Formal Sub-committees:
Standards & Guidelines Committee
Medicines Management Group
Safety Improvement Team (inc POCC)
Research Committee
Clinical Ethics Committee
Infection Prevention & Control Committee
HCAI T
Transfusion Committee
Quality Improvement Strategy Group
Deteriorating Patient Group (inc Resus)
Social Care Steering Group
Formal Sub-committees:
Statutory Functions Review Committee
Children's Safeguarding Committee
Adult Safeguarding Committee

Appendix C

Belfast Health and Social Care Trust
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Assurance Group & Committee Annual Schedule of Reports 2016

Assurance Committee	9 Feb	26 Apr	25 Jul	8 Nov
Assurance Group	**27 Jan**	**13 Apr**	**22 Jun**	**12 Oct**
Assurance Framework Principal Risk Document	✓	✓	✓	✓
Risk Management Strategy (every 3 years latest 2013-16)	✓			✓
Board Assurance Framework (Annual Revision)		✓		
Legal Services Quarterly Report	✓	✓	✓	✓
Legal Services Annual Report			✓	
Serious Adverse Incidents Quarterly Report	✓	✓	✓	✓
Serious Adverse Incidents Annual Report			✓	
Incident Quarterly Report	✓	✓	✓	✓
Incident Annual Report			✓	
Complaints Quarterly Report	✓	✓	✓	✓
Complaints Annual Report			✓	
Health & Safety Annual Report				✓
Information Governance Annual Report			✓	
Controls Assurance Compliance Annual Report		✓		
Fire Safety Annual Report			✓	
Infection and Prevention Control Annual Report			✓	
RQIA Thematic Reviews	✓	✓	✓	✓
RQIA Regulated Providers Inspections Summary	✓	✓	✓	✓
Trust Quality Improvement Plan (inc Graph Set)	✓	✓	✓	✓
Medical & Dental Revalidation Report		✓		
Professional Nursing Report	✓		✓	
Mater Trustee Meeting Minutes	✓	✓	✓	✓

Belfast Health and Social Care Trust
caring supporting improving together

Integrated Governance and Assurance Framework

Index

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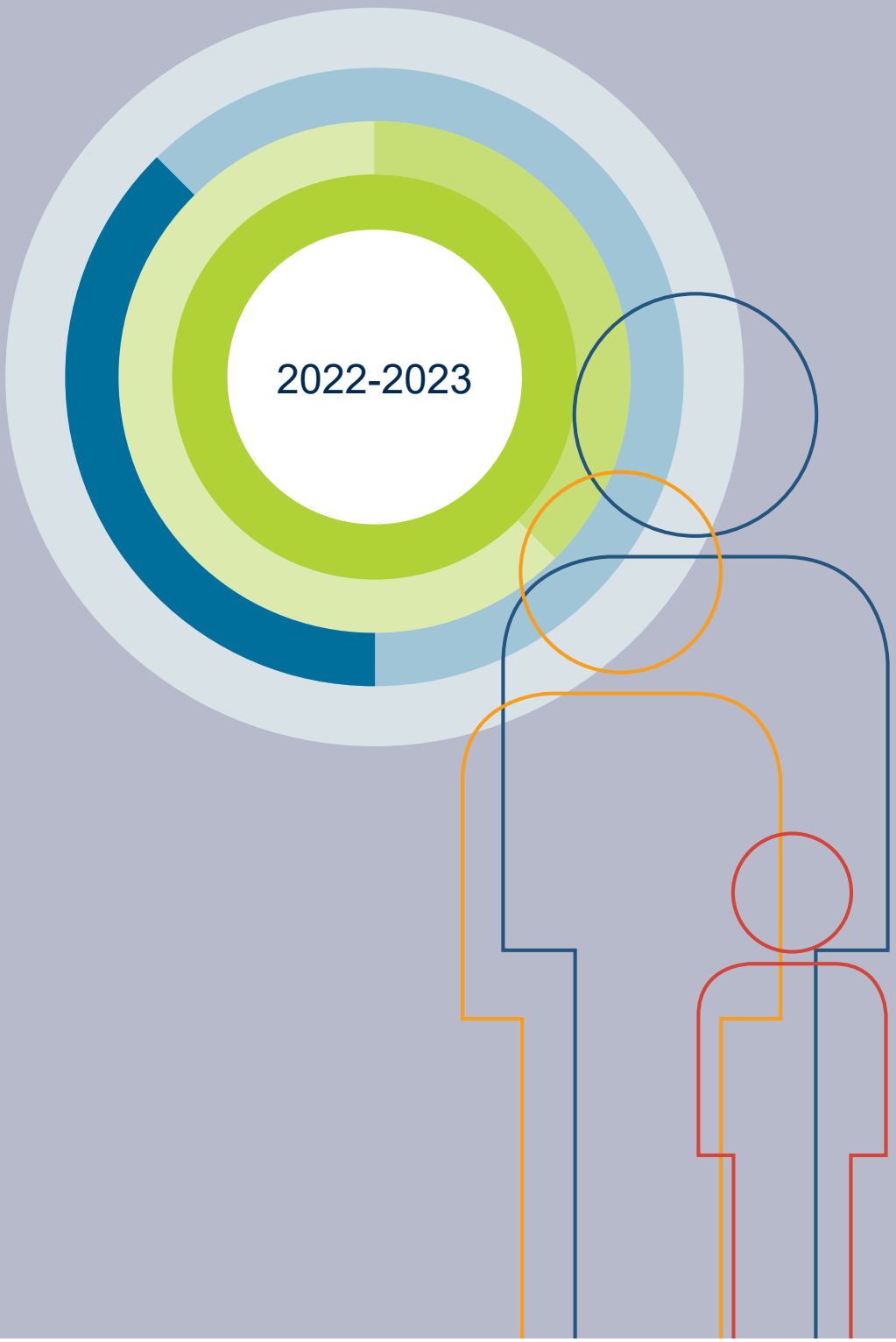
1. Introduction



1. Introduction

1. Introduction

'Belfast Trust is at the heart of our community. Our people – patients, service users, carers and staff – are the centre of Belfast Trust. The dedication, resilience, innovation and flexibility of our staff enables our services to rise to the enormous challenges to meet the needs of our community.'

Corporate Plan 2021-2023

This Integrated Governance and Assurance Framework Document sets out the Belfast Trust's Board arrangements for integrated governance and details the organisational structure and accountability arrangements by which Trust Board's responsibilities are fulfilled. It should be read in conjunction with the Belfast Trust Risk Management Strategy 2020-2021[1] and the Trust's Corporate Management Plan 2021-2023[2], which details the Trust vision, values, culture, priorities and its commitment's to patients, service users and staff.

As an integrated Health and Social Care Trust, Belfast Trust works in partnership with our community to deliver regional, local, emergency and elective services to older people, children and families, to those people with a learning disability, physical disability and mental health conditions.

Our service users need to be confident about the quality of care they receive. They want services that are readily accessible, are safe and are provided by competent and confident staff who will always work in their best interests. As a Trust, we provide and are accountable for the delivery of high quality, safe and compassionate care in an environment of openness and transparency.

We are committed to embedding all learning from many sources and in doing so improving the quality of care provided. We recognise the powerful contribution that theming and identifying trends in complaints can have and as a learning organisation, we prioritise the learning from this, across the organisation. It is the Trust's aim, that all staff will recognise that a complaint can be an 'early warning' to failings in treatment and care, and as such we prioritise that all staff, from ward to board respond positively to any concerns raised, take immediate action to resolve, escalate (where required) and learn.

Increased scrutiny has raised issues of concern with some of the treatment and care delivered by the Belfast Trust. This has undoubtedly affected the confidence and trust of our service users; which we as The Belfast Trust are committed to restore. We are committed to implementing and incorporating the learning from all sources of inquiry (eg. Hyponatremia related deaths[3], Neurology Inquiry, the 2020 Muckamore Leadership and Governance review[4] and the pending Muckamore Inquiry), complaint/NIPSO investigations, SAI reviews

1 BHSCT Risk Management Strategy 2020-2021
2 BHSCT Corporate Plan 2021-2023
3 Home | Inquiry Into Hyponatraemia-related Deaths (ihrdni.org)
4 A Review of Leadership & Governance at Muckamore Abbey Hospital (health-ni.gov.uk)

1. Introduction

etc., alongside to being committed to the implementation of all new guidance issued eg. Duty of Candour.

We recognise that this needs to happen within an environment of increased scrutiny, hard financial realities and an increased pace of change. Our commitment to improve and learn will be underpinned by our values of working together, excellence, openness & honesty and compassion, to work collaboratively with all stakeholders to achieve and sustain improvements. We accept that greater scrutiny is required, especially in services where due to vulnerability; patients are unable to speak for themselves and alert us to poor care.

The Board of Directors of the Belfast HSC Trust (Trust Board) has a responsibility to provide high quality care, which is safe for patients, service users, young people, visitors and staff, and which is underpinned by the public service values of accountability, probity and openness.

Trust Board is accountable for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives and in line with the objectives set by Ministers. To ensure we provide the Right Care at the Right Time and in the Right Place, we will be measuring and reporting on our achievements and progress against a number of key metrics within a Quality Management System

Trust Board, is required to have in place, integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance aspects. This will better enable Trust Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, social care, quality, safety and financial objectives.

Integrated Governance was defined by the NHS Confederation as 'systems and processes by which Trusts lead, direct and control their function in order to achieve organisational objectives, safety and quality of services and through which they relate to patients, the wider community and partner organisations.'[5]

5 2016 (Oct) The New Integrated Governance Handbook 2016: developing governance between organisations

1. Introduction

This Framework identifies Belfast Trust integrated governance and assurance arrangements, describing how Trust Board's responsibilities are fulfilled.

1.1 Aim of the Integrated Governance and Board Assurance Framework

The aim of this Framework is to ensure that there is a common understanding throughout the Trust of what is meant by assurance and its importance in a well-functioning organisation.

This Framework should provide Trust Board with confidence that the systems, policies and people are operating effectively, are subject to appropriate scrutiny and that Trust Board is able to demonstrate that they have been informed about key risks affecting the Organisation.

It can be utilised by Trust Board as a:

- Strategic but comprehensive method for the effective and focused management of the strategic risks to meeting the Trust Objectives
- Structure for the evidence to support the Annual Governance Statement
- Method of aggregated board reporting and the prioritisation of action plans which, in turn, allows for more effective performance management
- Document, to help inform decision making and prioritisation of work relating to the delivery of strategic objectives.

In addition, the Board Assurance Framework Risk Document (formally principal risk document) identifies potential risks to the achievement of organisational objectives, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It outlines the sources of evidence, which Trust 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 Directors of the Belfast HSC Trust have:

- Defined Corporate objectives/ Priorities[6]
- Identified strategic risks that may threaten the achievement of those objectives
- Controls in place to manage these risks, underpinned by core Assurance Standards
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas.

6 BHSCT Corporate Plan 2021-2023

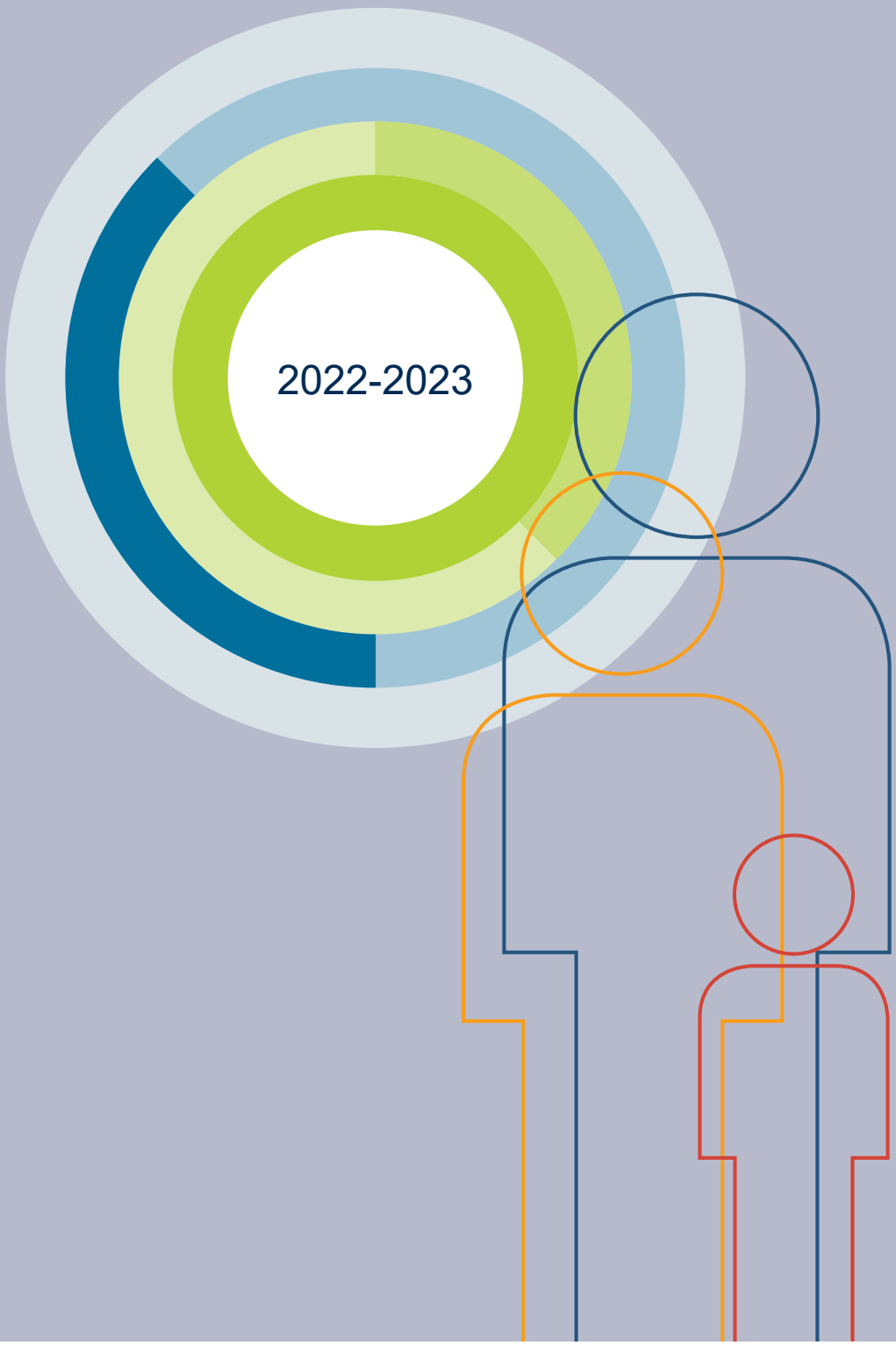
1. Introduction

On an ongoing basis, Trust Board will:

- Assess the assurances given
- Identify where there are gaps in controls and/or assurances
- Take corrective action where gaps have been identified
- Maintain dynamic risk management arrangements including, crucially, regularly reviewed Strategic Risks.

1. Introduction

2. Strategic Context



2. Strategic Context

The Programme for Government (PfG) Framework sets out the major outcomes that the Northern Ireland Executive wants to achieve for Northern Ireland society.[7] By setting clear priorities, the PfG Framework informs the targeting of funds. The Trust reflects these priorities and strategic outcomes in their own strategic directions and sets them out in their Corporate Plans.

In order to produce outcomes (for which the Department of Health (the Department) is ultimately responsible), a strong partnership is required between the Department and those HSC organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

Prior to the COVID-19 pandemic the DoH Commissioning Directions and the HSCB/PHA annual Commissioning Plan were in place to reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they formed an action plan for the HSC.

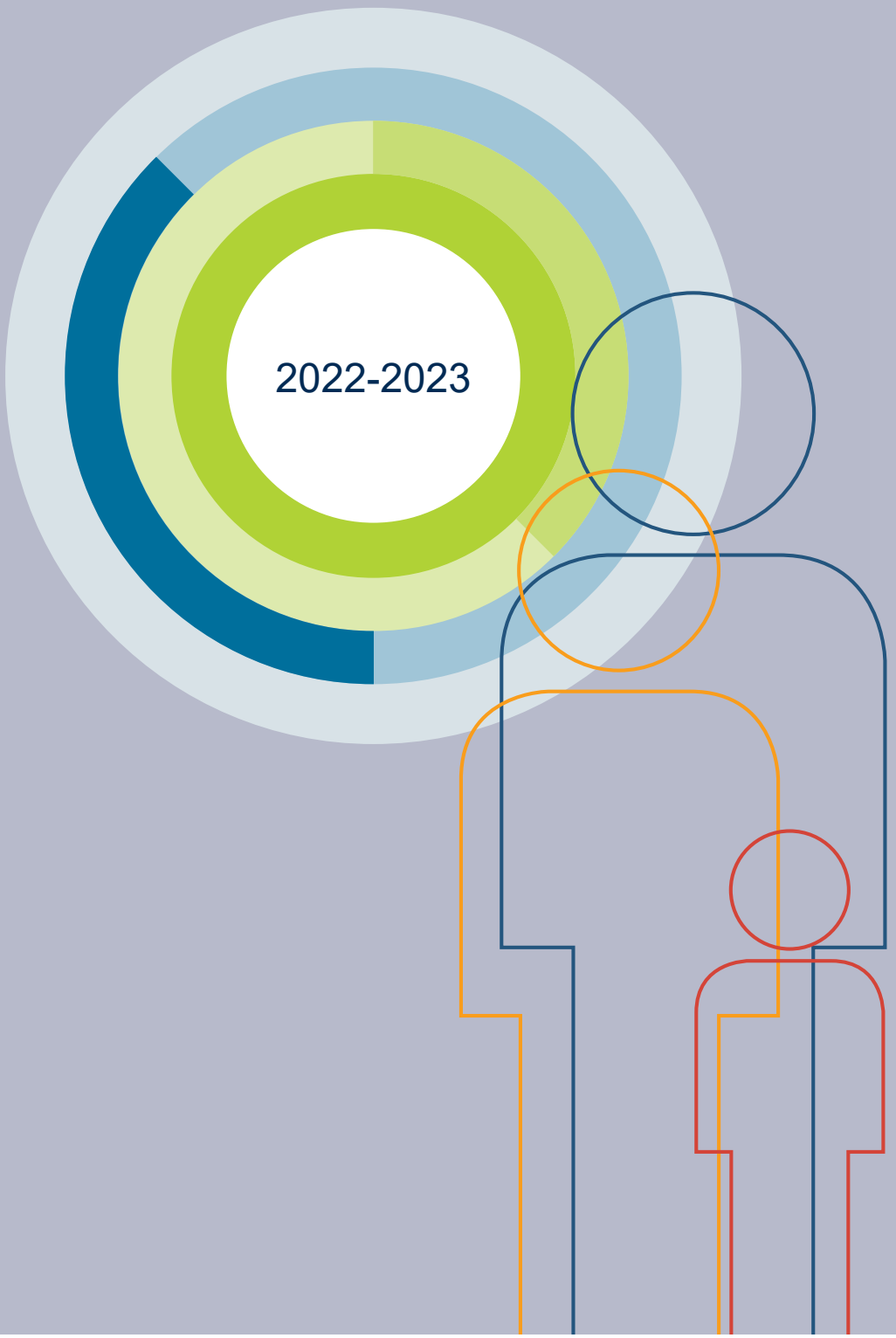
As a result of the COVID-19 pandemic, for 2020/21 the DoH advised that the Commissioning Plan Direction (CPD) and Commissioning Plan (CP) were rolled forward. A similar approach was adopted in relation to Trust Delivery Plans, which were formally replaced by three monthly Rebuild Plans, in line with the approach set out in the Minister's Framework for Rebuilding HSC Services. These include Trust plans for Service delivery and priorities, in response to service pressures resulting from the COVID-19 pandemic.

Rebuild plans have been submitted for review by DoH and Rebuild Management Board on a regular basis.

The Trust Corporate Management Plan (2021-2023) has been developed and affirms the Trust Vision and Values, and sets out a two-year commitment for Trust services with identified outcomes.

7 https://www.executiveoffice-ni.gov.uk/topics/making-government-work/programme-governmentoutcomes-delivery-plan

3. Objective/Priority Setting/ Performance Management



3. Objective/Priority Setting/Performance Management

3. Objective/Priority Setting/Performance Management

The two year Trust Corporate Management Plan (2021-2023) allows us to remain alert in the planning and delivery of our services as we respond to the changing needs of our patients and service users and whilst we start to engage on the development of our next Corporate Plan 2023-2028.[8]

This two-year plan is three-fold:

- To recognise the impact of COVID 19 and the last 18 months on our patients and staff
- To map out the key priorities to address the impact on all our services
- To highlight our regional role within the wider HSC system.

The Corporate Management Plan (2021-2023) has identified six priorities which are:

- New Model of Care for Older People - We are committed to ensuring the specific needs of older people are considered in everything we do
- Urgent and Emergency Care - We are committed to providing timely urgent and emergency care for patients
- Time Critical Surgery - We recognise the impact of Covid on those who are waiting for surgery

8 BHSCT Corporate Plan 2021-2023

3. Objective/Priority Setting/Performance Management

- Outpatient Modernisation - We are committed to modernising our outpatient services to enable patients and service users to receive the right care in the right place at the right time
- Vulnerable Groups in our Population - We are committed to improving and promoting the wellbeing of vulnerable people
- Seeking real time feedback from our patients and staff - We are committed to listening to you and changing the way we work for the better.

These organisational priorities are cascaded to Directorate, Division and Service Areas, where more detailed targets and actions are set in order to support or help meet the Trust's overall aims and objectives.

The Divisional Management Plans support the delivery of the priorities within the context of the overall regional direction and are reflected in local team objectives. The Accountability Process is designed to enable team ownership of the Trust's priorities.

The priorities and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Divisional Annual Management Plans
- Service/Team annual plans
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

The pandemic has significantly affected all our services and the way in which we worked. As such, it is important to remain agile and flexible in how we plan and deliver our services, responding to the changing needs of our population and the possibility of further COVID-19 surges.

To ensure we provide the Right Care at the Right Time and in the Right Place, we will be measuring and reporting on our achievements and progress against a number of key metrics within a Quality Management System (QMS). The 6 key parameters within the QMS are:

- Safety
- Experience

3. Objective/Priority Setting/Performance Management

- Effectiveness
- Efficiency
- Timeliness
- Equity.

The DoH HSC Performance Management Framework (issued June 2017)[9] sets out an enhanced framework for managing performance and accountability for HSC with the primary performance management role undertaken within Trusts (including by Trust Board). The key regional forum for holding Trusts to account is currently through the DoH accountability review meetings.

The Belfast Trust is committed to embedding effective organisational performance management arrangements (in response to DOH Performance Management Framework) under the QMS 6 key quality parameters set out above. This ensures clear and robust accountability and assurance arrangements to deliver better outcomes for patients and service users.

The Belfast Trust Quality Management System (QMS) 6 key parameters:

- Enable Directors and Divisional Teams to develop and report the management information they require to enable 'sense making' of their business in a consistent, integrated framework across all Directorates
- Integrates assessments of safety, outcomes, efficiency, access, patient and staff experience under the banner of quality
- Instils confidence and provides reliable, transparent assurance to Trust Board, Commissioners, Department of Health (DOH), our partners and public on the effectiveness of our decision-making and progress to meeting regional and local priorities and targets
- Continues to satisfy the reporting requirements of the Department of Health
- Builds and amplifies sensitivity to operations, using the Charles Vincent Model as methodology for measuring and monitoring safety both in our daily safety huddles and in regular sense making forums.

This QMS model provides consistency of approach across the Trust, reducing variability and better streamlining of how we do our business. It is summarised within Appendix B, to support Directorates and to ensure a standardised Trust wide approach.

9 HSC Performance Management Framework (issued June 2017)

3. Objective/Priority Setting/Performance Management

This QMS model and 6 key parameters provide the assurance for reporting at Corporate level to Trust Board on a regular basis.

Directorates and Divisions report on a regular basis to Executive Director Group using the QMS framework to provide assurance in relation to a range of metrics related to their service areas within the 6 quality parameters. Alongside the standardised minimum data set, additional agreed metrics will be included in these presentations regarding issues that are specific to individual services.

This assurance is achieved by providing data related to key indicators within the QMS reports from a range of Trust Information systems and also data from benchmarking sources (eg CHKS). The data and other relevant information presented demonstrates how the Trust is performing in relation to key assurance areas. Examples of this under the six QMS heading are below:

- Safety eg. Mortality data / SAIs / HCAIs / Safeguarding / Audit findings / Trust performance related to recognised service standards and specialty specific clinical indicators (with Trust data benchmarked against peer were relevant)
- Experience eg. patient/service user and staff experience scores. This includes independently assessed real time feedback
- Effectiveness eg. Population Health outcomes
- Efficiency eg. Workforce indicators (sickness and absence), agency spend, vacancies, financial indicators, use of estate, Length of Stay
- Timeliness eg. Access to services including waiting lists across services (hospital and community), response time
- Equity eg. Trust progress on the N.I. Equality legislative requirements / Equality impact assessments on service change and development, Equity of service in unscheduled programs of care work.

Each Directorate/Division/Team is also able to further develop relevant tailored data indicators for their areas to provide assurance related to how the service is being delivered in a safe and effective way.

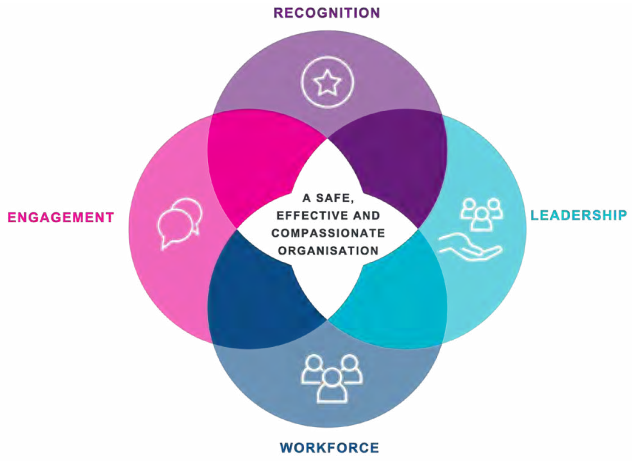
3. Objective/Priority Setting/Performance Management

3.1 Workforce Governance

The impact of the COVID-19 pandemic has brought the importance of 'workforce capacity' and 'workforce wellbeing' into sharp focus: highlighting the importance of having appropriate staffing levels and a healthy, skilled and engaged workforce.

The 'People and Culture Priorities' set out the Human Resources and Organisational Development strategy for the Trust. As a result of extensive work undertaken to understand our 'Culture', the Trust has identified 4 key 'People and Culture Priorities':

- Workforce
- Leadership
- Recognition
- Engagement.



A People and Culture Steering Group has been established and will oversee a number of work-streams, with each Directorate developing a specific 'People and Culture plan' to address key workforce issues.

Assurance is provided by individual Directorates reporting, using QMS to the EDG. Each Directorate will be required to present on a number of Workforce metrics including:

- Vacancies
- Absence
- Turnover
- Statutory / Mandatory Training Compliance
- Appraisal rates
- Staff Engagement / Staff Experience
- Data on usage / cost of agency staff.

The People and Culture Steering Group will provide a biannual report to Assurance Committee.

3. Objective/Priority Setting/Performance Management

3.2 Service User Involvement

The Health and Social Care Act (2009) placed a statutory obligation on Health and Social Care (HSC) organisations to involve service users, carers and the public in relation to their health and social care. Personal and Public Involvement is the term used to describe the concept and practice of involving people and local communities in the planning, commissioning, delivery and evaluation of the services they receive. PPI is a central policy in the HSC drive to make services more 'person centred'.

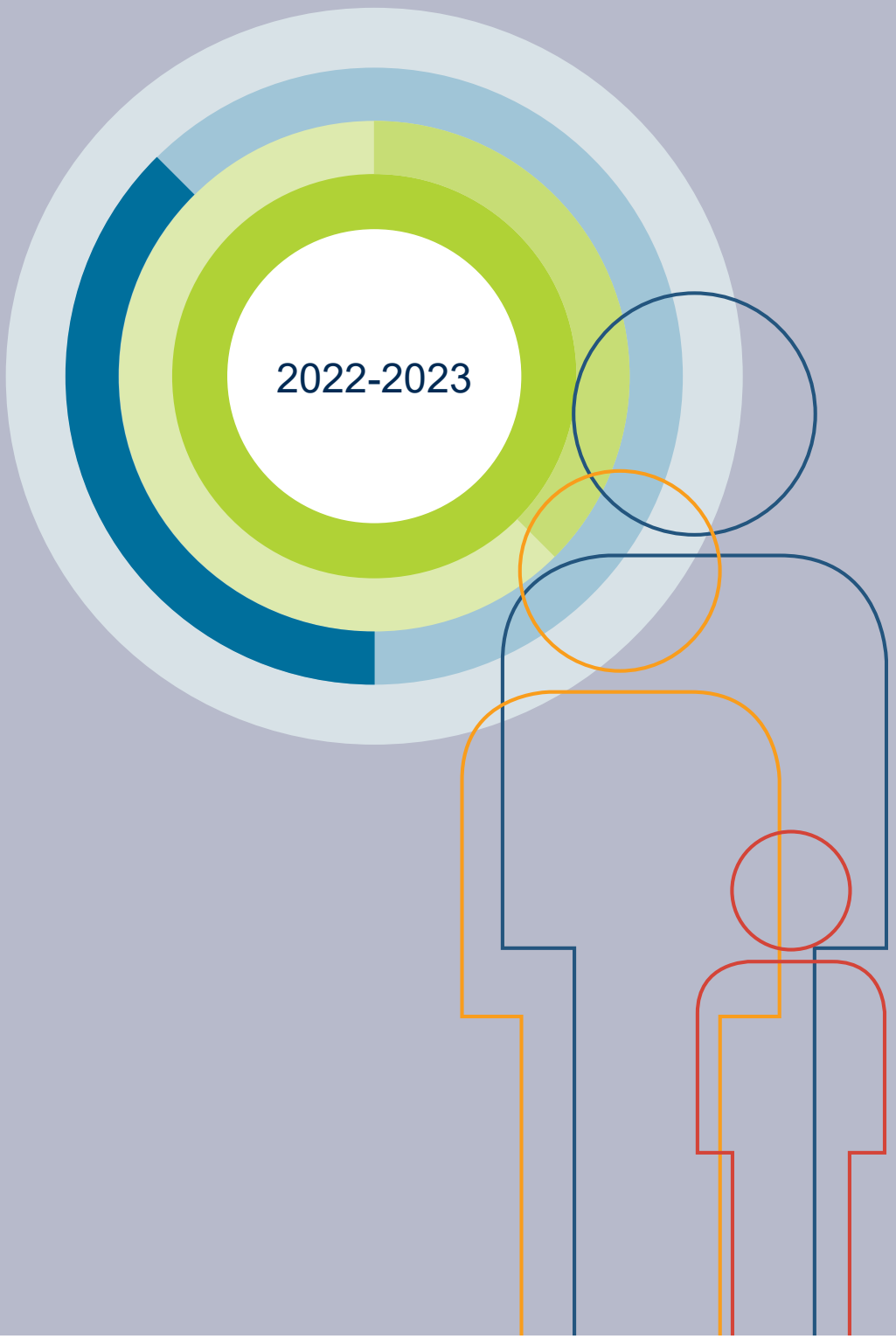
The Belfast Trust is committed to ensuring that the statutory duty for Personal and Public Involvement (PPI) is embedded into all aspects of its business and aims to ensure that service users and carers are at the heart of everything we do. Involvement of service users and carers should be central to the work of all staff in order to help us shape our services to meet their needs, improve patient experience, and enable us to use our resources in ways that have the greatest impact on their health and wellbeing. The Trusts involvement strategy, "Involving You - from 'Them and Us' to 'We", outlines the Trusts vision in relation to involvement and co-production.

There are a wide range of service user and carer 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 services.

A good experience for every patient/service user is a key priority. We want to build on existing good practices by continuing to design our services around the needs of our patients. Patient and service user experience enables those who use our services to direct us through feedback, involvement and engagement, to provide care that is not only clinically outstanding but holistic in approach. We proactively capture the experience of our patients/ service users through Real-time Patient Feedback, local patient experience surveys and Regional approaches such as 10,000 Voices and Care Opinion. The overarching aim is to translate this patient feedback into improving our services.

3. Objective/Priority Setting/Performance Management

4. Accountability



4. Accountability

4. Accountability

The existing HSC performance arrangements have been in place since 2009 and outlined by four domains of accountability:

- Corporate control
- Safety and quality
- Financial control
- Operational performance and service improvement.

The system within which the Belfast Trust operates is of significant size, scale and complexity. As such, assurance about the rigour of control mechanisms can only be derived from the development and operation of robust systems and processes at all levels of decision making.

HSC Trusts are accountable to the DoH for the services that they provide. They will operate at arm's length from Ministers but remain accountable to the Department for the discharge of the functions set out in their founding legislation.

4.1 Accountability to the HSC

The HSC Trusts are accountable to the public for the services that they commission and provide. The HSCB was established in April 2009 by the Health and Social, Care (Reform) Act (NI) 2009 and included five Local Commissioning Groups (LCGs) coterminous with the Trusts, the Public Health Agency (PHA), a Business Service Organisation (BSO) and a Patient and Client Council (PCC).[10] From the 1st April 2022, the HCSB has formally closed and responsibility for its functions transferred to the Department of Health, as part of the wider transformation of Health and Social Care Services in NI. Former HSCB staff have transferred to work in the Strategic Planning and Performance Group (SPPG) as an integral part of the Department of Health.

Before the COVID-19 pandemic, Trust Delivery Plans were the main vehicle for conveying where and by what means, performance indicators, efficiency savings and service improvements will be delivered, in response to the DoH Annual Commissioning Plan. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements.

10 https://www.legislation.gov.uk/nia/2009/1/contents

4. Accountability

The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social services to the people of Northern Ireland and for good integrated governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

In keeping with the transformation of Health and Social Care Services in NI, from the 1st April 2022, a new Integrated Care System (ICS) model was introduced, involving a Regional ICS Executive and Locality Planning Groups.

The ICS model was designed to improve partnership and collaboration between sectors and organisation's, so they can ultimately improve the health and wellbeing of the populations they serve, by delivering services in a more joined up way. The ICS model links to the N.I. Executive Outcome Delivery Plan objective to improve the health and wellbeing of the people of N. Ireland and enable the population to live long and healthy lives.

As indicated in the paper 'Future Planning Model – Integrated Care System NI (June 2021)'[11], an Integrated Care System will:

- Put the needs of the people at the heart of planning and delivering services
- Ensure involvement of communities are involved in the planning of services
- Help people stay fit and well in the first instance by managing their own health and wellbeing
- Avoid unnecessary visits to hospital by delivering care within the community
- Support people to manage their own health and wellbeing, and empower and support staff to deliver safe and effective services
- Improve efficiency and optimise capacity by making the best use of available resources.

It is recognised that with the development of the Integrated Care Systems model, organisational structures will change to meet the needs of an evolving framework of care delivery within a partnership approach. This will be achieved through a process of collaborative working and shared goals. Assurances will be an important element for consideration as these models and systems develop with clear governance and accountability arrangements established.

From the wider accountability perspective, there are two broad categories of HPSS activity:

- Category one: those services identified as being needed and commissioned from Trusts. The volume and quality of which are detailed in Service and Budget Agreements between

11 Microsoft Word - Consultation document Annex A - Future Planning Model - Integrated Care System NI - ~ July 2021 (health-ni.gov.uk)

- the commissioner and the providers (The format of these agreements under the new model is yet to be determined). This category also includes statutory obligations of Trusts including delegated directed statutory functions.
- Category two: certain duties to be performed by HSC organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

4.2 Scheme for Delegation and Direction of Social Care and Children's Functions

Delegated Directed Statutory Functions:

Trusts, as corporate entities, are responsible in law for the discharge of delegated directed statutory functions. The majority of these functions relate to services provided by the Trust's professional Social Work and Social Care workforce.

The Belfast Trust is directly accountable to the Department of Health (DOH) Strategic Planning and Performance Group (SPPG) through the Social Care and Children's Directorate (SCCD) for the discharge of those delegated directed statutory functions as detailed in the following circulars:

- Circular (OSS) 01/2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care and Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions)
- Circular (OSS) 02/2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight
- Circular (OSS) 03/2022: Role and Responsibilities of the DOH Deputy Secretary/Chief Social Work Officer, Director of Social Care and Children's Directorate, and Executive Directors of Health and Social Care Trusts for Children in Need, Children in Need of Protection and Looked After Children.

The above circulars outline the statutory duties and responsibilities of the Trust to have in place the professional oversight and governance arrangements to comply with the legislation as set out in the Establishment Order (The Health and Social Care Trusts (Establishment) (Amendment) Order (Northern Ireland) 2022 and to provide the Department of Health via

4. Accountability

the Social Care Children's Directorate any requested performance management data, monitoring and quality assurance data and reports requested.

The nature and scope of the delegated directed statutory functions and related services discharged by the Trust give rise to enhanced levels of public scrutiny. These include interventions in matters of personal liberty, the protection of vulnerable children and adults, the Trust's corporate parenting responsibilities, the provision of vital services and the exercise by the Trust of regulatory functions. Their effective discharge is central to organisational integrity. As a consequence, they have a heightened organisational and corporate significance and related assurance profile. The Trust is required to have in place systems that are robust and capable of balancing appropriately the complex issues of protection and care.

The Trust is accountable to the DOH for the effective discharge of its delegated directed statutory functions as well as the quantity, quality and efficiency of the related services it provides. The DOH through the SCCD has the authority to monitor and evaluate such services and requires the Trust to produce an annual report on how it has discharged its relevant functions.

4.3 Accountability for HSC Trust Boards

Trust Board have an overarching responsibility, (primarily through its Chair, Non-Executive Directors, Chief Executive and Executive Directors) to provide strong leadership, robust oversight, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its dealings with service users and the public.

Ensuring accountability is central to Trust Board. This has three main aspects:

- Holding the organisation to account for the delivery of the strategy
- Being accountable for ensuring the organisation operates effectively and with openness, transparency and candour
- Seeking assurance that the systems of control are robust and reliable.

Trust Board itself, will be held to account by a wide range of stakeholders, including the Minister for Health, for the overall effectiveness and performance of the organisation that it oversees. It is therefore necessary that it assure itself, that the requisite governance systems are in place to ensure the delivery of their statutory responsibilities.

4. Accountability

This Integrated Governance and Assurance Framework aims to support Trust Board in the fulfilment of their statutory duties.

The DoH may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc. on governance or financial control. The Trust, as an identified designated body by the General Medical Council and the Nursing and Midwifery Council, will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

4.4 Accountability for Belfast Trust Employees

Everything we do in the Belfast Trust is about people and for people. The Trust Values of Working Together, Excellence, Openness and Honesty, and Compassion underpin our commitment to provide safe, effective, compassionate and person-centred care. To support this, all staff are accountable for ensuring that acceptable standards of care delivery and practice are adhered to.

As individuals, staff are accountable for their own behaviours; however, everyone has a role in ensuring that the Trust Values and Code of Conduct for HSC Employee's[12] are followed. Professional staff are also expected to follow the code of conduct for each of their own professions

The Code of Conduct for HSC Employees, identifies the values and core standards expected of all staff. It details a number of key principles that all staff must follow, alongside staff responsibilities when an individual staff member has concerns about improper conduct or poor standards. The principles expect all HSC employees to:

- Make the care and safety of patients and clients their first concern and act to protect them from risk
- Contribute to improving and protecting the health of the population as appropriate to their role
- Maintain confidentiality, respecting and protecting, at all times patients/clients, service users and their families' right to confidentiality, privacy and dignity
- Communicate openly and honestly to promote the health and well-being of patients/ clients, service users and their families
- Respect the public, patients, clients, relatives, carers, HSC employees and teams and partners in other agencies. Show commitment to working constructively as a

12 Code of Conduct for HSC Employee's

4. Accountability

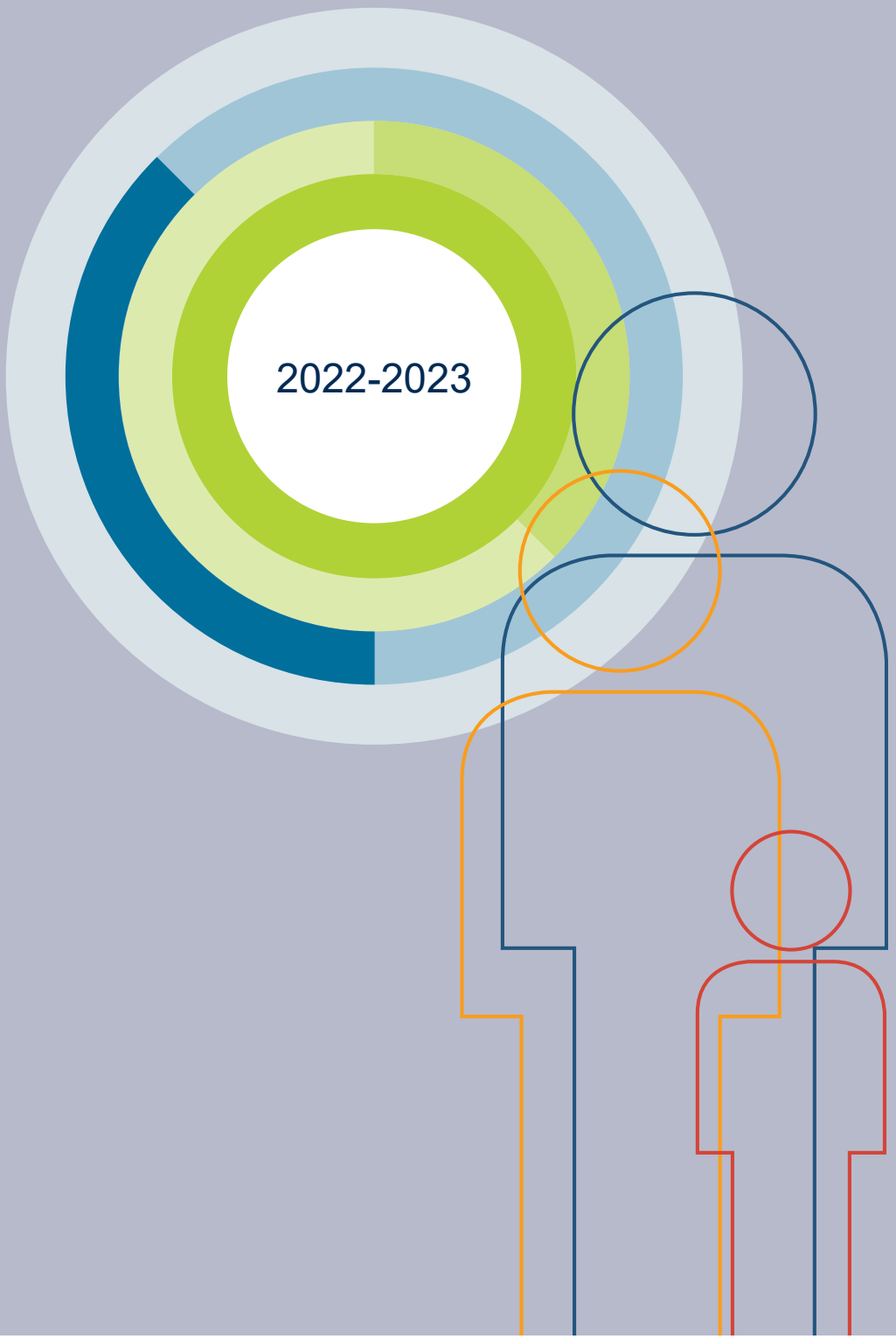
team member by working collaboratively with all colleagues in the HSC and the wider community

- Be accountable and accept responsibility for their own work and be honest and act with integrity
- Share responsibility for their learning and development in order to improve the quality of care to patients/ clients/service users and their families.

Trust Board expects that all staff working within the Belfast Trust, familiarise themselves with this Code and crucially, if any staff member has a concern, that an acceptable standard of care or practice is not being adhered to, that they should always raise that concern.

4. Accountability

5. Integrated Governance



5. Integrated Governance

In 2006, integrated governance was defined as the 'systems, processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to service users and carers, the wider community and partner organisations'.[13]

Key to delivering these systems, processes and behaviours are the Trust's Integrated Governance arrangements clearly articulated in a framework which also encapsulates the organisation's accountability and assurance arrangements.

5.1 Integrated Governance Frameworks

The way a Trust is directed and controlled is critical to its likelihood of achieving its strategic objectives. Trust Board's role, is to provide leadership of the organisation within a framework of prudent and effective controls, which enables risk to be assessed and managed.

The key elements of any governance framework are:

- Clear strategic objectives for the organisation
- A well-organised board, focused on the achievement of these objectives and the management of related risks
- A sensible scheme of delegation from Trust Board to the executive and subcommittees
- All component parts of the framework understanding their roles and responsibilities, as well of those of others, and how the pieces fit together.

The Belfast Trusts Integrated Governance and Assurance Framework arrangements outlined within this document provide details of the structure for reporting key information to Trust Board. The priorities that are contained in the Corporate Plan form the basis of the Framework. It identifies which of the Organisation's objectives are at risk because of inadequacies in the operation of the controls or where the Organisation has insufficient assurance about them. At the same time, it provides structured assurances about where risks are being effectively managed and which objectives are being delivered.

The Board Assurance Framework Risk Document and the corporate risk register detail the assurances against risk. This enables the Trust and Trust Board to make decisions on the ability to meet its strategic objectives, and to address issues identified, which includes the quality and safety of services.

13 DoH 'Integrated Governance Handbook' 2006.

5. Integrated Governance

Trust Board can only properly fulfil its responsibilities when it has a full grasp of the strategic 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.

Trust 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).

This framework defines the approach of Trust 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.

This framework will support Trust Board take the lead on, and oversee the preparation of, the Trust's Governance Statement for publication with its resource accounts each year.

5.2 Governance Statement

The governance statement sets out the Trust's system of internal controls and is signed by the Chief Executive, for inclusion in the Annual Report and Annual Accounts. The statement will include the Trust's capacity to handle risk, its risk and control framework, as well as a review of effectiveness of its internal control.

In addition to the Governance Statement, the Trust must complete a Mid-Year Assurance Statement, to be signed by the Chief Executive and submitted to the Department of Health by the end of October each year. The Mid-Year Assurance Statement enables the Accounting Officer(Chief Executive) to attest to the continuing robustness of the Trust's system of internal control, at the mid-year position and, therefore, covers the same areas as the Governance Statement at the end of the year.

The aims and purpose(s) of the governance statement and Mid-Year assurance statement include:

5. Integrated Governance

- Providing a comprehensive statement describing the Trusts' approach to governance, risk management and internal governance arrangements
- Providing an account of the Trust's Integrated Governance and Assurance Framework, including their performance and effectiveness
- Providing an opportunity for the Directors to highlight any new and ongoing significant governance issues identified during the current or previous reporting period(s)
- Detailing the measures that are in place to ensure the appropriate management and control of all public resources for which the accounting officer has overall responsibility
- Providing evidence of compliance with departmental issued policies and procedures; designed to contribute to the overall governance, assurance and risk management processes across the HSC.

Inputs to the statement include:

- BAF risks, associated controls and mitigations
- Internal reports of relevant integrated governance and assurance framework committees including organisational assurance statements
- Internal audits (eg. clinical audits etc.)
- Audit reports arising from internal audit eg: Details of controls/mitigations in place for those areas with less than satisfactory assurance provided by internal audit
- Sources of independent external (regulatory) assurance (eg. reports from RQIA, MHRA, HTA etc.)
- Sources of independent external (non-regulatory) assurance (eg. Quality systems ISO etc., training centre accreditation etc.)
- Divergences from internal control

  - New in-year divergences

  - Progress on any divergences occurring in previous years that have not yet been closed/ adequately addressed.

While the Chief Executive has overall responsibility for the control and management of the Trust's resources and its Governance Statement, in practice this is achieved through a scheme of delegated responsibility. Trust Directors are responsible and accountable to the Chief Executive for the control, management and overall governance for their respective

5. Integrated Governance

Directorates including the production of specific content.

Prior to submission, the Chief Executive will also seek assurances from individual Director's around full disclosure of significant divergences.

5.3 Risk Management Framework

5.3.1 Risk Management

HSC organisations face a wide range of uncertainties and factors that may affect achievement of their objectives. This can create a positive risk (opportunities) or a negative risk (threats).

Risk management focuses on identifying threats and opportunities, while internal control helps counter threats and take advantage of opportunities. Proper risk management should help organisations make informed decisions about the level of risk that they want to take and implement appropriate internal controls that allow them to pursue their objectives.

Risk management is not the same as minimising risk. It is important to remember that being excessively cautious can be as damaging as taking unnecessary risks. Risk-taking is the basis of progress. Without it, an organisation cannot have innovation and the benefits that come from developing new procedures and interventions or changing business practices. Boards have to carefully consider whether or not potential long-term rewards will be greater than short-term losses.

The management of risk is a key organisational responsibility. All staff must accept that the management of risk is one of their most important responsibilities.

The Belfast Trust has a Risk Management Strategy that underpins its policy on risk and explains its approach to acceptable risk.[14] (appendix A)

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the strategic risks to achieving these objectives. These are encapsulated within the Board Assurance Framework Risk Document. There are systems in place to monitor and review risks, which are delegated below Corporate level.

The Trust recognises that risk reduction and management can be enhanced by the effective involvement of stakeholders at an early stage of planning or making decisions about care, treatment or service development.

14 http://intranet.belfasttrust.local/policies/Documents/Risk%20Management%20Strategy%202020-2021.pdf

5. Integrated Governance

The Trust is committed to promoting and maintaining an open and learning culture in which the emphasis is placed on continual quality improvement, learning lessons and being open and transparent when care goes wrong. The Trust has processes in place for learning from experience, learning from adverse incidents, complaints, litigation and external reviews/ inspections. This is underpinned by the Trust's Being Open Policy.

Organisational Assurance (formerly the Controls Assurance process) remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard.

5.3.2 Risk Appetite

Risk appetite is:

'The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time' (HMT Orange Book definition 2020).[15]

It is the role of Trust Board to decide which risks they need to reduce, which they are prepared to accept and what their tolerances are for those risks they are willing to accept.

Trust Board must make a considered choice about its risk appetite, taking account of its legal obligations, business objectives, and public expectations.

The Trust needs to know about risk appetite because:

- If the Trust does not know what it's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development
- If Trust leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected.

The Good Governance Institute (GGI) believes it helps to identify different vectors of risk appetite (money, policy, outcomes and reputation) but always to assess these in the round. To support this, GGI have developed a Risk Appetite Maturity Matrix for NHS organisations to support better risk sensitivity in decision-making.[16] (see Appendix C).

The GGI Matrix sets five levels of risk appetite for each of the risk vectors (money, policy, outcomes and reputation). There are no right answers, but the matrix allows board members to articulate their appetite and tolerances and arrive at a corporate view, taking into account

15 HMT Orange Book- Management of risk – Principles and concepts
16 GGI Risk Appetite Maturity Matrix

6. Assurance

the risk appetite of others and the capacity for management to communicate and deliver. Trust Board should consider each strategic objective against the matrix and agree its level of risk appetite, what it can delegate, and what additional assurance it requires. The matrix can also be used for individual initiatives and emerging problems and should help Trust Board to better manage its agenda and the level of routine reporting required.

A key part of determining risk appetite is the analysis and assessment of each risk. This needs to be done against a common set of metrics.

5.3.3 Risk Registers

The Board Assurance Framework Risk Document (BAF Risk Document) is designed to allow Trust Board to concentrate on that very limited number of top-level risks, but without restricting its freedom to maintain a watch on the full array of risks to strategic objectives.

It is essential that the Trust has robust systems in place to deal with a wide range of risks and these systems should be reviewed routinely. As risks (and the appropriate response) can change over time and depending on circumstances, the systems should include the routine monitoring of risks and procedures to raise concerns with Trust Board as quickly as possible and in line with their risk tolerances. Regular risk assessments should be carried out and information provided on ‘close calls’ and ‘near misses’ to enable Trust Board to evaluate the strength of the risk management procedures.

The management of risk at strategic, directorate and divisional levels needs to be integrated so that the levels of activity support each other. All staff should be aware of the relevance of risk to the achievement of their objectives.

Risk registers are a record of all forms of residual risks ie. those risks which remain after treatment. It is accepted that, in order to be accurate and complete, the risk register should be constantly updated to reflect new risks and changes to existing risks.

Risk registers can gather risk details from many assessment sources. As such, it is very important that the risk identification process determines the relevance and significance of such risks to corporate objectives.

The BAF Risk Document acts as high-level strategic risk identification in regard to corporate objectives, highlighting gaps in control and/or gaps in assurance process and the details of necessary action.

Strategic risks are those that represent major threats to achieving the Trust’s strategic objectives or to its continued existence. Strategic risks will include key operational service failures. For example, a failure to meet key targets or provision of poor quality care would be very damaging to all trusts’ strategic objectives.

5. Integrated Governance

These can be readily identified, but some can be much harder to identify and manage for a number of reasons:

- They can be more qualitative than operational risks, for example to do with reputation or partnership working
- They are frequently multi-faceted and hence more complicated, deriving from a series of events that combine and cumulatively escalate
- They can be hard to anticipate as they can be outside the experience of board members or have not happened before.

Strategic risks are maintained in the BAF Risk Document, which ensures they are made an integral part of the risk management process. Where they affect service delivery, they should also appear in related divisional/directorate risk registers. This way, they feature in the business planning processes of divisions/directorates, whose plans reflect actions to manage strategic risks as well as their own immediate operational ones. For example, Workforce may be a strategic risk on the BAF Risk Document due to the potential impact it could have on the safe and effective delivery of services. In addition, it would be expected (in divisions/ directorates where workforce challenges exist) that this risk would be on their divisional/ directorate risk registers. The action plans from divisional and directorate areas would thus support the management of the risk operationally and strategically.

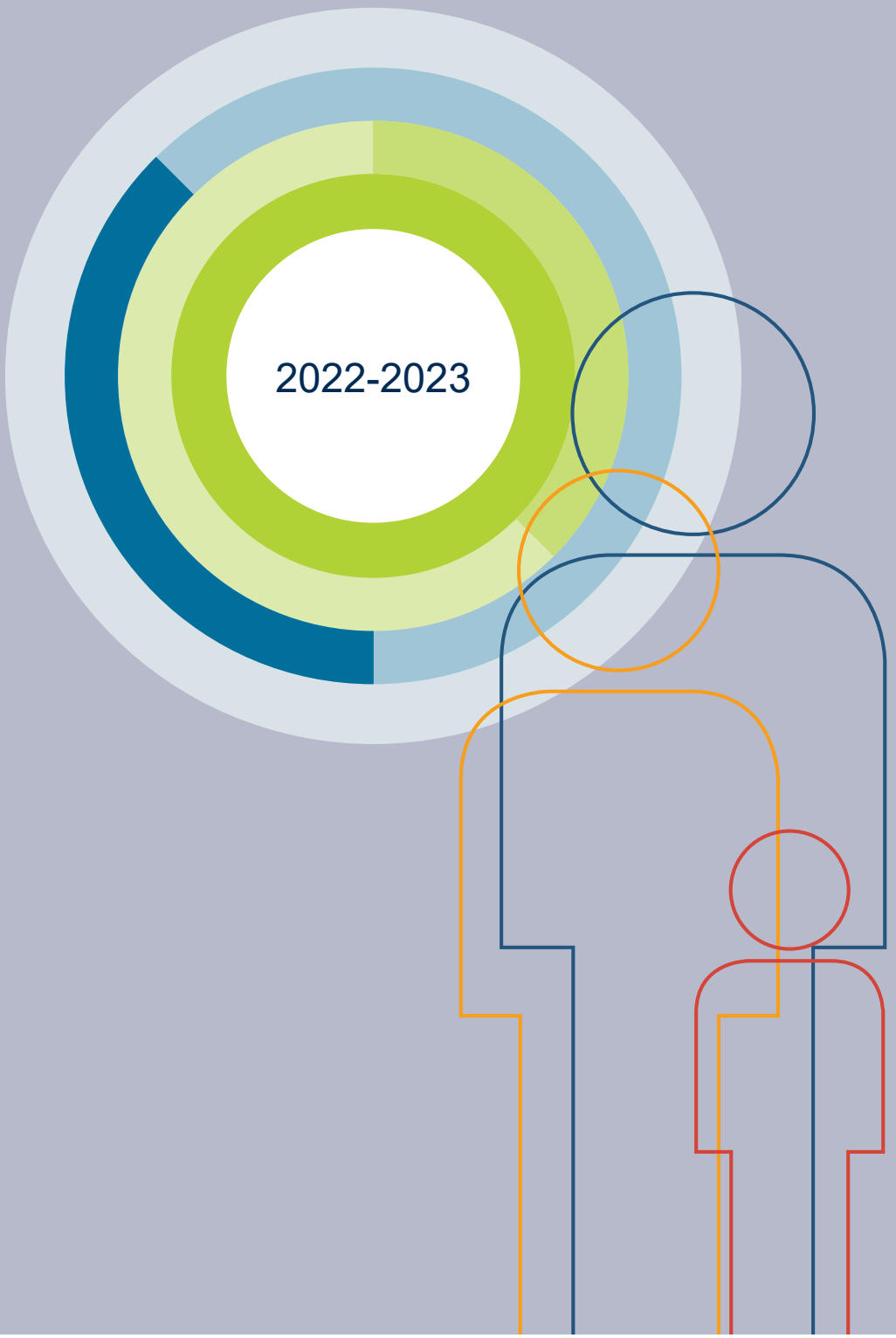
Directorate risk registers are comprised of a mixture of operational or corporate Risks. Corporate risks are those risks that meet the corporate risk criteria as detailed in the BHSCT Risk Management Strategy.[17] The corporate risk register is a collection of all corporate risks from directorate risk registers trust wide. It is utilised to review and support the BAF Risk Document. This provides an assurance to Trust Board as to the identification and management of the organisations strategic risks.

Being clear about the strategic risk allows Trust Board to ensure that the information they receive in board reports is pertinent to the objective. It is also a much clearer starting point for mitigation and control as well as business planning.

Operational risks are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, fraud risk, financial risk, legal risks arising from employment law or health and safety regulation, and risks of damage to assets or systems failures. They are the responsibility of line management and should be identified and managed by the division/directorate, and only considered by Trust Board on an exception basis, excepting situations where the Board is checking the effective implementation of Trust policy and procedures.

17 Risk Management Strategy BHSCT (2020/2021)

6. Assurance



6. Assurance

6. Assurance

6.1 What Assurance Means

Assurance is the bedrock of evidence that gives confidence that risk is being controlled effectively, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed.

The word assurance is used a lot in everyday language and can mean different things to different people. It is important that everyone involved in developing, implementing and maintaining the integrated governance and assurance framework, is clear on what is meant by assurance and where assurances come from.

Figure 1: Definitions of Assurance

Assurance	Definition
Provides:	'Confidence' / 'Evidence' / 'Certainty'
To:	Directors / Non-executives / Management
That:	What needs to be happening is actually happening in practice

The Good Governance Institute defines assurance as a 'positive declaration that a thing is true'. Assurances are therefore the information and evidence provided or presented which are intended to induce confidence that a thing is true amongst those who have not witnessed it for themselves. For an individual to 'be assured', they must trust the assurance(s) they have been provided with and therefore be confident themselves that the thing is true'.[18]

Assurance draws attention to the aspects of risk management, integrated governance and systems of internal control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. It helps Trust Board to judge whether or not its agenda is focussing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources.

When challenging assurance information at a Board level, the questions the Trust should continually ask are:

- Where does the assurance come from?
- How reliable is this assurance?
- What is this assurance telling me?

18 GGI - Building-a-Framework-for-Board-360-Governing-Body-Assurance

6. Assurance

- Is the assurance proportionate to the level of risk?

6.2 Assurance Mapping

Assurance mapping is a key part of developing and maintaining board assurance arrangements. It provides the Trust with an improved ability to understand and confirm that they have assurance over key controls or where control gaps exist and whether actions are in place to address these gaps. The assurance mapping process and the way of illustrating the results using a BAF Risk Document can give confidence to senior management and Trust Board that they 'really know what they think they know'.

The assurance mapping process identifies and records the key sources of assurance that inform board members of the effectiveness of how key strategic risks are managed or mitigated, the key controls and processes that are relied on to manage risks and as a result support in the achievement of the Trusts strategic objectives.

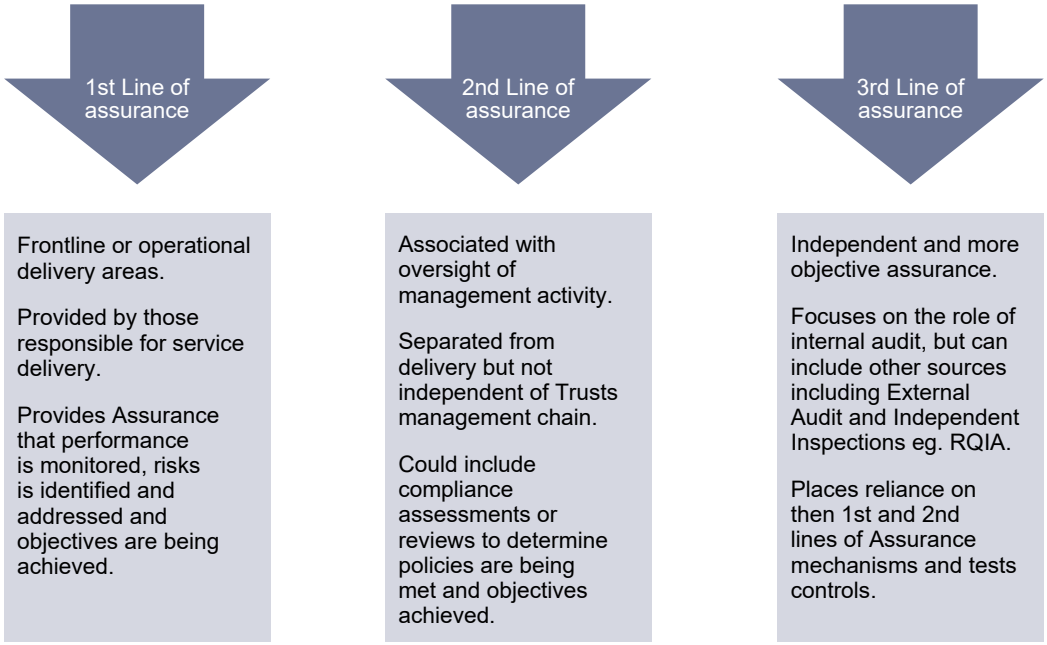
6.3 Three lines of assurance

Assurance can come from many sources within the Trust. Understanding where this assurance comes from helps provide a clearer picture of where the Trust receives assurance and whether it has too much, is duplicated, or has none at all, and whether the coverage of assurances is set at the right level to provide confidence to Trust Board.

The 'three lines of assurance' approach is a model that pulls risk management and compliance into a common and robust framework. By defining the sources of assurance in three broad categories, it helps to understand how each contributes to the overall level of assurance provided and how best they can be integrated and mutually supportive.

6. Assurance

Figure 1 The three lines of assurance model within a HSC Trust



First Line: Responsibility lies with frontline staff to understand their roles and responsibilities and to carry them out properly and thoroughly. Controls are designed into systems and processes, so, assuming the design is sound, compliance should mean the internal control environment is sound. Therefore, others within a department, preferably not frontline staff, are responsible for routinely verifying compliance with policies and procedures, both in respect of service delivery and decision-making processes. They are also responsible for providing the second line of defence with current information on key risk and control indicators.

Examples of 1st line assurance may include (but is not limited to): reviewing incident data, KPIs, risk registers, improvement work, reports on the routine system controls and other management information, review of caseloads, safety briefs, minutes of meetings, peer reviews, leadership walk rounds, self-assessments, patient/service user feedback. This assurance is at service level.

Second Line: A corporate integrated governance framework, incorporating compliance and risk management functions, which reviews the operation of the internal control framework. This is made up of assorted executive committees, which set and police policies, define work practices and oversee the operation of the first line of defence. Typically, this would be by holding them to account for the effectiveness of their risk management and compliance arrangements but, for particular high-risk matters, they would also routinely inspect for compliance with policies and procedures.

6. Assurance

Examples of 2nd line of assurance may include (but is not limited to): Budget reports, Managerial reports, performance reports, HCAI reports, KPI, Infographics report, Committee meetings. This assurance is usually at senior management/divisional oversight level. It may also include the Executive Team and Trust Board.

Third Line: This is independent review, which is used to monitor the operation of the overall compliance, risk management system, and examine the first and second lines of defence. This is the role of internal audit but there are other sources of independent review that can be used as well. Review findings are considered, which can then ensure that the executive team is addressing identified weaknesses properly on behalf of Trust Board.

Examples of 3rd Line of assurance may include (but is not limited to): RQIA Reviews/reports, Internal/External audit reports, Professional /Regulatory bodies eg. NISCC/Royal Colleges/ accreditation

Trust, Demonstrate, Check

Trust

First line assurance involves a level 'Trust' by line management, that operational staff are delivering services within the expected standards, policy, legislation, and that they are using regular review/local audit/data analysis, from of a variety of sources to support this trust. Divisional Senior Leadership teams will routinely use first line assurances to support their decision-making about service risks.

Demonstrate

Second Line assurance necessitates senior management to provide evidence and 'Demonstrate' that controls and assurances are in place regarding performance, delivery of service, compliance with legislation, guidelines and policy, and that risk management systems are robust. It requires a level of internal independence from immediate line management to support what is believed to be true, as true. The metrics and information to support the position held are presented to the Executive Director Group as the agreed metrics analysed within QMS.

Check

Third line assurance requires a level of independent verification 'Check'. This means that an external party independent to the organisation will review and confirm the position held by the Trust is accurate and where there are gaps allow for further planning and actions to be taken. The outcome of such verification is considered by both Executive Director Group and Trust

6. Assurance

Board or audit committees. Identified gaps in control and or assurance, will be monitored by Trust Board until resolved and in line with agreed risk appetite.

Example: Hand Hygiene Audits

How a senior leadership team can Trust, Demonstrate and Check on line 1, 2 and 3 assurance

Line 1 – Trust

Ward managers carry out hand hygiene assessments on their ward. This self-assessment can provide 'Trust' to senior management that compliance with hand hygiene practices are within policy guidelines. Management can utilise this assurance.

Line 2 - Demonstrate

Staff external to a service area can complete independent hand hygiene audits. (These external staff are internal to the organisation eg. Infection Prevention and Control Team) The data and assurance provided by these independent audits can be used to 'Demonstrate' to senior management that the area is compliant with policy guidance and that the line one assurance provided it true. This assurance is more robust due to its independence.

Line 3 – Check

RQIA may complete a ward hygiene inspection, encompassing hand hygiene. Their review of hand hygiene practice is independent to the organisation, and as such, senior management can utilise the results to 'check' that the Line 1 and Line 2 assurance previously provided is reliable and true. This type of assurance is the most robust assurance.

Sources of Assurance (these are not exhaustive lists)

Line 1	Line 2	Line 3
Examples • 1:1 meetings • Peer review of work • Self Assessment returns eg. hand hygiene • Incident review	**Examples** • Performance reports • Financial reports • HCAI reports • Committee meetings • Managerial reports • KPI's	**Examples** • RQIA • Internal/external audit • Professional regulatory bodies eg. NISCC/Royal Colleges etc.

6. Assurance

6.4 The Role of Internal and External Audit

As a 3rd Line of Assurance, internal audit provide the Belfast Trust with an independent, objective assurance about the Trust's risk management, controls, reporting and governance processes. Their main purpose is to provide the Accounting Officer (The Chief Executive) with an evaluation of the overall adequacy and effectiveness of these processes. The Chief Executive will use the Head of Internal Audit's opinion as a key assurance element when completing the Trusts annual Governance Statement. It is one of the key elements of good governance and adds value to improve the Trusts achievement of our corporate objectives.

Internal audit plans are devised in partnership with The Trust, with each audit focused on one the corporate objectives. They do not typically include clinical audit.[19] Examples of internal audit include:

- The review of governance and operational aspects of the Trust's new Quality Management System both at a Corporate level and within the divisional structure
- Information Governance: Review of Information Governance arrangements and processes within Trust
- Mandatory Training: Review of establishment, management and compliance of mandatory training requirements.

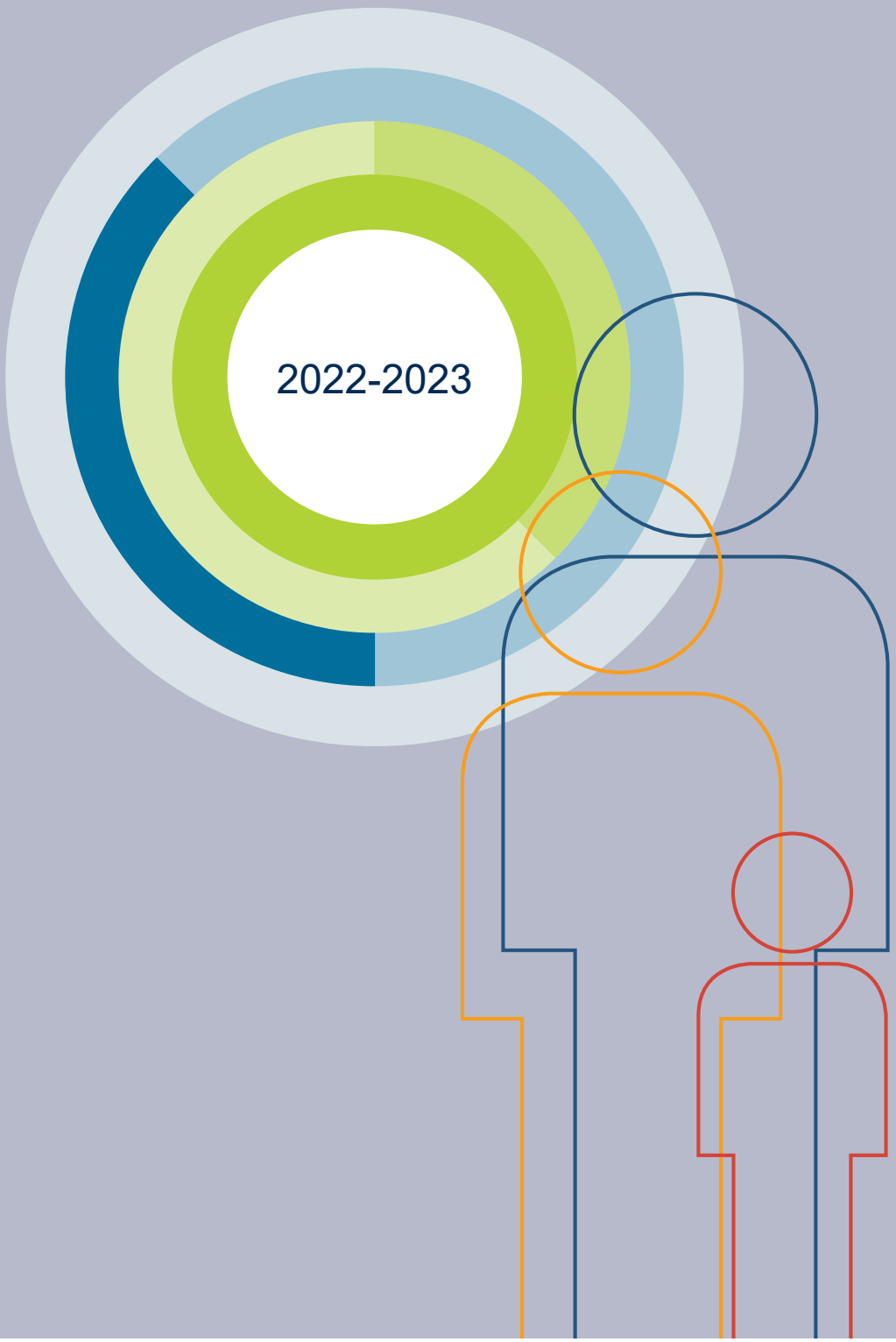
While internal auditors can be used by the Belfast Trust to provide advice and other consulting assistance, external audit do not typically providing such close support to the Trust. This is because external audit are not responsible to management or the Trust, their primary responsible lies with providing assurances to the public that public resources have been safeguarded appropriately by us as an organisation.

As a 3rd line of assurance, Trust Board should utilise the independent evidence from internal and external audit when making decisions about how to manage and control opportunity and risk. Non-financial/clinical audits will be included on the assurance committee agenda.

19 Clinical audit is a way to find out if healthcare is being provided in line with standards. It lets care providers and patients know if their service is doing well and if there could be improvements (NHS England)

6. Assurance

7. Quality Improvement



7. Quality Improvement

7. Quality Improvement

To achieve the Trust's vision of delivering safe, effective and compassionate care, the Senior Leadership Teams identified three Trust wide improvement priorities:

- Right care in the right place
- Real time patient feedback
- Staff engagement.

Central to the delivery of this vision, is the recognition that the Trust needs to create the conditions and culture that reflects quality and supports the requirement for continuous quality improvement and innovation. These include:

1. Placing the person clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation.
2. Ensuring a relentless focus on safety and quality improvement aligned to our corporate objectives and assurance framework.
3. Ensuring that we are an open, transparent and supportive organisation that is continually learning and sharing both within and beyond the organisation.
4. Using measurement and real time data, linked to goals, to learn and improve at every level.
5. Enhancing our will, capability and structures to undertake quality improvement consistently, everywhere and every day.

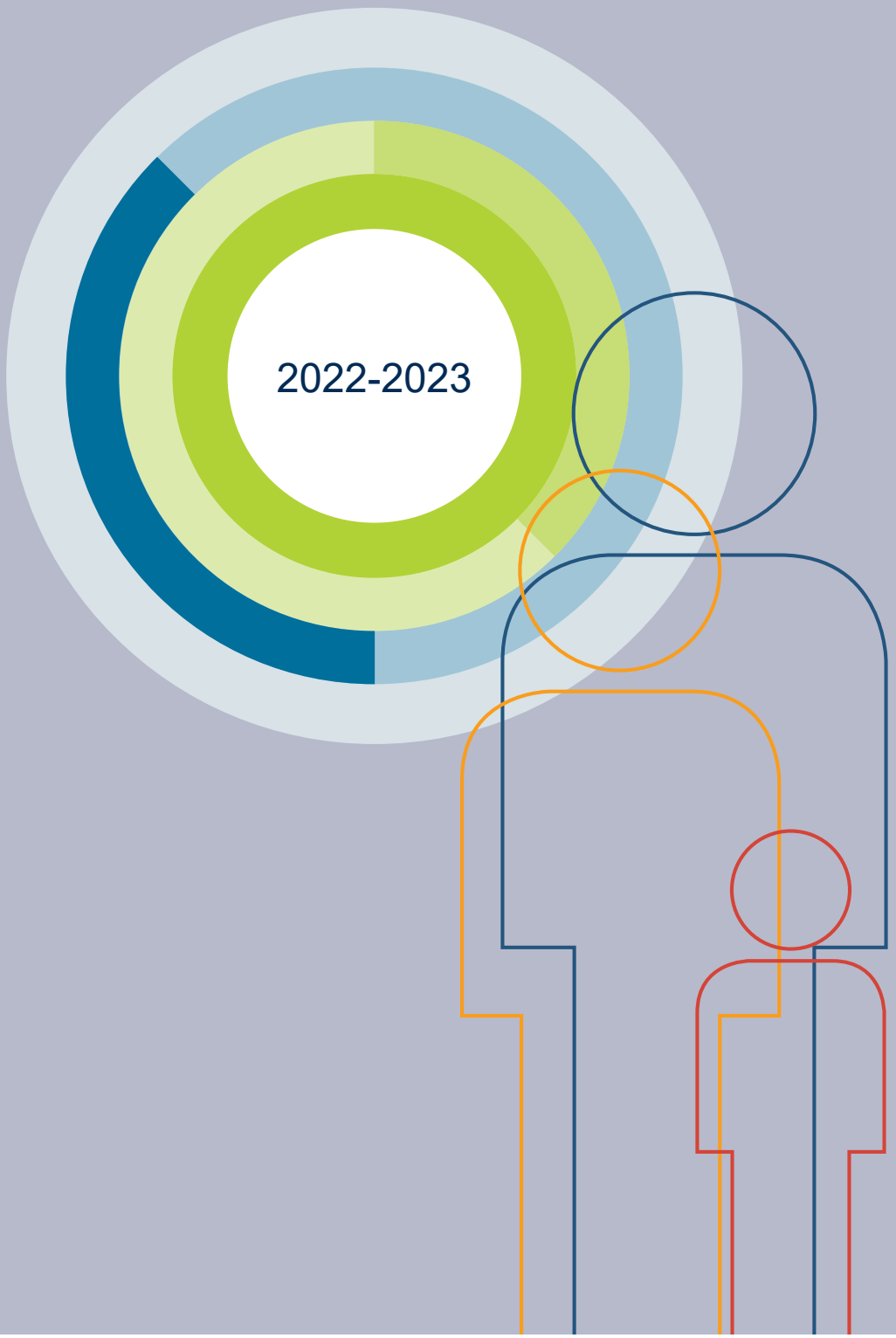
Quality Improvement is a key component of the Trust's overall system of quality management. In September 2020, the Trust developed a Quality Management System bringing together different approaches to performance management, quality improvement, assurance and accountability processes into a single integrated system to support the delivery of this vision.

The vision of the Quality Improvement Team is "to strengthen and embed safety and quality improvement through leadership, support and education to ensure the achievement of ambitious outcomes aligned to the Trust key priorities".

The Trust is committed to being a 'learning organisation', one that is continually seeking to share best practice, to share learning when the care we have provided could have been better and also to proactively identify risk and to be a 'problem sensing' organisation.

The Trust continues to build a culture of improvement by engaging, inspiring and supporting the workforce to deliver improved outcomes and experience for those in our care.

8. The Assurance Framework



8. The Assurance Framework

8. The Assurance Framework

This Integrated Governance and Assurance Framework is the 'lens' through which Trust Board examines the assurance to discharge its duties. An important element of the Trust's Integrated Governance and Assurance Framework is the need for robust organisational arrangements at Trust, Directorate, Divisional and Service level which is tested internally through the Trust accountability arrangements.

8.1 Organisational Arrangements

An important element of the Trust's arrangements is the need for robust governance within Directorates. This will be tested through the accountability review process. There are a number of internal and external mechanisms that support this.

Trust Board is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team
- Ensuring accountability to the public for the organisation's performance
- Assuring that the organisation is managed with probity and integrity.

The membership Trust Board is defined in the Establishment Order to include the Directors of Social Work, Medicine, Nursing and Finance.

The accountability, roles and responsibilities of the Committees in respect of governance and assurance in accordance with the Terms of Reference of each of the Committees and reporting sub Committees are detailed below. The Trust's governance and assurance organisational structure is kept under constant review.

Proposed organisational arrangements for governance and assurance are set out in Appendix E & D.

Appendix G outlines the Schedule of Key Documents to be presented (Including Annual Reports).

The Audit Committee

The Audit Committee (a standing committee of Trust Board) is comprised of Non-Executive Directors. Its role is to assist Trust Board in ensuring an effective system of financial

8. The Assurance Framework

governance and internal control is in operation. This includes the effectiveness of the full range of internal controls including the identification of financial risks, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance (including financial reporting) in the Belfast Trust.

The Committee's programme of work is largely dictated by Internal Audit's risk-based annual audit plans which enables Internal Audit to provide an opinion on the adequacy and effectiveness of the Trust's risk management, control and governance arrangements.

The Assurance Committee

Trust Board have a responsibility to oversee the effective implementation and management of governance and assurance within the Belfast Trust.

Assurance committee, a standing committee of Trust Board supports this by providing oversight of governance, risk management and assurance in a protected space, where risks are considered and sense making is made of assurance information. Its role is to assist Trust Board in ensuring an effective Integrated Governance and Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance.

The committee is is informed by intelligent and timely information covering the full range of health and social care information, providing a line of sight over all of our business. It is also responsible for the identification of strategic risks and significant gaps in controls/assurance for consideration by Trust Board.

It reviews and interrogates information from a variety of sources in order to ensure that decision is informed by accurate, timely and concise data, to support the delivery of the Trusts corporate objectives.

Key information sources include:

- Board Assurance Framework Risk Document – articulates each risk, its controls, gaps and assurance provided utilising the 'Three Lines of Assurance' model. It enables Trust Board to have an improved ability to understand and confirm that they have assurance over key controls or where control gaps exist and whether actions are in place to address these gaps
- Directorate QMS Sense-making Presentations – Accountability and assurance is scrutinised through the presentation and critical analysis of key data, utilising the 6 QMS metric's, establishing individual Directorates performance in relation to key assurance areas and the identification and escalation of issues and risks

8. The Assurance Framework

- Steering Group Reports
- Infographic Reports
- Emerging issues.

The Assurance Committee provides a second line of assurance within the Integrated Governance and Assurance Framework. It has six Steering groups, which oversee the implementation of robust assurance process across all aspects of our business. (Appendix F).

The Remuneration Committee

The Remuneration Committee (a standing committee of Trust Board) is comprised of three Non-Executive Directors. The main function of the Remuneration Committee is to provide advice and guidance to Trust Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of Trust Board) is comprised of Executive and Non-Executive Directors of Trust Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

The Executive Directors Group

The Executive Directors Group (EDG) is chaired by the Chief Executive and is comprised of all Executive Directors and the Deputy Chief Executive. The purpose of the group includes provision of:

- Overall strategic oversight, leadership, direction along with accountability & assurance for the organisation
- Expert professional advice and guidance on regulatory and statutory requirements to the Chief Executive
- Expertise and advice to the Chief Executive in assisting with the provision of accountability and assurance in line with the Integrated Governance and Assurance Framework by holding directors to account for their specific services through regular and thorough review of:

8. The Assurance Framework

- Regulatory compliance

- Directorate performance

- Quality Management System (QMS) Information.

QMS presentations to the EDG, along with the Director of Planning, Performance & Informatics, are a central and critical tool in the EDG's role in seeking and providing organisational accountability and assurance.

Individual directors are responsible for the delivery of respective directorate QMS presentations to the EDG. As part of this process, the EDG will:

- Seek and assess assurance from respective directorates through critical review of QMS and other relevant presentations and information
- Identify gaps in controls and assurance and, in conjunction with relevant service directors, ensure that comprehensive and robust action plans are developed, put in place, reviewed and completed.

This process provides a robust means of demonstrating organisational accountability and assurance to the Assurance Committee in line with the overall Integrated Governance and Assurance Framework

The Executive Team

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update the Board Assurance Framework Risk Document, which will inform the management planning, service development and accountability review process.

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by Trust Board as part of the performance management and assurance processes, is available.

The Executive team have implemented a Charles Vincent Safety Huddle (Appendix D) on a daily basis, at which additional members may be invited.

8. The Assurance Framework

The Integrated Governance and Assurance Framework Steering Groups (Appendix F)

These committees report through the Assurance Committee. They are standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. The Steering groups are:

- Social Care Steering Group
- People and Culture Steering Group
- Clinical and Social Care Governance Steering Group
- Organisational Governance Steering Group
- Safety and Quality Steering Group
- Involvement and Experience Steering Group.

They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice across the Trust.

Social Care Steering Group

The Social Care Steering Group acts on behalf of the Trust Board in seeking assurance from the Trust in respect of the delivery of its Delegated Directions and advising Trust Board accordingly.

The Social Care Steering Group, on behalf of Trust Board, is also responsible for reviewing relevant Annual Reports such as Annual Children's Residential Report, Annual Regional Emergency Social Work Service Report and for escalating any issues of concern arising from these reports to Trust Board.

The Social Care Steering group also has a role in ensuring that the Social Care Governance arrangements established within the Trust are robust and effective. A list of reports that are presented at the steering group is included within Appendix H.

People and Culture Steering Group

The People and Culture Steering Group provides sponsorship, oversight and accountability

8. The Assurance Framework

for the Trust's People and Culture priorities and the associated work undertaken to address the 4 identified priorities areas of:

- Workforce
- Leadership
- Recognition
- Engagement.

The steering group will have oversight of the key metrics that indicate progress in relation to the priority areas as described in the People and Culture Priorities 2021-2023 document.

The group will provide assurance through:

- Holding each Directorate and Division to account for having a People and Culture action plan based on relevant data and for achieving their aims
- Providing challenge, advice and ongoing review of organisational level and divisional level People and Culture Metrics as part of the quarterly QMS reports and will provide feedback on progress to Trust Board on a biannual basis
- Ensuring that People and Culture key risks and challenges are identified and appropriately escalated through existing assurance frameworks.

Clinical and Social Care Governance Steering Group

The Clinical and Social Care Governance steering group acts on behalf of the Assurance Committee in seeking assurance from within the Clinical and Social care arena.

The group will provide assurance through:

- The systematic and continuous review of patient outcomes across the Trust, including mortality and morbidity
- Learning from SAI's, and that risks identified from SAI's are appropriately progressed
- The review of external reports (including social care) following inspection by statutory bodies, RQIA and NIMDTA and other external bodies, and facilitate integration of recommendations
- Review, approval and implementation of all policies, clinical guidelines, standards and patient safety alerts

8. The Assurance Framework

- The systematic and continuous review of adult and children's safeguarding, to include all learning and implementation of recommendations.

Organisational Governance Steering Group

The Organisational Governance steering group acts on behalf of the Assurance Committee in seeking assurance and ensuring the effectiveness of its committees.

The group will provide assurance through:

- Ensuring that the required standards are met in relation to centralised and local decontamination, in relation to reusable devices, and that risks identified are managed and appropriately progressed
- Safeguarding the health, safety and welfare of all staff, service users, patients and visitors and that any risks identified are managed
- Maintaining a Trust wide approach to the management of licensed and regulated activities under statutory requirements of competent authorities
- Ensuring the procurement, usage, maintenance and disposal of all medical devices and that their use/application does not create a risk to patients, staff and visitors
- Continuous scrutiny and challenge of the organisation's Corporate Risk Register.

Safety and Quality Steering Group

The Safety and Quality steering group acts on behalf of Assurance Committee in seeking assurance around the effectiveness of its committees. It sets direction for safety and quality in the Trust and provides assurance that the services we deliver are safe and are constantly seeking to improve in quality.

The group will provide assurance through:

- Leading and driving improvement on Infection prevention and control initiatives
- Establishing and maintaining a Trust strategy for Medicines Management and associated work plans
- Driving a multi-professional culture of safety across the Trust through the promotion of trend analysis, triangulation and effective shared learning to improve patient safety and reduce risk
- Facilitating the implementation Ionising (Radiation) and Non-ionising Radiations

regulations and overseeing the development, implementation and review of the Trust Radiation Safety policy

- Promoting and monitor the safe and appropriate use of blood components and blood products.

Involvement and Experience Steering Group

The Involvement and Experience steering group acts on behalf of Assurance Committee in seeking assurance around the effectiveness of its committees. It sets direction for Involvement and Experience within the Trust

The group will provide assurance through:

- Oversight, implementation and review of the Trust's framework for Personal and Public Involvement (PPI)
- Ensure a strategically consistent approach to collaborative working, through involving patients, service users, carers and communities, to improve health and wellbeing and reduce health inequalities. The Trusts Carer Network will help support this work
- Learning from Complaints, and that risks identified from patient and service user feedback is appropriately progressed
- The systematic and continuous review of all patient and service user feedback, to include all learning and implementation of recommendations from NIPSO, RQIA or other professional bodies.

Directorate and Divisional Governance Groups

Within the Trust, there needs to be a clear chain of delegation that cascades accountability for delivering quality performance from Trust Board to the point of care, ensuring that robust internal monitoring is undertaken enabling assurance and quality intelligence.

Individual Directors are responsibility for governance arrangements within their respective Directorates. They have established Governance Groups/Frameworks across their Directorates and Divisions to support this responsibility. Governance requirements vary from one Directorate to another depending on the nature of their work and the type of risk involved. The Directorate/Divisional Governance Groups can act as the first line of assurance in the Integrated Governance and Assurance Framework.

Directors will receive assurance by the information and reports provided at governance

meetings escalated from the front line and communicated through the line management and reporting structure and will regularly monitor their own governance performance eg. incident rates and risk register and will consider information and trends on incidents, complaints, claims, inquests, safeguarding and morbidity and mortality reviews. Directors will also get assurance by monitoring compliance on health and safety risk assessments, standards and guidelines, audits and improvement work. An example Governance Group Agenda template is provided at Appendix I.

8.2. Accountability and Responsibility for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Deputy Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be clear about the functions of governance and their roles and responsibilities. Good governance means promoting organisational values at all levels, taking informed and transparent decisions, managing risk, and ensuring accountability. The Assurance Framework provides Trust Board with the capacity and capability to engage effectively with stakeholders.

The Role of Trust Board

The role of Trust Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review the performance of management in meeting objectives. By setting the Trust's values and standards, Trust Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

The Role of the Chair

The Chair has a key leadership role in the Integrated Governance and Assurance Framework. They provide leadership through his/her chairmanship of Trust Board and Assurance Committee. They work closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of timely information to Board members and effective communication with staff, patients and the public.

8. The Assurance Framework

The Role of the Non-Executive Directors

Non-Executive Directors will assure themselves and the Trust Board that the Audit Committee and Assurance Committee and related committees are addressing key governance issues within the organisation. Their responsibilities include:

- Strategy: by constructively challenging and contributing to the development of strategy
- Performance: through scrutiny of the performance of management in meeting agreed goals and objectives
- Risk: by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible.

Assurance and accountability is enhanced through active involvement and visible leadership of Non-Executive Directors across the organisation by:

- Listening and hearing the voices of staff, service users, carers and families through a programme of regular visits and meetings
- Taking account of major strategic changes that can impact on the organisation
- Enabling and inspiring a safe, open and learning culture within a highly complex and demanding environment.

Non-Executive Directors are responsible for ensuring Trust Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

The Role of the Chief Executive

The Chief Executive through leadership creates the vision for Trust Board and the Trust to modernise and improve services. She/he is responsible for the Statutory Duty of Quality, is responsible for ensuring that Trust Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. Her/his responsibilities include leadership, delivery, performance management, governance and accountability to Trust Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

8. The Assurance Framework

The Role of the Deputy Chief Executive

The Deputy Chief Executive deputises for the Chief Executive as directed and leads on specific cross cutting and key projects essential to the improvement of the operational and strategic management of the Trust. The deputy also supports the Chief Executive in developing, integrating and co-ordinating the work of the Exec Team, improving accountability and effective governance and driving forward safety and improvement agendas. The role also includes ensuring directors make sense of their business and that matters are escalated appropriately.

The Role of the Executive Team Members

Executive Team members are accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility.

Collectively Executive Team members are responsible for providing the systems, processes and evidence of governance. Members are responsible for ensuring that Trust Board, as a whole, is kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

The Executive Team is responsible for the (operational) management of the Trust and the delivery of its clinical & non-clinical services in a safe and effective fashion, within available resources and in compliance with regulatory and statutory standards; guidance and the requirements of good governance.

The Role of the Senior Leadership Group Members

The group is responsible for providing alignment of the Trust's strategic vision, to the plans and improvements taking place within and across Divisions.

Together they have a collective impact on service delivery, improvement and performance. They are involved in collective decision-making, bringing forward priorities, issues and opportunities to shape the Trusts Strategic direction. As a group, they provide Collective insight, ensuring that strategic discussions and decision-making are informed by the diversity of all groups across the Trust.

8. The Assurance Framework

The Role of the Director of Finance & Estates

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. They, with the Chief Executive, are responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with the Department of Health and Treasury requirements.

The Director of Finance and Estates ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meets it statutory and legal responsibilities relating to finance, financial management and financial controls. They ensure that the Trust has in place Standing Orders and Standing Financial Instructions, including Reservation of Powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

The Director of Finance and Estates is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to Trust Board.

The Medical Director – Lead Director responsible for Integrated Governance and Risk Management, including Clinical Governance, and Quality Improvement

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management, patient safety and excluding finance. This responsibility is shared with the Director of Nursing & User Experience, Director of Social Work and the Director of Finance & Estates.

The Medical Director ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet its statutory and legal responsibilities relating to their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in Trust Board's information schedule. They will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on Trust Board's ability to fulfil its governance responsibilities.

8. The Assurance Framework

As part of the Trust's performance and assurance process, the Director of Performance Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is accountable for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements.

They are accountable for providing professional leadership and for ensuring high standards of nursing and patient/service user experience in all aspects of service delivery within the Trust. They have specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. They have specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and service users in both hospital and community, and holds professional responsibility for all AHPs. They have lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

The Executive Director of Social Work (EDSW) – Lead Director for Governance in Social Services

The Executive Director of Social Work role is to provide strong professional leadership for social work and social care, across the full range of social care services; provided by or commissioned within the Trust for children and adults in the statutory, voluntary and private sectors, and providing assurance that satisfactory arrangements are in place for the exercise of social care and children's functions by the Trust.

The Executive Director of Social Work has professional responsibility and is accountable to the Chief Executive, for ensuring the exercise of social care and children's functions in accordance with the law, the approved Scheme for the exercise of Delegation Directions to agreed professional standards and for providing strategic advice at board level on future developments and direction.

They are responsible for seeking assurances from any other Operational Directors who have responsibility and accountability for the relevant service area that all social care and children's functions are being fulfilled to the required standard.

8. The Assurance Framework

The Executive Director of Social Work is responsible for the managerial and professional oversight of the social care and children's functions exercised by the Belfast Trust as directed by the Department and are directly accountable to their Chief Executive Officer(CEO), who reports to the Trust Board in relation to the Trust's performance in respect of social care and children's functions.

The Executive Director of Social Work is directly accountable to the Trust CEO and Trust Board for the provision of authoritative professional advice and insights in respect of all social work and social care matters, social care and children's functions and for reporting on relevant statutory functions across a range of children's and adult services.

They are responsible for the maintenance of professional standards and all regulatory issues pertaining to the Trust's social work and social care workforce

They have responsibility for ensuring organisational arrangements across social work and social care and enable them to:

- Ensure services provided are of a high quality and a focus is maintained on continuous improvement in all aspects of social work and social care service delivery
- Contribute to service improvement, positive user experiences and improving outcomes
- Be transparent about responsibilities and accountabilities
- Support effective inter-agency and partnership working.

The Executive Director of Social Work has a lead responsibility to provide a high quality of professional social work advice to ensure the Board of Directors can fulfil the function of continuous improvement effectively and efficiently.

The Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development (HR & OD) is accountable to the Chief Executive for ensuring the Trust has in place appropriate HR systems which meet legal and statutory requirements which are based on best practice and which are in line with the Department of Health requirements and other external advisory bodies. Working closely with other Directors the Director of HR & OD will lead on the development and implementation of the Trust's People and Culture Priorities including the development of appropriate policies and procedures and will ensure the Trust Board receives the relevant information/annual reports according to Trust Board's information schedule.

8. The Assurance Framework

The Trust's Organisational Development and Learning and Development functions fall within the remit of the Director of HR & OD. As such, the Director will work with Executive Team colleagues to ensure appropriate systems are in place to support the Trust's Organisational Development and Learning & Development requirements.

The Director of HR & OD also has responsibility for the delivery of Occupational Health Services in the Trust and to a number of external organisations.

The Director of Performance, Planning and Informatics

The Director of Performance, Planning and Informatics is accountable to the Chief Executive for ensuring that a performance and accountability framework suitable for the delivery of the Trust Delivery Plan and Corporate Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

The Director of Performance, Planning and Informatics leads on statutory compliance for Equality. Personal and Public Involvement and GDPR.

Service Directors

The Service Directors are accountable to the Chief Executive for effective management and overall governance in their Directorate:

- Director or Unscheduled Care
- Director of Adult Community, Older Peoples and Allied Health Professionals
- Director of Cancer and Specialist Services
- Director of Mental Health and Intellectual Disability
- Director of Trauma, Orthopaedics, Rehab Services, Maternity, Dental, ENT, Obstetrics and Sexual Health
- Director of Child Health and NISTAR & Imaging, Medical Physics and Outpatients
- Director of Children's Community Services
- Director ACCTSS and Surgery.

The Service Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance.

To do this they lead, organise and effectively manage the Directorate, including performance

8. The Assurance Framework

development and performance management of the staff managing and providing services. Effective risk management, including escalation of risk is key to this; therefore, it is essential that they ensure Directorate wide adherence to the Risk Management Strategy.

It is important that they have an excellent understanding and insight into the day to day business with a highly developed sensitivity to operations through the Charles Vincent Model – seeking out problems and building better anticipation and preparedness to constantly improve.

To support this, Service Directors will produce regular, effective, contemporary management information, which makes sense of the service, and provides a detailed analysis for presentation to the Trusts Executive and Non-Executive Directors.

Each Directorate will:

- Establish a Directorate Assurance Committee
- Develop Directorate and Divisional Governance Frameworks
- Develop systems and structures to support the Trust Integrated Governance and Assurance Framework, to include escalation of risk
- Have Integrated Governance strategies, policies and procedures and ensure these are audited and monitored.

Within Divisions, Collective Leadership Teams are responsible for ensuring that, within their area of responsibility, staff are aware of and comply with the processes for assuring sound governance.

Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management, QMS and the Integrated Governance and Assurance Framework, Service Directors agree (in partnership with the Chief Executive and the Director of Performance, Planning and Informatics), the objectives and targets for their Directorate, based upon the management plan agreed by Trust Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Directorate performance reviews.

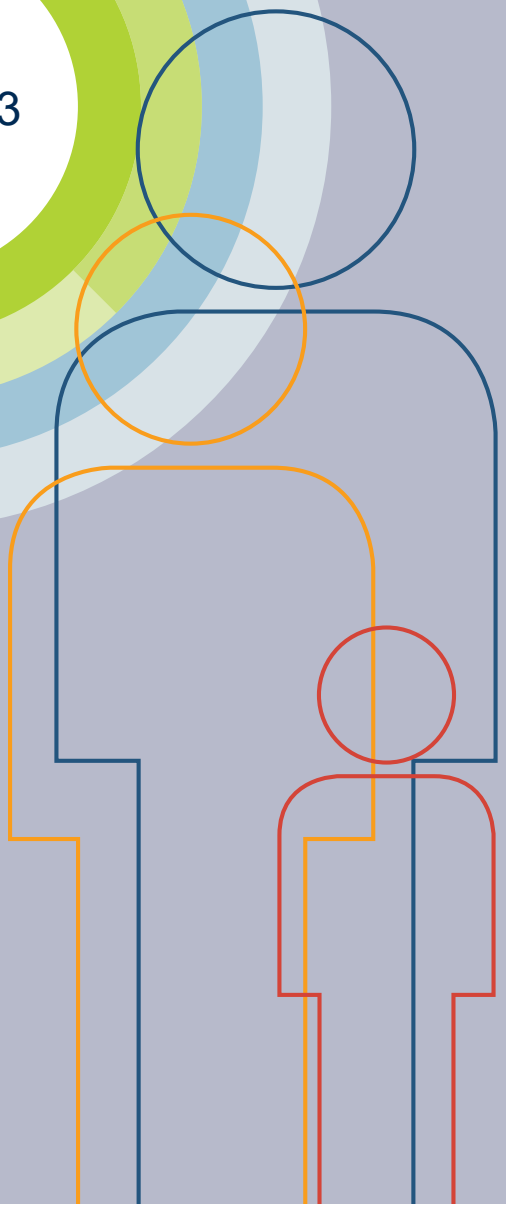
Directorate objectives, corresponding management plans and governance processes must consider the patient profile of each service area. Directorates must ensure, when delivering care to vulnerable patients, unable to speak for themselves, that appropriate scrutiny and assurance arrangements in place.

8. The Assurance Framework

The Directorates are supported and facilitated to meet their governance requirements by their dedicated Governance leads/managers, and the staff of Risk and Governance in the Medical Directorate Office. (A paper is currently in development, reviewing the Governance and Quality Managers location within the organisational structure.

9. Board Reporting

2022-2023



9. Board Reporting

9. Board Reporting

It is important that key information (including threats and opportunities to meeting the corporate objectives) is reported to Trust Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow Trust Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Chief Executive, Director of Finance and Estates, Medical Director, and Director of Planning, Performance and Informatics will be responsible for providing the monitoring and support for the Integrated Governance and Assurance Framework.

Together they have the responsibility in providing:

- An updated position on performance and governance
- An updated position on the effectiveness of the Trust's system of internal control
- Details of positive assurances on strategic risks where controls are effective and objectives are being met
- Detail where the organisation's achievement of its objectives is at risk through significant gaps in control
- Detail where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It is important for the quality and robustness of this Integrated Governance and Assurance Framework that it is evaluated by Trust Board annually.

Appendix A

Appendix A: Risk Management Policy Statement
(Incorporating a definition of acceptable risk)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

Policy Statement:

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

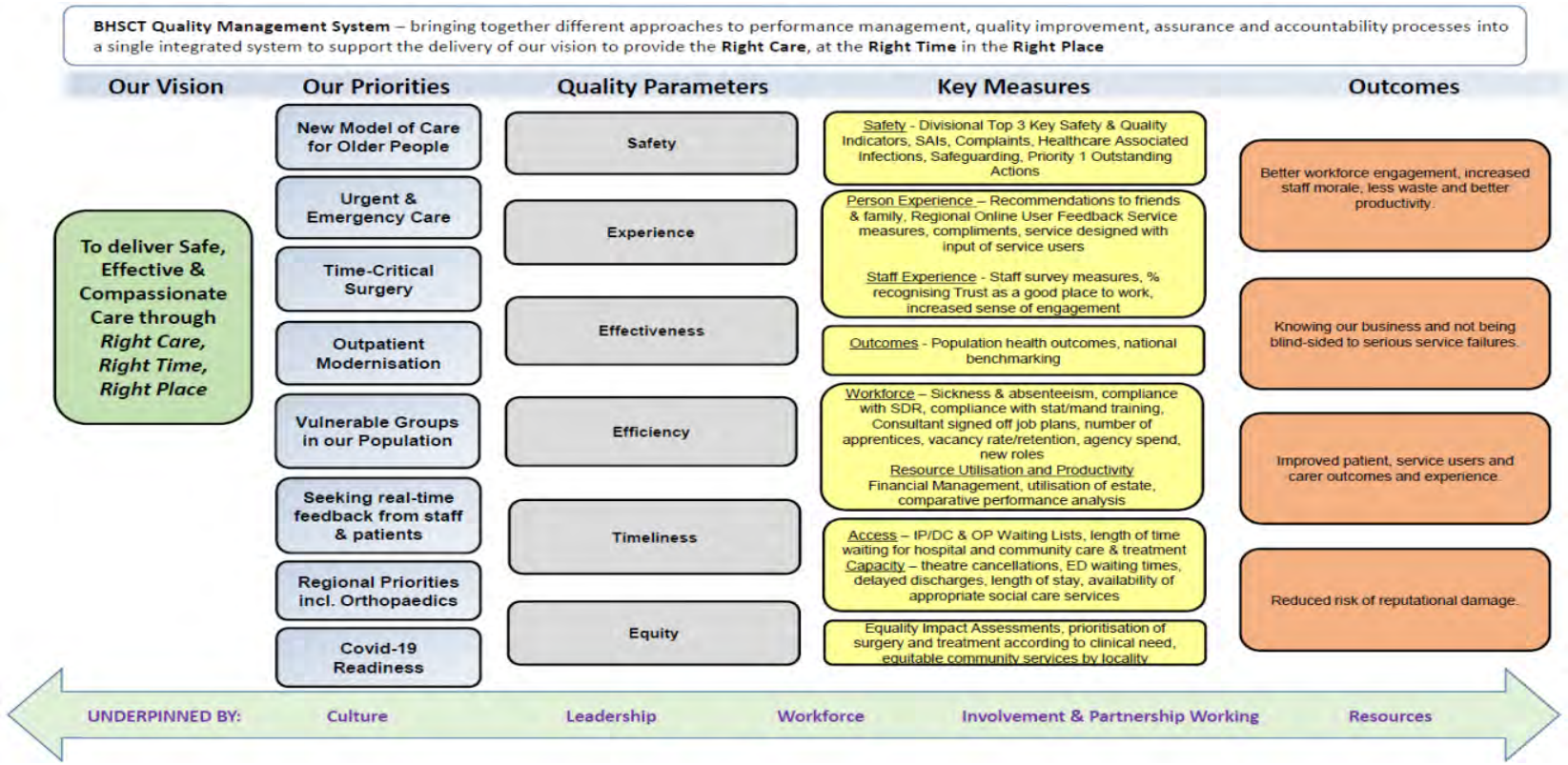
The Belfast Trust recognises that a robust integrated governance and assurance framework, risk management strategy, integrated with QMS and performance management, focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through "an open and fair culture".

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. It will identify acceptable risks through a systematic and objective process. 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 involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

Appendix B

Appendix B: Summary of BHSCT Quality Management System



Appendix C

Appendix C: GGI Risk Appetite Maturity Matrix

RISK APPETITE FOR NHS ORGANISATIONS
A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

Risk levels / Key elements	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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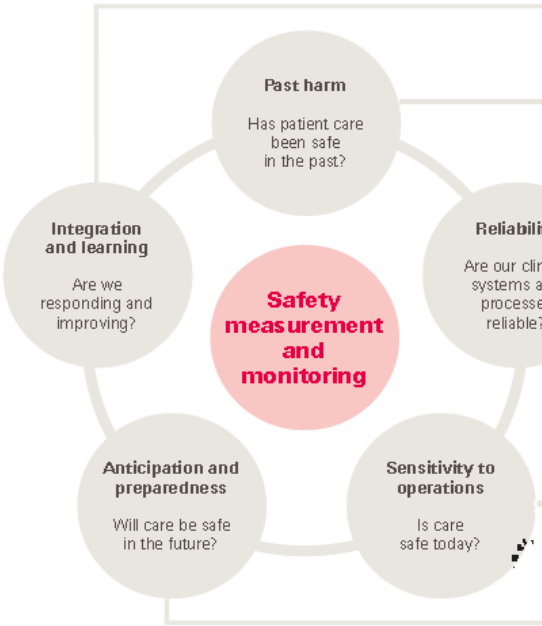
Appendix D

Appendix D: Overview of Charles Vincent Model: The Framework for Measuring and Monitoring Safety

Figure 2: The framework for measuring and monitoring safety – and useful prompts for using it in practice



Integration and learning prompts
- Use the analysis of incidents as a starting point to reveal the wider issues in the system
- Place more emphasis on learning, feedback and action than simply on data collection
- Integrate and tailor information to make it meaningful from the ward to the board

Past harm prompts
- Identify the different types of harm that can exist in your setting
- Use a range of safety measures, while understanding their strengths and limitations
- Ensure the measures are valid, reliable and specific

Reliability prompts
- Specify the level of reliability you would expect in areas of standardised practice
- Use local and national audits and initiatives to monitor reliability
- Understand what contributes to poor reliability

Sensitivity prompts
- Select an appropriate mix of formal and informal safety monitoring mechanisms
- Use this information to take timely action to avert safety issues
- Reflect on whether current structures and committees enable timely action to be taken

Anticipation and preparedness prompts
- Don't wait for things to go wrong before trying to improve safety
- Explore new opportunities to develop systematic ways to anticipate future risks
- Use a variety of tools and techniques to build an understanding of the factors that give rise to safety issues

Appendix E

Appendix E: Trust Assurance and Accountability Organisational Overview

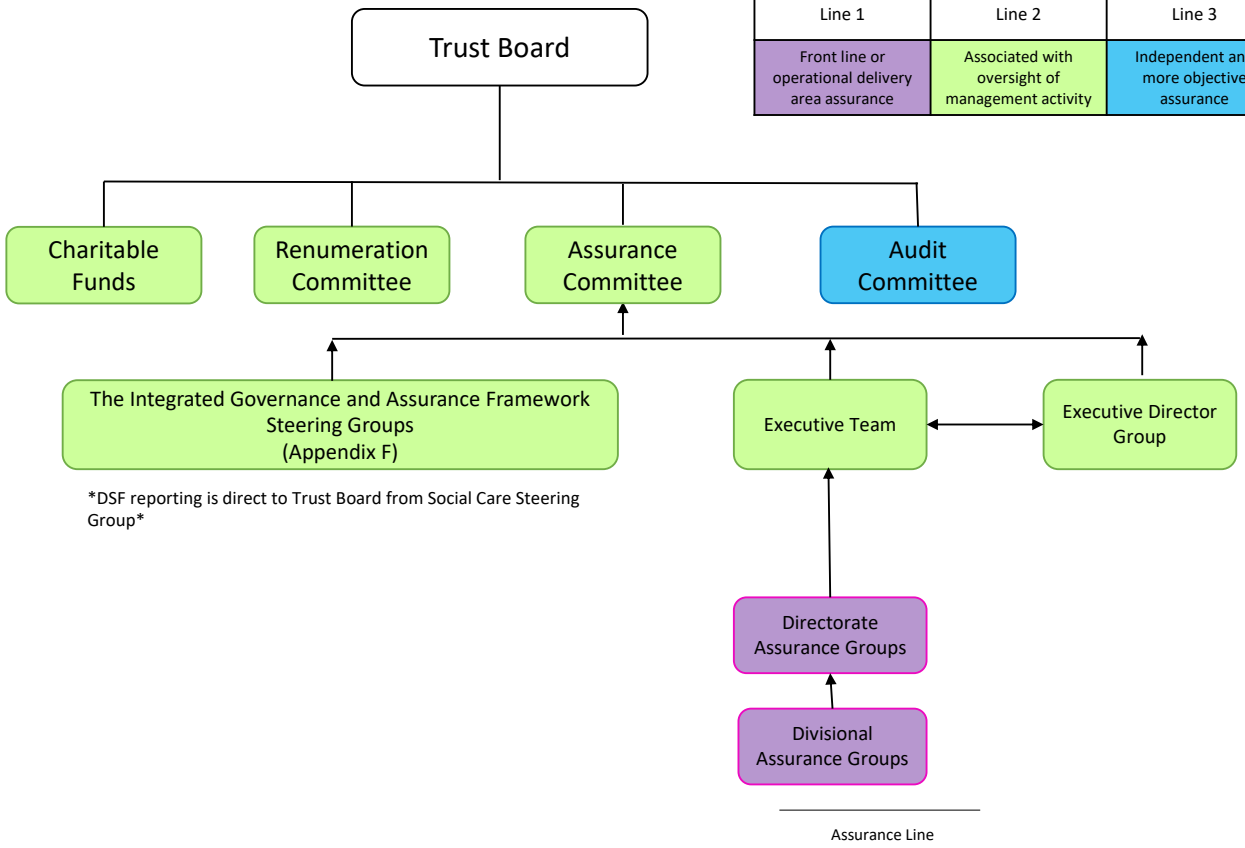
Receives assurance, provides challenge and strategic leadership, holds to account for performance and standards

Seeks and receives assurance, provides challenge, escalates risks to Board.

Provides Strategic Leadership, holds to account, unblocks and assists with problem solving.
Seeks assurance, provides challenge and leadership. Escalates risks to appropriate Trust Board Committee

Seeks assurance, provides challenge and leadership. Escalates risks to Executive Team. Reviews governance and manages risk at Directorate/Divisional level. Provides information and assurance to Steering Groups and Executive Team

Three Lines of Assurance		
Line 1	Line 2	Line 3
Front line or operational delivery area assurance	Associated with oversight of management activity	Independent and more objective assurance



Appendix F

Appendix F: Assurance Steering Groups and Committees

Social Care Steering Group

Scrutinises and provides assurance
- Annual Delegated Statutory Functions (DSF) Report **
- Annual Corporate Parenting Report
- Annual DSF Action Plan
- Interim DSF Action Plan
- Interim Corporate Parenting Report
- Regional Emergency Social Work Service Annual Report
- Children's Residential Child Care Service Annual Report
- Adoption and Permanence Service Annual Report
- Senior Social Work Leaders Assurance Committee Bi Annual Report

- **DSF reporting is direct to TB outside of Assurance Committee schedule**

People and Culture Steering Group

Sponsorship, oversight and accountability for work streams
- Workforce
- Leadership
- Engagement
- Recognition

Clinical and Social Care Governance Steering Group

External Reports and Review Group

Independent Sector Group
- Acute ISP

Learning from Harm Committee
- Outcome Review Group
- SAI Review Group
- Including learning from Complaints and Clinical negligence

Policy, Standards and Guidelines
- NICE Adoption and Implementation
- Patient Safety Alerts
- Trust Policies (including Clinical and Social Care)

Safeguarding Committees
- Adult Safeguarding
- Children's Safeguarding

Organisational Governance Steering Group

Joint Health and Safety Committee
- Employer Liability/Occupier Liability

Decontamination Committee

Licenses Committee

Medical Devices Committee

Organisational Assurance Committee

Risk Register Review Committee

Involvement and Experience Steering Group

Involvement Committee

Service User Experience Feedback Committee

Safety & Quality Improvement Steering Group

Hospital Transfusion Committee

Infection, Prevention and Control

Medicines Optimisation Committee
- Drugs and Therapeutics
- Immunoglobulin/biologics
- Non Medical Prescribing
- Medical Gas
- Medicines Risk Safety and Assurance Group

Radiation Protection Committee

Safety Optimisation Assurance Committee
- Deteriorating Patient
- Falls Group
- Food and Nutrition
- Peri Operative Improvement Team
- Resuscitation Group
- Tissue Viability Group

Appendix G

Appendix G: Integrated Governance and Assurance Framework Schedule of Reports

Social Care Steering Group

Scrutinises and provides assurance

- Annual Delegated Statutory Functions (DSF) Report **
- Annual Corporate Parenting Report
- Annual DSF Action Plan
- Interim DSF Action Plan
- Interim Corporate Parenting Report
- Regional Emergency Social Work Service Annual Report
- Children's Residential Child Care Service Annual Report
- Adoption and Permanence Service Annual Report
- Senior Social Work Leaders Assurance Group Bi Annual Report
- **DSF reporting is direct to TB outside of Assurance Committee schedule**

People and Culture Steering Group

Sponsorship, oversight and accountability for work streams

- Workforce
- Leadership
- Engagement
- Recognition

Clinical and Social Care Governance Steering Group

Reports from:

- AHP (Annual) Report
- Bereavement
- Commissioned Services
  - ISP Acute Annual Report
  - ISP Community Annual Report
- Coroners
- Incidents & SAI's
- Legal Services
- Medical and Dental (Annual) Assurance
- Nursing Assurance (Annual)
- Policies
- RQIA Thematic review report
- Safeguarding (children & adult)

Organisational Governance Steering Group

Reports from:

- Decontamination Emergency Planning
- Health and Safety
- Information & IT Governance (including Digital Steering Group, Cyber Programme Board and Information Governance Annual Report
- Risk Management Strategy action plan

Patient Environment reports from:

- Fire Safety Group
- Ventilation Group
- Water Safety Group

Involvement and Experience Steering Group

Reports from:

- Involvement/Equality Report
- Complaints/Compliments /NIPSO
- 10000 voices

Safety & Quality Improvement Steering Group

Reports from:

- Annual Quality Report
- Hospital Transfusion
- IPC Annual Report
- Research Annual Report
  - Water safety
  - Ventilation – TB & Aspergillis

Reports for Executive Director Group

- Quality Management System reporting
- Inquiry oversight Groups (including Neurology, Muckamore Abbey Hospital, IHRD , Infected Blood inquiry etc.)
- RQIA Inspections Report
- Whistleblowing

Reports direct to Trust Board

- Corporate Parenting report
- Clinical Ethics
- Organ donation
- Statutory Functions report
- People and Culture Board

NB: Steering group TOR to include the requirement to consider reports for onward submission to Assurance Committee.

This consideration will take account of statutory requirements

Appendix H

Appendix H: Reports to Social Care Steering Group

- Annual Delegated Statutory Functions (DSF) Report
- Annual Corporate Parenting Report
- Annual DSF Action Plan
- Interim DSF Action Plan
- Interim Corporate Parenting Report
- Regional Emergency Social Work Service Annual Report
- Children's Residential Child Care Service Annual Report
- Adoption and Permanence Service Annual Report
- Senior Social Work Leaders Assurance Group Bi Annual Report.

Appendix I

Appendix I: Example Agenda for a Directorate/Divisional Governance Group

Belfast Health and Social Care Trust
caring supporting improving together

Directorate/Division Governance Group

Date

Venue

AGENDA

1. Apologies
2. Previous minutes
3. Matters arising
4. SAIs
5. Early Alerts
6. Incidents
7. Risk Register/New Risks
8. Policies, standards and guidelines
9. Complaints/Compliments
10. Safeguarding
11. Health and Safety
12. RQIA
13. Infection prevention control
14. Professional issues
15. Shared Learning
16. Quality Improvement
17. Statutory Functions (in directorates/divisions where relevant)
18. Directorate business matters relevant to governance
19. Any other Business
20. Date/Time of next meeting

BT22-2750

Belfast Health and Social Care Trust

Minutes of the Trust Board Meeting
Held on 4 June 2015 at 10.00 am
in the Boardroom, Trust Headquarters
Belfast City Hospital

PRESENT:

Mr Peter McNaney	Chairman
Mr Les Drew	Non-Executive Director
Professor Martin Bradley	Non-Executive Director
Mr Tom Hartley	Non-Executive Director
Mr James O'Kane	Non-Executive Director
Dr Val McGarrell	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Michael McBride	Chief Executive
Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Dr Cathy Jack	Medical Director
Mr Cecil Worthington	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Brian Barry	Director Specialist Hospitals and Women's Health
Mr Shane Devlin	Director Performance, Planning and Informatics
Mr Damian McAlister	Director Human Resources/ Organisational Development
Ms Catherine McNicholl	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Specialist Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

APOLOGIES:

Mr Charles Jenkins	Non-Executive Director

Mr McNaney welcomed everyone to the meeting with a special welcome to Martin Bradley and Nuala McKeagney attending their first meeting following their recent appointment as Non Executive Directors'.

21/15 Minutes of Previous Meeting

The minutes of the Trust Board meeting held on 2 April 2015 were considered and approved, subject to an apology being recorded for Dr McGarrell.

22/15 Matters Arising

There were no items raised.

23/15 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest noted.

b. Non Executive Director Appointments

Mr McNaney reported that in addition to Professor Bradley and Mrs McKeagney being appointed as Non Executive Directors' from 18 May 2015, Dr Patrick Loughran had been appointed as Mater Hospital Trustees representative and would take up post on 1 July 2015. Professor Stuart Elborn would take up post on 1 April 2016 as the QUB representative. All appointments were for a four year term.

Members noted that another Non Executive appointment had been made and was currently the subject to the required checks.

Mr McNaney reminded members' that a dinner would be held on the evening of 22 June in QUB to mark the completion of Les Drew, Tom Hartley and Charlie Jenkins term in office.

c. Trust Board Meetings – Future Venues

Mr McNaney sought members' views to Trust Board meetings being held in Trust facilities.

Mr O'Kane said that it was important that appropriate notice was given to allow travel time.

Following discussion it was agreed that the workshops should be held in Trust facilities.

Ms McNicholl advised that she was arranging for service users from with the Learning and Disability programme to present at the July workshop and suggested it would be appropriate to use a room on the Muckamore Abbey Hospital site. Members supported this proposal.

d. Health Minister's Visit – 21 May 2015

Mr McNaney reported that the newly appointed Health Minister Simon Hamilton had visited the Cancer Centre on 21 May, 2015 when he had taken the opportunity to deliver a keynote address outlining his vision for the future provision of health and social care in Northern Ireland.

23/15 **(Contd.)**

Minister Hamilton had toured the Cancer Centre and met with staff and patients before travelling to Hemsworth Court, the new supported living apartments provided in partnership with Helm Housing enabling people with dementia to continue to live in the community.

Dr McBride said that feedback from the Minister's Office had been very positive.

Mr McNaney wished to record his appreciation to Mrs Dalzell and the Events Team for the excellent preparation put in place for the Minister's visit.

24/15 **Chief Executive's Business**

i. Emerging Issues

a. Critical Care Building - Phase 2B, RVH

Mr Dillon advised members that the Critical Care building had been handed over to the Trust on 24 April 2015 and gave an overview of arrangements being put in place to relocate the ED from its temporary accommodation to the new building. The Trust was liaising closely with the HSCB regarding the appointment of additional staff to support the new model of care, particularly around the establishment of a 24/7 Clinical Assessment Unit with the aim to avoid unnecessary admission to hospitals.

In response to a question from Mr Hartley, Mrs Dalzell advised that there was a Communication Plan in place to hold open days for key stakeholders, media and local communities, etc prior to the ED transferring.

Dr McBride proposed that arrangements be made for Non Executive Directors' to visit the new building and receive a presentation on service.

b. RQIA Unscheduled Care – Update

Dr McBride advised that ED attendances continued to increase and that in the first quarter of the year there had been a 12% increase compared to the previous quarter. Patients were presenting with more urgent complex conditions and there had also been an increase in the number of elderly patient attendances.

In response to a question from Mr O'Kane, Dr McBride said that it was an on-going struggle to meet the demands of the population and paid tribute to nursing, medical, social work and AHP staff who work diligently to provide high quality care despite the on-going pressures.

24/15 **(Contd.)**

Mrs Owens referred to the RQIA Review of Unscheduled Care in January/February 2014 when 25 recommendations had been reported and the follow-up inspection in December 2014 which resulted in a further 12 recommendations being made. She presented the Quality Improvement Plan outlining the Trust position in relation to each of the recommendations. Mrs Owens reported that all of the original 25 recommendations and 11 of the 12 additional recommendations have been addressed by the Trust. The recommendation relating to the appointment of sufficient middle grade doctors remained a challenge. Mrs Owens advised that the Trust had embarked on a marketing and advertising recruitment campaign and was exploring alternative new roles.

In response to a comment from Mr Hartley, Dr Jack explained the NIMDTA requirements in relation to middle grade doctors. Dr Jack explained that the appointment of Physicians Associates was also being discussed with the DHSSPS.

Miss Creaney advised that Advanced Nurse Practitioners had also been appointed and they could carry out some treatments previously provided by clinicians.

Mr O'Kane sought reassurance that the Trust had an action plan in place to address the outstanding recommendations.

Dr McBride said that the Trust continued to monitor the situation and liaise closely with RQIA, HSCB and DHSSPS regarding the matter.

Mr McNaney referred to the IMPACT programme and the positive impact it was having on improving services within ED.

c. The Human Rights Inquiry Report into Emergency Healthcare

Mr Dillon reported that the Trust had received a draft copy of the Human Rights Inquiry Report into Emergency Healthcare for factual accuracy. The Trust had submitted comments and it was anticipated the final report would be published in the near future.

Mr Hartley said that he would anticipate human rights issues would continue to grow within public institutions.

Mr McAlister stated that Human Rights was embedded in practice across the Trust

24/15 **(Contd.)**

d. Right Time Right Place – Donaldson Feedback

Mr Devlin reported that the Trust had contributed to the joint HSC response to the Right Time Right Place Donaldson Report, which had submitted to the DHSSPS for consideration.

Decision: Chief Executive's Business – noted.

25/15 **Safety and Quality**

a. Discharge of Statutory Functions Report 1 April 2014 – 31 March 2015

Mr McNaney welcomed Mr Growcott, Co-Director, Primary and Social Care and Mrs Marie Heaney, Acting Co-Director Older Peoples Services.

Mr Worthington presented the Statutory Functions Report for the period 1 April 2014 to 31 March 2015 providing an overview of assurance arrangements pertaining to social care service delivery by the Trust's social work and social care workforce. The report addressed the assurance arrangements underpinning the delivery of services across the individual Service Areas, outlined levels of compliance with the standards specified in the Scheme for the Delegation of Statutory Function and identified on-going and future challenges in the provision of such services.

Mr Worthington reminded members that the Trust, as a corporate entity, is legally responsible for the discharge of statutory functions as delegated under the HPSS (NI) Order 1994. The Trust is accountable to the HSCB for the discharge of such functions and is required to establish sound organisational and related assurance arrangements to ensure their effective discharge. The Scheme of Delegation provides the overarching assurance framework for the discharge of statutory social care functions.

Mr Worthington stated that the discharge of statutory functions was demanding, complex, challenging and rewarding work and paid tribute to the professionalism, knowledge, skill and dedication of the Trust's social care workforce.

Mr Worthington reminded members that as Executive Director of Social Work he was professionally accountable to report to Trust Board on the discharge of statutory social care functions. He explained that the report had been presented on the required HSCB template and was sub-divided in to the following sections.

25/15 **(Contd.)**

Section 1: An introduction to the Report.

Section 2: a strategic overview of the Trust's performance across the respective Service Areas by the Executive Director of Social Work in relation to the discharge of its statutory functions.

Section 3: Individual Service Area reports incorporating information returns pertaining to statutory services delivery.

Members noted the report included the following:

- The Belfast Local Adult Safeguarding Report 2014-2015.
- The Trust's Annual Social Services Learning and Development Accountability Report 2014-2015.
- The Trust's Annual Assessed Year in Employment Report 2014-2015.

Mr Worthington pointed out that the Trust's exercise of its statutory duties, in particular those related to the protection of children and vulnerable adults and the restriction of personal liberty, give rise to significant levels of public interest and scrutiny.

Members' noted the individual Service Area reports provided a detailed commentary on issues relating to their own operational setting, and a number of the principal corporate themes addressed across the Service Areas.

In relation to workforce, the individual Service Area reports reflected Service-specific and corporate workforce issues. While there had been relative stability across the workforce, lengthy recruitment processes had proved problematic. The Older Peoples Service had been engaged in a workforce review linked to modernisation of social work and social care organisational and service delivery structures with a focus on strengthening professional social work capacity within integrated community care teams. A number of the Adult Service Areas had indicated proposals to review current arrangements for the delivery of Care Management functions. The Mental Health Services were currently leading a review of the Trust's Approved Social Work (ASW) service in the context of the pending mental capacity legislation and a reduction in the overall ASW workforce cohort. ASWs discharge key statutory functions under the Mental Health (NI) Order 1986. Members' were pleased to note that previous retention difficulties within the Family and Child Care Service had improved.

25/15 **(Contd.)**

Mr Worthington reported that the Trust had prioritised on-going investment in staff development through access to a comprehensive range of training programmes with a particular focus on the consolidation of assessment and risk management skills, the promotion of reflective learning opportunities and leadership and management development, incorporating supervision skills.

The Regional Social Work Strategy 2012-2022 outlined the framework to support the delivery of a vision for social work which is centred on optimising the skills, knowledge base and expertise of the workforce to deliver key policy objectives at both regional and local levels. Within Adult Services the nature of the social work role, the retention of a coherent professional social work structure and the accessibility of career pathways for social work practitioners and managers had been identified as areas for particular focus at both Trust-wide and regional levels. With regard to the social care workforce, the Trust had continued to profile the importance of consolidating and developing staffs' engagement in accredited training programmes and promoting a coherent career pathway within a lifelong learning ethos.

Across all Service Areas there had been an emphasis on articulating and profiling the social work and social care role within multi-disciplinary and integrated service delivery structures and promoting the on-going acquisition across the workforce of the skills and knowledge necessary to respond to the complexity and range of service delivery demands.

Mr Worthington reported that the social work and social care workforce were engaged in the reform and modernisation processes. The promotion of a service delivery framework predicated on a citizenship model which incorporates inclusion, service user engagement and choice, whilst promoting the importance of locality/community capacity and the social dimension to health and well-being were reflected in each of the individual Service Area reports.

Mr Worthington referred members to the Annual Belfast Local Adult Safeguarding Report, appended to the Statutory Functions Report, which provided information in respect of the delivery of adult safeguarding. During the reporting period there had been relative stabilising of referrals within Learning Disability and Physical and Sensory Disability Services. However, within Older Peoples Service there had been a rise of approximately 10% in referrals.

The Mental Health Service had witnessed an exponential rise in referrals of 283%. This appeared to relate to the adult safeguarding awareness raising focus across all service settings. This rise in safeguarding activity had had a significant impact on social work capacity.

25/15 **(Contd.)**

Mr Worthington pointed out the implementation of the Draft Revised Adult Safeguarding Policy, which profiled social work as the lead profession in safeguarding, would give rise to particular operational and workforce planning challenges. He explained that adult safeguarding is a complex, demanding and highly skilled area of work, requiring strong multi-disciplinary and multi-sectorial partnership approaches at both strategic and service delivery levels within a person centred practice approach. Safeguarding adults without capacity or those whose social, emotional and physical limitations give rise to particular vulnerabilities is a key priority for the Trust.

The Trust's Adult Safeguarding Committee had been established to strengthen the corporate focus and assurance arrangements with regard to adult safeguarding.

The Regional Safeguarding Board for Children had been operational since April 2012 and had assumed statutory responsibility for the Belfast Safeguarding Panel (which replaced the previous Belfast Child Protection Panel in October 2012). Members noted the Safeguarding Board was a statutory agency with an independent Chair reporting to the Minister and accountable to the Assembly, with a statutory responsibility to promote qualitative safeguarding services to children and their families.

Mr Worthington referred to the recent publication of the Marshall Review Report and pending publication of the SBNI's Thematic Review both address the key area of safeguarding children who are at risk of sexual exploitation. The conclusions and recommendations from both Reviews will provide the template for the delivery of services to individual children at risk of abuse/exploitation within a multi-sectorial strategic approach to promoting a whole societal engagement in safeguarding children.

Mr Worthington highlighted the following challenges related to the delivery of statutory functions:

- The complexity and volumes of service delivery activity result in significant demand and capacity pressures across all Service Areas.
- The consolidation and further development of community services infrastructure across adult and children's services to secure positive, person centred outcomes for services users.
- The implementation of self-directed support as a vehicle for transformational change in service delivery culture and processes.
- The overarching financial and resource context and the implications for the delivery of statutory functions.

25/15 **(Contd.)**

- The challenges associated with the delivery of safeguarding functions across adult and children's services.
- The need to continue to focus on workforce development, learning and skills acquisition.
- Consolidation of the PARIS information system across adult services and the Implementation of PARIS within children's services. The development of the information infrastructure across social work and social care service delivery will be central to on-going service improvement and effectiveness.

Mr Worthington pointed out that each of the Service Area reports capture substantial achievements in respect of innovative, person centred, quality service delivery, he drew particular attention to:

- Hemsworth Court Community Integration Project -the development of a dementia friendly community initiative in the Shankill area to promote the integration of Hemsworth Court, a supported housing development for people with dementia, into the wider Shankill community, optimising their social inclusion and raising awareness of dementia.
- The on-going development of services for carers in partnership with carers' representatives and utilising direct feedback and commentary from carers themselves - a focus on person centred, flexible and innovative initiatives.
- Partnerships: the on-going investment in partnership working across all Service Areas. A commitment to developing multi-sectorial approaches to the identification of need and service delivery predicated on securing improved outcomes for service users through their engagement in planning for and reviewing service delivery; the maximising of available resources linked to demonstrable improvements in service user outcomes; and an investment in strengthening community capacity and resilience-opportunities associated with Community Planning .
- Workforce: a range of individual and service awards across the Service Areas reflecting the commitment, professionalism and skills of the workforce.

Mr McNaney asked about the age profile of the workforce providing the service.

Mrs Heaney advised that there was an ageing workforce and this would be a significant challenge for the future of the service. Mr Worthington emphasised the importance of the reform and modernisation programme to ensure the workforce was fit for purpose for the future.

25/15 **(Contd.)**

In response to a question from Dr McGarrell, Mr Growcott advised the current absentee rate was around 5.5%.

Dr McBride referred to the detail and volume of activity contained within the report and said he had found it very informative and wished to commend all those involved.

Mr Worthington advised that he and the Chairman had discussed the establishment of a small sub-committee, chaired by a Non Executive Director to review the report in detail prior to presentation to Trust Board. Mr McNaney said he would discuss this further with Mr Worthington when the new Non Executive's had taken up post.

Having considered the report in detail members approved the Delegation of Statutory Functions Report for the period 2014/15.

Mr Worthington thanked members and advised that the Trust would be meeting the HSCB to present the report.

b. Corporate Parenting Report - 1 October 2013 to 30 April 2014

Mr Worthington presented the six monthly Corporate Parenting Report which provided an overview of the Trust's discharge of its responsibilities to those children who meet the statutory threshold of "in need" as detailed in Section 17 of the Children (NI Order) 1995 and the cohort of children who are looked after by the Trust and inspect of whom it has the statutory duty to promote their workforce and to afford them the opportunities and supports which might reasonably be expected of a good parent.

Members were reminded the Trust's services to children in need were delivered within a multi-professional and multi-agency framework. Whilst social work staff have lead responsibility for the discharge of statutory functions relating to children, other health and social care staff have key roles in promoting and protecting the welfare of vulnerable children and their families.

Mr Worthington drew members attention to the following sections detailed within the report:

- Children in Need
- Child Protection
- Looked After Children
- Transitions: Leaving and After Care
- Fostering
- Adoption
- Early Years

25/15 **(Contd.)**

Mr Worthington highlighted the following challenges facing the Trust:

- **Implementation of Care Pathways** - following consultation with young people and their parents, a proposal has been drawn up and shared with the HSCB to ensure greater consistency of social work input for young people in Care where this is the Permanency plan. 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.

- **Unallocated Cases** - on-going focus on securing a significant reduction in unallocated cases and a reduction in caseloads in Family Support to a level considered appropriate for the nature of risk and consequent work required with such cases.

- **Families with No Recourse to Public Funds** - the Trust continues to experience increasing 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 extent of resource required and is developing a business case to ensure effective and safe working with this vulnerable group.

- **Operationalising of the Edge of Care Project** - this Trust project will seek to prevent a 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 their 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.

  The purpose and function of the short term children's home at 57a College Park Avenue will change to that of a Resource Centre housing a team of staff providing a multi-disciplinary/multi-agency approach on an outreach basis to safely manage young people within their families and local communities and so reduce the need for admissions to care.

- **Overarching Financial Context** - challenges associated with the need to meet statutory obligations in respect of service delivery in the context of the complexity and volumes of service demands and the requirement to achieve further significant efficiencies and savings.

25/15 **(Contd.)**

- **Safeguarding - c**hallenges associated with the delivery of the recommendations and action plans linked to the Marshall Report and SBNI Thematic Review.

Mr McNaney sought clarification regarding 91 you people awaiting allocation of a Personal Advisor due to current capacity and funding gap.

Mr Worthington assured members that whilst these young people are awaiting to be allocated a Personal Advisor they continue to have Social Worker support.

In response to a question from Mr McNaney, Mr Worthington explained that discussion was continuing between the HSCB and DHSSPS regarding the number of secure places required for the region. He further advised that in the event of a young person awaiting placement in secure accommodation increased support is put in place pending a place becoming available.

Mr McNaney asked if the introduction of the Family Support Hubs had seen a reduction in children being referred to the service.
Mr Worthington said the Family Support Hubs were in their infancy and they would need to be operation for 12 to 18 months in order to evidence their impact on referrals.

Mr Drew welcomed the Edge of Care Project with agencies working in partnership to prevent young people being admitted to care.

Mr Worthington said it was important that families can avail of early intervention at the right time to prevent young people entering the care system.

Dr McBride emphasised the importance of keeping young people out of care and supporting them with education and career opportunities.

Mr McNaney paid tribute to Mr Worthington and his staff for the high standard of professionalism proved to very vulnerable and complex children for whom the Trust is responsible as the Corporate Parent.

Mr Worthington that the imminent publication of the Thematic Report is likely to have implications for the Trust.

Following detailed discussion members approved the Corporate Parenting Report for the period 1 October 2014 to 31 March 2015.

Decision: Corporate Parenting Report - 1 October 2014 to 31 March 2015 – approved.

26/15 Director of Adult Social and Primary Care

a. Improving Dementia Services in West Belfast – Re-provision of Ballyowen EMI Residential Home to Supported Housing Model – Proposal to Proceed to Public Consultation

Ms McNicholl referred to the previous presentation to Trust Board on 5 February when approval had been granted to commence a pre-consultation discussion with key stakeholders regarding improving Dementia Services in West Belfast through the re-provision of Ballyowen EMI Residential Home to a Supported Housing Model on the old Grovetree House site. Having carried out the pre-consultation Ms McNicholl presented a paper outlining a proposal to enter into a twelve week public consultation on the re-provision of Ballyowen EMI.

Members were advised the Trust proposal would improve services for people with dementia through the provision of a fourth supported housing scheme in west Belfast, linked to the re-provision of Ballyowen EMI home. Ms McNicholl pointed out that if the proposal is to proceed it will result in the closure of Ballyowen EMI.

The scheme would see the provision of 30 self-contained apartments, designed to dementia specific standards, offering tenancies for people with dementia and if appropriate their spouse, sibling or family carer.

Ms McNicholl pointed out that if the scheme did not get approval to proceed, the Trust would need to identify another source of revenue funding and invest in significant structural improvements in the home, with minimal improved outcomes, due the size, location and outdated model of the building.

Members noted that whilst Ballyowen had capacity for 31 residents currently there were 18 residents; 3 of whom are on a temporary basis as their long term needs are assessed.

Mrs McNicholl pointed out that the proposal was in line with the strategic direction for dementia services, including the DHSS Bamford policy Living Fuller Lives, 2007 and the N.I. Dementia Strategy, 2012 and was in keeping with the Trust's strategy for improving dementia services and enabling people to live well with dementia and is also underlined as the strategic direction for special needs housing with the NIHE Supporting People Strategy 2005/10

Mrs McNicholl advised that the pre-consultation discussion had been positive with all relevant stakeholders had engaged. The primary concern was how the Trust would manage the on-going care of the current residents and assurances had been given that their options would be discussed with them and their families/carers and if they choose to do so they could remain within the home.

26/15 **(Contd.)**

It was noted that an Equality Impact Assessment had been carried out on the proposed service change with no issues identified.

In concluding her presentation Ms McNicholl sought approval to proceed with a twelve week public consultation.

Dr McBride referred to the low occupancy rates in Ballyowen and said it was understandable that people with dementia were choosing to go into supported housing models as they provide real opportunities for them to continue to live meaningful, active lives in the community.

In response to a question from Mr Hartley, Mrs Heaney advised that, in the past few years there had been a decline in the occupancy of Ballyowen and there was no one on a waiting list. She further advised that the Trust would continue to liaise closely with re current residents and their families regarding their future care.

Mr Barry commended the pre-consultation process which had highlighted better models of care and gained the support of stakeholders and the local community.

Mrs McKeagney sought clarification regarding the financial commitment for the scheme.

Mrs McNicholl advised that a housing association would provide the capital to build the new facility and the Trust would be responsible for revenue costs, staff and manage the care provision.

Mr Bradley sought assurance that staff, residents and their families were aware of the proposed development.

Mrs Heaney confirmed that the Trust had and would continue to engage with all staff and residents and their carers regarding the scheme.

In response to a question from Mr Hartley, Ms McNicholl said the Trust in partnership with Belfast City Council and voluntary agencies had a menu of schemes for elderly people living in the community, i.e. luncheon clubs, befriending schemes, etc.

Mrs Heaney also advised that there were community hubs established to sign post people to schemes running within their areas.

26/15 **(Contd.)**

Following a full and lengthy discussion members approved a 12 week public consultation process son the proposed development of a fourth supported housing scheme for people with dementia on the old Grovetree site, which will include consulting on the closure of Ballyowen House. During the consultation period the Trust would cease permanent admissions to Ballyowen pending a formal decision being taken by Trust Board.

Decision: Public consultation process on the proposed development of a fourth supported housing scheme for people with dementia on the old Grovetree site, which will include consulting on the closure of Ballyowen House – approved.

27/15 **Director of Performance, Planning and Informatics**

a. Proposed Outline Procurement Model for Domiciliary Care Services for 2015/16 – Outcome of Public Consultation

Mr Devlin referred to the need for the Trust to meet the new legislative requirements of the Contract Regulations 2015 and move forward with the procurement of domiciliary care services via an EU compliant tender process. Following approval at the February 2015 Trust Board meeting a public consultation on the proposed outline procurement model for domiciliary care services for 2015/16 had been undertaken. He advised that the consultation had concluded on 8 May 2015 and presented a report detailing the outcome.

Mr Devlin explained that the proposed outline procurement model was a mixture of guaranteed volume and flexible spot purchasing arrangements, to offer sustainability of service and to allow for flexibility, key features were of which were:

- A guaranteed volume equating to 80% of baseline activity
- A range of tiered volumes to offer levels of business opportunity
- A total of 9 Providers to be awarded contracts for service provision
- A contract term of 3 years with potential to extend for up to a further 24 months

In adopting the proposed model, the Trust had revised and refined one of the features of the model with regard to guaranteed volume. In the light of responses to the consultation the level of flexibility applied to the model had been increased from 20% of baseline activity to 25% i.e. the level of guaranteed volume has been reduced from 80% to 75% baseline activity. He pointed out that this increased flexibility will facilitate any potential changes to the split of statutory and non statutory service provision.

27/15 **(Contd.)**

Mr Devlin advised that allowing for a timeframe to fully developing the service specification and supporting tender documentation, it is the intention of the Trust to subsequently advertise the tender in quarter 3 of this financial year i.e. between October and December 2015. Contract award and the implementation plan to manage the outcome of this will take place for the start of the next financial year i.e. 2015/16. The planning for implementation will be given priority in order to prepare Service Users, Providers and Trust staff for the transition period. In addition, the Trust will work alongside Providers to ensure the delivery of TUPE principles with the key objective of promoting continuity of care to Service Users.

In conclusion Mr Devlin sought Trust Board approval to progress the procurement process via an EU compliant open tender.

Following a query from Mr Hartley, Mr Devlin advised that the proposed model would not change the current balance of in-house and external domiciliary care provision.

Mr Drew asked if there had been communication with the Trade Unions regarding the model.

Mr Devlin advised that the Trade Unions had responded to the consultation.

In response to a comment from Mr O'Kane, Mr Dillon said that there was an EU regulation for the Trust to have a procurement model for Domiciliary Care. Mr Devlin also advised that the Trust had taken legal advice on the proposed model.

Having considered the proposal in detail Trust Board approved the outline procurement model for Domiciliary Care Services for 2015/16 via an EU compliant open tender.

Mr Devlin advised that the consultation outcomes report would be published on the Trust website.

Decision: Outline Procurement Model for Domiciliary Care Services for 2015/16 via an EU compliant open tender – approved.

28/15 **Deputy Chief Executive/Director of Finance, Estates and Capital Development**

a. Use of Charitable Funds for Capital Projects

Mr Dillon presented a paper outlining a list of capital schemes to be funded from Charitable Funds Expenditure totalling £999,249 for Trust Board approval.

28/15 **(Contd.)**

Mr Drew, as Chair of the CFAC, advised that at a meeting on 11 May 2015 the CFAC had considered the schemes and endorsed the charitable funds expenditure on these projects.

Members approved the Charitable Funds Expenditure on the list of Capital Schemes.

Decision: Use of Charitable Funds for Capital Projects – approved.

29/15 **Audit Committee**

Mr O'Kane, Chairman, Audit Committee presented the minutes of the minutes of a meeting of the committee held on 13 January 2015 for information.

Members noted the content of the minutes.

Decision: Audit Committee Minutes 13 January 2015 – noted.

30/15 **Assurance Committee**

Mr McNaney presented the minutes of a meeting of the Assurance Committee held on 10 February 2015 for information.

Members noted the content of the minutes.

Decision: Assurance Committee Minutes 10 February, 2015 - noted

31/15 **Any Other Business**

a. Trust Delivery Plan/Corporate Management Plan 2015/16

Mr Dillon referred to the Trust Delivery Plan and Corporate Management Plan for 2015/16, however information was awaited from the DHSSPPSP/ HSCB before the draft plans could be considered by Trust Board and therefore he sought approval to hold a Trust Board Workshop on 23 June, 2015 to approve the plans before submitting to the HSCB.

Members agreed to the workshop and expressed concern at the delay in strategic information being provided by the DHSSPS/HSCB.

Dr McBride advised he was not available on 23 June, but was happy for Mr Dillon to deputise on his behalf.

31/15 **(Contd.)**

b. Non Executive Directors' Final Meeting

Mr McNaney reminded members that Mr Drew, Mr Hartley and Mr Jenkins would be completing their role as Non Executive Directors' at the end of June and paid tribute to their commitment and support to the Trust since its formation in 2008.

Dr McBride, on behalf of the Executive Team, also wished to acknowledge the commitment and support of the Non Executive Directors' when at times there had been difficult and challenging decisions to be taken.

Mr Drew and Mr Hartley thanked everyone for their kind words and wished the Trust well for the future.

Mr McNaney reminded members that he would be hosting a dinner on 22 June 2015 to honour the Non Executive's leaving the Trust.

32/15 **Date of Next Meeting**

Mr McNaney advised the next meeting of Trust Board was scheduled for 3 September, 2015.

2.030

Belfast Health and Social Care Trust
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Minutes of the Trust Board Meeting
Held on 14 January, 2016 at 10.00 am
in the Boardroom, Trust Headquarters
Belfast City Hospital

PRESENT:

Mr Peter McNaney	Chairman
Dr Michael McBride	Chief Executive
Professor Martin Bradley	Non-Executive Director
Mrs Miriam Karp,	Non Executive Director
Dr Paddy Loughran	Non-Executive Director
Mr James O'Kane	Non-Executive Director
Ms Anne O'Reilly	Non Executive Director
Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Dr Cathy Jack	Medical Director
Mr Cecil Worthington	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Brian Barry	Director Specialist Hospitals and Women's Health
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
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mr Aidan Dawson	Co-Director, Trauma and Orthopaedics
Mr John Growcott	Co-Director, Governance, Children's Services

APOLOGIES:

Dr Val McGarrell	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Mr Damian McAlister	Director Human Resources/ Organisational Development

Mr McNaney welcomed everyone to the meeting

Service User Story – Specialist Hospitals and Women's Health

Mr Barry introduced Mr Aidan Dawson, Co-Director and explained that the Service User Story being presented related to a Serious Adverse Incident (SAI) Review following the death of a child post operatively in the Royal Belfast Hospital for Sick Children (RBHSC). He explained that the presentation would focus on how the Trust properly and sensitively involved the family in the investigation.

Mr Dawson advised he had chaired the SAI Review and explained the process undertaken involving discussing the parents' involvement in their child's care and the subsequent SAI investigation following the child's death. He referred to the Departmental timescales for reporting, investigating and closing SAIs. However, given the circumstances the Trust had delayed the SAI Review to allow the family to come to terms with their child's death to allow for more meaningfully and empathetic engagement with them.

Mr Dawson explained that the family had particularly welcomed being involved in the development of the Terms of Reference for the review. The family had indicated they felt appropriately involved in the investigation and the Trust had been fully open and transparent. Learning from the investigation had resulted in the Trust's protocols in relation to withdrawal of care currently being revised.

In concluding Mr Dawson acknowledged the importance of Personal and Public Involvement in SAI Review process in line with Donaldson's recommendations, he also pointed out that the case demonstrated the positive impact that a SAI review can have for the service and the family.

Dr McBride advised that following recommendations by Sir Liam Donaldson regarding the SAI process the DHSSPS would be issuing revised guidelines in the near future.

In the discussion which followed members welcomed the learning from the SAI Review.

Mr Dawson left the meeting.

01/16 Minutes of Previous Meeting

The minutes of the previous meeting held on 5 November were considered and approved.

02/16 Matters Arising

There were no items raised.

03/16 Chairman's Business

a. Conflicts of Interests

There were no conflicts of interest noted.

b. Retirement – Mr Brian Barry, Director of Specialist Hospital and Women's Health – Retirement

Mr McNaney acknowledged that this was the last public meeting of Trust Board Mr Barry would be attending as he would be retiring from at the end of February following 38 years of service.

03/16 (Contd.)

On behalf of Trust Board he paid tribute to Mr Barry's contribution to health and social care and wished him success for the future.

Mr Barry thanked Mr McNaney for his kind words and acknowledged the support he had received from Trust Board members' past and present during his career.

04/16 Chief Executive's Report

a. Professor Rafael Bengoa, Chair, Expert Panel – Fact Finding Visit

Dr McBride advised that Professor Rafael Bengoa, Chair, Expert Panel established by the Minister to consider, and lead debate on, the best configuration of Health and Social Care services in Northern Ireland, would be carrying out a Fact Finding Visit between 18 to 20 January. Professor Bengoa would be visiting the Trust on 19 January to receive a presentation on the regional services provided by the Trust. The Northern Trust will host Professor Benoga on the 20 January to learn of the provision of services from a General District Hospital/local perspective.

In response to a question from Mr. McNaney, Dr McBride outlined the timeframe for the Expert Panel and advised that the final report was due in September 2016.

05/16 Safety and Quality

a. Performance Report

Mr Devlin presented the Performance Scorecard Report for the period ending November, 2015, providing an overview of the Trust's position in relation to key standards and targets. The report indicated that of the 39 standards and targets the Trust was delivering/slightly behind/expected to achieve the required level of performance in 20 areas. The remaining targets would continue to be a challenge for the Trust to achieve.

Miss Creaney referred to concerns in relation to the performance in respect of Health Care Acquired Infections (HCAI) and explained that HCAI Recovery Plans targeted in certain areas had been put in place to ensure improvement against targets. Miss Creaney referred to a recent fact finding visit the Trust had undertaken, together with PHA colleagues, to St James Teaching Hospital Leeds in respect of HCAI, and advised the learning from this visit would be implemented within Trust processes.

Following a comment from Mrs Karp, Dr McBride confirmed that, indeed, a more targeted approach was being taken to ensure improvement in relation to HCAI performance.

05/16 (Contd.)

Mrs Welsh gave an overview of action taken by the Trust to improve performance in the 14 day breast cancer target. A recovery plan was in place to manage the increased level of referrals into the service, whilst dealing with key staff absences. Mrs Welsh explained that the Trust continued to liaise with the HSCB regarding regional capacity issues and the impact on the 62 day Inter Trust Transfer (ITT) target.

Following discussion it was agreed that a presentation on Cancer Services and the background and detail behind the Trust performance against targets should be included in a future Trust Board Workshop.

Mr McNaney expressed concern at the number of targets continually reported as unachieved/unachievable and the need for more realistic targets to be set at Departmental level.

Mr Devlin advised that the DHSSPS was currently reviewing targets in line with the Commissioning Plan.

Members noted the Performance Report.

Decision: Performance Report noted for Assurance

06/16 Corporate Parenting Report 1 April to 30 September 2015

Mr McNaney welcomed Mr Growcott to the meeting.

Mr Worthington presented the Corporate Parenting Report for the period 1 April to 30 September, 2015. He advised that the inaugural meeting of the Social Care Committee (SCC) had been held on 7 January 2016, when the report had been considered in detail.

Ms O'Reilly, Chair SCC had agreed its role was to assure Trust Board that the discharge of delegated statutory functions could be thoroughly scrutinised and reviewed strengthening corporate governance arrangements.

Members noted that the SCC had considered an overview of key data pertaining to statutory services across Children in Need; Child Protection; Looked After Children; Leaving and After Care Services; Fostering; Adoption; and Early Years provision. SCC had sought clarification in relation to trend analysis with regard to Children in Need and Looked After Children.

The SCC members had received assurance from the Executive Director of Social Work that statutory responsibilities in relation to safeguarding children were being appropriately discharged.

06/16 (Contd.)

In particular they focused on the Trust's response to the recent reports in respect of child sexual exploitation (CSE), current arrangements for the identification of children at risk of exploitation and the effectiveness of intra and multi-agency structures to support such children, their families and communities.

It had been agreed that there was a need to develop a robust data collation and analysis infrastructure across Children's Community Services linked to outcomes to inform performance and to enhance evidence based approaches to service delivery and developments.

The SCC had expressed full support for the implementation of the PARIS community information system and the Directorate's engagement with Corporate Information to develop an information management resource base. It had been requested that future Corporate Parenting reports might include baseline data from other Trusts to assist in benchmarking Trust performance.

The SCC had sought assurance from the Executive Director of Social Work with regard to Personal Advisor provision for young people and young adults in receipt of Leaving and Aftercare services and arrangements for the management of risks in respect of those particularly vulnerable young adults who had significant ongoing difficulties after they had left care.

Reference had been made to the SCC's remit across both adults and children's services and the need for engagement with the Director of Adult Social and Primary Care and the Trust's Associate Directors of Social Work Group on a regular basis would enable the Committee to develop the necessary level of experience and expertise to discharge its responsibilities.

Mr McNaney welcomed the establishment of the Social Care Committee which gave further assurance to Trust Board regarding the discharge of Statutory Functions and Corporate Parenting responsibilities.

Following consideration members approved the Corporate Parenting Report for 1 April to 30 September 2015.

Decision: Corporate Parenting Report Approved

07/16 Deputy Chief Executive/Director Finance, Estates and Capital Development

a. Finance Report

Mr Dillon presented the finance report for the period ending November 2015 indicating a deficit of £6.6m. He advised that a revised year-end funding gap of £7.5m had been agreed with the HSCB and submitted to DHSSPS, approval of which was awaited.

07/16 (Contd.)

Members noted that the projected gap of £7.5m had been included in the HSCB's overall plan to achieve financial balance, therefore it is regarded as of fundamental importance that the year-end projected position is achieved.

Mr Dillon advised that the Trust is on track to achieve the 2015/16 financial plan targets.

In relation to 2016/17 Mr Dillon advised that the Trust had submitted a draft financial plan to the HSCB at the end of November 2015, which identified an overall projected gap of £57.4m. He explained this included the Trust's recurrent underlying gap of £16.6m and the £3.6m 2015/16 savings target shortfall, which is being addressed by non recurrent measures in 2015/16 as well as a new 2016/17 potential gap of some £37m. The Trust has asked the DHSSPS to consider funding the £16.6m gap before any 2016/17 deficit is identified in order to put the Trust into an opening recurrent balance position, thereby achieving equity in terms of opening positions with other Trusts.

Members shared Mr McNaney's views regarding the need for more long term financial allocation to allow Trusts to better plan services.

Decision: Finance Report - Noted

a. Banking Arrangements

Mr Dillon advised that the new Banking contract was due to commence on 1 February 2016 and sought approval for Trust Board to authorise the signing of documents in relation to the Trust's banking arrangements with the Bank of Ireland.

Members approved the documents being signed as required by the Chairman, Chief Executive and Director of Finance on behalf of the Trust.

Decision: Banking Signatories Approved.

08/16 Assurance Committee

Members noted the contents of the minutes of the Assurance Committee meeting held on 23 June, 2015.

Decision: Assurance Committee Minutes Noted

09/16 Any Other Business

There were not items raised.

10/16 Date of Next Meeting

Members noted the next meeting was scheduled for 10.00am on 3 March 2016.

Belfast Health and Social Care Trust
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SOCIAL CARE COMMITTEE
ADULT SOCIAL & PRIMARY CARE

Tuesday 14 May 2019
Held in the Boardroom, A Floor, Belfast City Hospital

MINUTES

PRESENT

Ms Anne O'Reilly, Non-Executive Director – Chairman
Ms Miriam Karp, Non-Executive Director
Professor Martin Bradley, Non-Executive Director

IN ATTENDANCE

Mrs Carol Diffin, Director of Social Work/Children's Community Services
Ms Yvonne McKnight, Trust Adult Safeguarding Specialist (TASS)
Ms H425 Divisional Social Work Lead, Learning Disability Services
Ms Tracy Reid, Divisional Social Work Lead, Adult Community & Older People Services
Miss Laura Dickson, Minute Taker

APOLOGIES

Ms Mary O'Brien, Divisional Social Work Lead, Mental Health Services
Ms Nuala McKeagney, Non-Executive Director
Ms Katie Campbell, Co-Director, Adult Community & Older People Services
Mrs Marie Heaney, Director of Adult Social & Primary Care

01/19	**Previous Minutes – 29 November 2018** Section 23/18 will be amended and minutes will be recirculated to all members. **Action** – Miss Dickson will make necessary amendments and recirculate.
02/19	**Chairman's Business**
	a) Conflicts of Interest No conflicts of interest reported.
	b) Chairman's update <u>Progress of committee</u> Achievements of the committee were noted. The committee have been successful in: • The separation of committees into Adult Committee and Children's Committee

	• Seeking an additional non-executive member to strengthen the committee • Identifying an HR and Finance representative to join the meeting and assist with strategic issues as required Terms of reference It was noted the terms of reference are currently in the process of being updated. **Action** – Mrs Diffin will finalise and circulate for comment. Strategic themes It is important to note that the committee remains focused on the strategic themes arising from the reports submitted. Strategic themes include: • Workforce • Approved social work daytime rota • Supported housing needs • Domiciliary care • Prevention/Early intervention The committee will discuss and keep track of themes as they emerge.
03/19	**Matters Arising** Section 22/18 of previous minutes – PIP payments The committee queried if any progress had been made regarding PIP payments and the impact they were having on service users. It was noted that following a statement from the Department of Health regarding the deprioritising of care homes, Adult Community & Older People division had engaged with Citizen's Advice Bureau who had agreed to assist service users on an individual basis. **Action** – Ms Reid will follow up with Mrs Heaney.
04/19 **04.1/19**	**Statutory Functions Report, Adult, Social & Primary Care, 1 April 2018 – 31 March 2019** The committee thanked members for their hard work and commitment on producing the statutory functions report. **Older People Services – Update by Ms Tracy Reid** Ms Reid provided an update to the committee and discussed issues emerging across the service area. Issues include: Workforce It was noted that workforce had been a significant challenge in the previous year. However, the service have been successful in stabilising the structure of Band 7 through to Band 8B. It was also noted that community social work teams have been strengthened from a previous 10% of professionally qualified social work

team to a current 50%. Concerns were raised that 50% staff remain in non-professional roles whilst the teams have statutory requirements such as:

- Key assessments which must be complete by professional social work staff
- Care Management circular
- Carers Assessment
- Adult Safeguarding

Suggestions were made to review the role of the non-professional staff in attempts to have different skill mixes within the team.

It was agreed that a workforce plan is needed and should be tabled at this meeting.

Action – Ms Tracy Reid to draft and bring to social care committee for discussion.

Domiciliary

It was noted there is a significant need for domiciliary care across Older People, Physical and Sensory Disability Services with 3,600 hours of unmet need and 600+ service users waiting a care package. There have been a number of issues with the sustainability of providers, which is bringing significant risk to service users and challenges to front line staff. Ms Reid updated the committee in relation to the TUPE process that is ongoing with Colincare.

CReST (Care Review and Support Team)

The development and role of the CReST team was discussed. The committee were advised that each individual nursing home in Belfast are aligned with their own CReST member of staff. They are currently holding weekly governance meetings, which includes reflection and analysis of information on the profile of each home, information such as the level of escalation they are on. Each staff member will work with individual homes in attempts to deescalate the matter(s). Ms Reid provided the committee with results from a feedback questionnaire undertaken with homes in Belfast, which sought their satisfaction with the CReST service. Ms Reid advised that the lowest ranking given was 7/10 with the highest being 9/10. The service felt this was a success.

Four seasons

Ms Reid updated the committee of the issues arising with the provider Four Seasons. Ms Reid also highlighted that a Residential Home from a small independent provider, in East Belfast has given notification of their intention to close at the end of June 2019 and that placements are needed for eighteen service users. The committee asked if this was on the risk register to which it was advised at present it was not. It was therefore suggested that it is placed on the risk register which would give committee members an opportunity to discuss at Assurance Group.

	Action – Ms Reid to process onto appropriate risk register. The committee made a suggestion that timelines would be included in the detail of the DSF report. This would allow the committee to measure the progress of previous issues. Ms Reid advised there are detailed action plans therefore it was suggested they may be referenced in future reporting. The committee also asked if more focus could be placed on carers assessments.
04.2/19	**Hospital Social Work – Update by Ms Tracy Reid** Ms Reid updated the committee on issues emerging with hospital social work the previous year. Workforce was a matter also discussed throughout this section as the hospital social work teams have been previously made up of mainly agency/temporary staff however, the service are working to stabilise the structure. Ms Reid advised that the aim of the service area is to strengthen governance systems, balancing this with need to support timely discharges from hospital. The performance indicator moving forward is to include services in addition to discharge planning. **Action** – Ms Reid to include workforce in the workforce plan for the service area and bring to the committee for discussion.
04.3/19	**Physical & Sensory Disability Services – Update by Ms Tracy Reid** It was noted that the PSD service is a stable service with a number of agendas going forward this year. One project discussed was the establishment of a partnership to develop an ARBD (Alcohol Related Brain Damage) assessment unit. The successes of the team were discussed which include the on-going promotion of carers. Ms Reid advised this is the approach she would like to mirror in Older People Services. The committee queried if there was a carers celebratory event and was advised that Maire Gratton had been brought into the Trust to scope carers. It was agreed that it would be a helpful if the committee could raise the profile of carers. **Action** – H425 is to raise at the Carers Strategy Group that a suggestion came from the social care committee that a broader approach to carers should be taken. The committee referred to page 42 of the statutory functions report and asked if there was any progress on the interface issues. Ms Reid advised there is a lot more work needed with discussion needed on how to commence working across both services. **Action** – Ms Reid will liaise with Ms Mary O'Brien in attempts to reach a solution.

	The committee thanked Ms Reid for her contribution to the meeting.
04.4/19	**Mental Health – Update by Ms** H425 It was noted that in Ms Mary O'Brien absence, Ms H425 provided cover for the service. The difficulties maintaining the ASW daytime rota were discussed. H425 advised that the Belfast Trust have reviewed a pilot that the NHSCT implemented and advised that the BHSCT intend to implement a similar small pilot. However, in order to do so the service area will first have to consider and address any resource implications. H425 also advised that the Multi-Agency Interface GAIN meetings between the PSNI, ambulance, ASW Trust lead, bed flow etc. have recommenced which will give an opportunity to improve communication and also to resolve any issue as they arise. The committee were advised of the on-going working arrangements between the ASW daytime rota and RESW (Regional Emergency Social Work). There is now a memorandum of understanding between the two services so that if an Approved Social Worker (ASW) on the daytime rota is out on a call which extends to afterhours then the ASW can consider transferring the case to an ASW from the RESW service. Likewise, RESW ASW's can also consider passing referrals to the daytime ASW if their call extends beyond 9am. The committee congratulated the service on this piece of work and recognised it as a great outcome. The committee were advised that the mental health capacity legislation was due to be partially implemented in October 2019. This will give rise to a number of challenges such as workforce issues, training, establishment MCA panels etc. H425 advised that steps were being taken to try to retain ASW's on the daytime rota. Ms H425 and Miss Kerry McVeigh have been working with HR to develop an ASW job specification which will specify that there is a requirement to participate on the daytime rota. A number of services within Mental Health were discussed including the new hospital which is due to open in June 2019. The committee state this is a very successful outcome. Another service discussed was the proposal to have a crisis de-escalation service, which will provide short-term services for service users who are in crisis in the community. The committee advised GP's are complaining regarding the number of beds available in the hospital. H425 advised that the Pipa (Purposeful Inpatient Assessment) has been rolled out across Mental Health inpatient units and this has helped to reduce the length of stay of inpatients allowing better throughput from the hospital to the community. In

	addition, H425 advised that within mental health there are a number of services that can be considered as alternatives to hospital admission such as input from the Home Treatment Team and Home Treatment House. The committee congratulated the services for the tremendous work completed.
04.5/19	**Learning Disability – Update by Ms H425** H425 provided a brief overview of the Muckamore Abbey Hospital investigation. Throughout the investigation, there have been a number of recommendations made which require to be addressed. The include recommendations arising from the Independent SAI, RQIA, the Permanent Secretary and the DoH etc. H425 advised that although this has been a challenging time, this has provided an excellent opportunity for the service to improve services for service users and carers. One of the concerns raised in the SAI Independent Report surrounded the lack of meaningful activity that patients were engaged in during their stay in hospital. Since January 2019, the service has been successful in the recruitment of a Band 7 activity co-ordinator within Muckamore. The role involves engagement with service users seven days per week. This was one of the major recommendations from the SAI report. The service has also been successful in the recruitment of a carer consultant. The successful candidate has already carried out some tremendous work and is very passionate and focused on coproduction. She has already established a carer forum within Muckamore. There has been a huge focus also on identifying suitable placements for patients in Muckamore who are delayed discharges. There has been significant work done in forging working relationships with a range a private providers to develop services and improve the community infrastructure within the community. The development of Cherryhill supported living scheme was discussed. It was noted that the Belfast Trust will remain the landlord and will provide the care staff. It will be registered with RQIA. Cherryhill is due to open in June 2019 and will help facilitate the discharge of nine patients from Muckamore. The intensive support service is also being redesigned to provide intensive input at home and reduce admissions to hospital in the future. The committee recognised the phenomenal work that is ongoing and recognised the triangulation of information is beginning to provide assurance that patients in Muckamore are safe.

	The committee also recognised that staff in these environments require a lot of support and suggestions were made to repeat a listening exercise for staff. The committee thanked H425 for her contribution.
04.6/19	**Adult Safeguarding Report – Update by Ms Yvonne McKnight** Ms McKnight provided the committee with a context to the Adult Safeguarding Report and explained the reporting structures at regional and local level in terms of NIASP and LASP. She advised the Committee that Marie Heaney is the named Adult Safeguarding Champion for the Belfast Trust. It was noted that the service has been struggling to focus on strategic matters as the key focus has been on operational matters. The committee were advised that Adult Safeguarding is driven by three key documents, these are: – Adult Safeguarding Prevention and Protection in Partnership (July 2015) – DOH Policy document – Adult Safeguarding Operational Procedures – Adults at Risk of Harm and Adults in need of Protection (Sept 2016) – Protocol for Joint Investigation of Adult Safeguarding Cases (August 2016) It was noted that the Muckamore Abbey review created some challenges for the Adult Safeguarding team and a focus remains on the service as a whole. Ms McKnight discussed the statistics with the committee. Of 3,517 referrals 1,723 were accepted by the Adult Protection Team. It was noted that Belfast Trust have consistently over the last five years had the highest number of referrals across the region. She explained that this normally accounts for approximately 36% of all regional referrals but will be higher given the large scale investigation in relation to Muckamore Abbey Hospital. The committee thanked Ms McKnight for her input. All elements of the report were agreed and will be submitted to Trust Board on 6 June 2019.
05/19	**Any other business** None discussed.
06/19	**Date of next meeting** 16 December 2019 – Time to be confirmed.

Belfast Health and Social Care Trust
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Social Care Committee - Adults

Tuesday 29 September 3.00 pm
Teams Teleconference

Draft Minutes

Present:

Ms Anne O'Reilly, Non Executive Director (Chair)
Professor Martin Bradley, Non Executive Director
Ms Nuala McKeagney Non Executive Director
Ms Miriam Karp, Non Executive Director

In Attendance:

Ms Carol Diffin, Director of Children's Community Services/Executive Director of Social Work
Ms Dawn Shaw, Deputy Executive Director of Social Work
Ms Yvonne McHugh, Service Manager for Governance, Performance & Administration
Ms Gillian Traub, Interim Director ASPC
Ms Tracy Reid, Divisional Social Worker ACOPS
Ms Mary O'Brien, Divisional Social Worker, MH
Ms H425 Divisional Social Worker LD
Ms Natalie Magee, Co-Director ACOPS
Mr Aidan Dawson, Director Specialist Hospitals and Women's Health and Mental Health
Ms Julia lewis, Co-Director Mental Health and CAMHS

1. **Apologies:**

There were no apologies to record

2. **Chairman's Business**

Ms O'Reilly welcomed everyone to the meeting explaining it is a formal committee to review the Discharge of Statutory Functions Report. Ms O'Reilly explained there are four Adult Service Areas and this work is complex.

a. Conflicts of interests

There were no conflicts of interests reported

3. **Minutes of Previous Meeting**

   The minutes of the previous meeting of the Social Care Committee (SCC) held on 26 June 2020

   The minutes of the previous meeting were agreed as an accurate record.

   Professor Bradley requested Non Executive Directors are recorded as 'Present' rather than 'In Attendance'. This will be recorded as such in future Minutes.

4. **Matters Arising**
   There were no Matters Arising from the Previous Reports

5. **Discharge of Statutory Functions Report**
   1 April 2019 – 31 March 2020

Individual Service Area Reports

Ms O'Reilly highlighted our responsibilities and accountability regarding statutory functions, she noted the roles of the Divisional Social Workers are now clearly outlined within the report. Ms O'Reilly noted the importance of integrating the work of the Social Care Steering Committee. Ms O'Reilly commented that the Work Force Learning and Development report has given insight to the area of Adult Safeguarding. Ms Diffin and Ms McHugh will present the Adult Safeguarding Report at the next Social Care Committee meeting. Ms Diffin welcomed Ms McHugh to the meeting in her role of Adult Safeguarding Champion. Ms Diffin explained the roles of accountability within the Trust have been outlined clearly within the report.

Ms O'Reilly welcomed the Divisional Social Workers and invited Ms Reid to outline her programme of care summary:

i. Older People's Services including Hospital Social Work (pages 18-43)

Ms O'Reilly specifically requested assurance regarding the 6,159 individuals currently in receipt of Social Work / Social Care in relation to Older People physical and sensory disability.

Ms Reid reported that it was a challenge to condense the report and the Board has requested clarification on a number of points.

Workforce Planning

- Progress has been made in defining roles
- Recruitment drives have been successful
- Improvement in staff retention
- Reduced dependency on Agency Staff
- High dependence on Social Care Staff and low ratio of Social Workers this issue has improved and currently 55-65% of the Community Social Work team are professionally qualified. There is a significant administration role around domiciliary care. This will be re-dressed

Professor Bradley referred to Page 39 Carers Assessments, he asked for clarification regarding the increased waiting lists and why this is not in the remit of Band 4 staff currently.

Ms Reid explained these assessments are required to be completed by Professional qualified staff Band 5 and above. Ms Reid clarified that not all clients require a Carers Assessment are work is currently underway to improve more efficient alternative options. Professor Bradley believes the Trust should be responsible for creating a Work Force Plan and taking this forward. Professor Bradley understands the funding issues and suggested the Trust HR Department and Universities could be included in this plan.
Ms Shaw welcomed Mr Bradley's comments and advised there is an on-going piece of work which will be Strategic throughout the Trust. She has met with Catherine Shannon and agreed a Social Care and Social Work lead will be put in place to understand need and develop the work force. Funding has been successful for two posts and Ms Shaw has requested an equivalent of the Academies Framework for Social Care/Social Work.

Ms Magee commented on the workforce planning issues within Commissioning Services is reflective of recruitment of Nurses across the Trust. Ms Magee believes this model is correct but development of roles need reviewed, a business case is currently being put in place to review this model.
Professor Bradley clarified that RQIA are accountable for the inspections but we commissioned this and therefore the Trust is responsible and remains our Duty of Care.

Hospital Social Work Workforce

- Staffing levels are stabilized

CREST Team

- Challenge surrounding recruitment of Nursing Staff which is continuous
- CREST Model from 2017 should be developed, Business Paper has been submitted
- Care Home regionally have been negatively impacted due to Covid19 and has caused recruitment challenges

Ms Reid stated the Report is dated to 31 March 2020 and the impact of Covid 19 has affected services. Day to Day CREST support reviews are stood down due to guidance. Monitoring and support to 80 Independent Sector Care Homes has created additional pressure.
Ms Karp thanked Ms Reid for her update, she raised the point of staffing in CREST and Valencia and how we can make these areas attractive for recruiting new staff. Ms Reid outlined the current initiatives including the introduction of Individual Profiles and Case Load Management, analysis of Risks is taking place. Ms Reid is currently working on identifying qualified staff and staff that have Mental Capacity Training throughout the Trust who could share their expertise in CREST or Valencia. Christine Wilkinson has carried out a number of recruitment drives. Ms Karp proposed an exceptional case be made and Ms Reid agreed.

Professor Bradley is delighted that morale is being improved and a visible career structure is being put in place.

Ms Traub commented regarding Valencia and explained the team have worked very hard to stabilize the ward. Discussions will take place with the Executive Team regarding improvements for staffing issues and location of the ward. Ms McKeagney asked if Valencia is on the Corporate Risk Register. Ms Magee reported it is on the Divisional Risk Register. Ms Magee confirmed it is also on the Corporate Risk Register but this relates to staff recruitment only and is not specifically named.

Mental capacity

- A large number of people require Deprivation of Liberty to be reviewed and put into formalised process has caused resource challenges

Supervision Arrangements

- A new Regional Policy is now in place to support this, this will be reviewed via Annual Supervision Audit

Caseload Weighting Tool

- Work has been carried out regarding this Risk Stratification Tools are in place, this will be raised with the Board

BSO Care Management Audit

- Care Management Procedures and Training have been reissued and available on Paris
- Standardisation of Care Management across the Directorate is currently being implemented and new Audit cycles have been arranged to achieve this
- Currently planning how Care Home Visits can be carried out Winter 2020 without causing risk to clients

Innovation Fund

- New Pilot has been introduced in East Belfast to introduce a Multi-Disciplinary Front enabling clients to receive the most effective care referrals

Shared Lives/Domiciliary Reform

- Domiciliary Reform currently stood down due to Covid 19
- Shared Lives continues

Continuing healthcare

- Main challenge is identifying people with healthcare that are entitled to funding
- Challenges due to a ten year gap in Policy, communication has been sent to the Board

Adult Safeguarding

- Adult Safeguarding and Quality Monitoring issues continue
- Continuation of overhaul of Policies is required by the Trust
- An area of concern is Valencia Ward RQIA inspection noted Adult Safeguarding issues. Instability of work force is a challenge

Governance and Accountability

Ms O'Reilly referred to the Statutory Functions Report and asked if enough attention is paid to Social Care Workforce, particularly relating to Older People's Services. There is currently a workforce of 750. 28% are or 60 years old. Where does Social Care/Social Work interface connect with our Statutory Function.

Ms Reid confirmed the Social Care is managed via the Social Care Managers, but feels the Governance structure and role of the Divisional Social Worker needs to be reviewed. She highlighted the areas of risk being Domiciliary Care and Home Care Modernisation processes. Ms Magee is taking the lead on the review of the Home Care Provision to ensure a Divisional Structure can be put in place to provide the necessary assurance.

Ms O'Reilly is confident that the Social Care Governance review will provide assurance and integration of Social Work and Social Care. This will be highlighted as an area for review.

Ms Reid discussed Physical and sensory disability Page 44 – 63

Ms Reid reported there has been significant progress in this area and that it is a stable workforce. This includes Day Centres and Community Brain Injury services.

- Day Centres are currently re-opening post Covid
- Bernie Kelly will review the Care Management Model and bring forward Social Work Professional Assessments to this area in order to reduce high dependency on Social Care Staff
- Ms Reid stated there are not as many risks involved in this area in comparison to older people services
- Risks include complex care packages for Community Brain Injury Services a paper is being prepared on how best to integrate Regionally and with Mental Health. Alcohol and Drugs related issues can create complexity within this, specifically ARBD
- A Beginning Pathway has been agreed from Children's into Physical and Sensory Disability
- Mental Health Order (NI) 1986 continues to be used

Ms Reid summarised her areas within the Report including Community Brain Injury Team, and reported Self Directed support has been a positive initiative.

Ms O'Reilly thank Ms Reid for the work she has completed to date. She welcomed Ms O'Brien to summarise her programme of care:

ii. Mental Health (pages 64-93)

Ms O'Reilly requested Ms O'Brien draw out any key areas for discussion.

Ms O'Brien highlighted:

Adult Safeguarding Audits

- 107 cases only 83 were compliant and good standard 17% needed improvement.
- Action plan now in place for these services 50% of services have gaps within them
- Only 50% of services have DAPO roles
- IO issue resolved
- Small number of current nursing staff that do not comply with IO this is being progressed on-going

BSO Audit

- Recommendations met

Social Work Audit

- 80% were high level
- No cases that did not meet the required standards
- Some room for improvement regarding quality

Performance Review

- Monthly review is in place to monitor KSF

DSF

- Template of data set has been devised to assist Service Managers and ASMs and monitored monthly

Inpatient Adult Safeguarding Audit

- Significant improvements have been made following the Audit and reviewed monthly

Adult Safeguarding Team

- Small team now in place 1 x 8A 1.5 x Band 7 to fill DAPO deficit

Annual Audit

- In place and reviews all quality and standards

Carers Management Audit

- Commencing in October 2020 across all Service Areas, self assessment tools have been completed and a team will be reported in December 2020 and a Service Improvement Plan will be devised from outcomes.

ASW

- Staff retention issue
- Challenge around conveyance regarding Ambulance Service and PSNI
- A proposal has been submitted
- Colleagues have been requested to promote ASW Role
- Case Load Weighting Tool currently being developed
- Queen's University Belfast Audit found a shortage of ASW staff

Mental Capactiy Act

- Moving towards full implementation
- Recruitment underway
- Action plan in place regarding Deprivation of Liberty cases, Legacy Case note will be addressed before December 2020 deadline

Ms O'Reilly requested clarity of Page 80 statement An operational structure is currently being developed by the Trust to review ASW current and future roles in Mental Health and asked if this will provide assistance for the obligations around Mental Health, Mental Capacity, Adult Safeguarding and ASW. Is a timeline required?

Ms O'Brien is happy to provide a timeline, she continued by stating that at this stage there is no assurance, but this is not a reflection on the current staff as they work incredibly hard. She reiterated the burden on Mental Health Services due to a small workforce. Considerable recruitment, review and investment is required.

Ms Diffin agreed a workforce plan for ASWs is required. A Corporate Plan is required and Ms Diffin progress and this will remain on the Agenda.

Mr Dawson Mental Health Capacity Act is wide and has not been sufficiently resourced by the Health & Social Care Board and is an ongoing issue for Belfast Trust. A Human Resource plan will be worked on but this plan will require resourcing to back up the plan. The Legal Obligations are clear but this is a challenge to meet which has been discussed at the Executive Team specifically regarding Deprivation of Liberty. A Regional Workshop took place and the issues were discussed, and will be discussed at the weekly Director of Mental Health meetings. Ms O'Reilly agreed that from a mitigation point of view that Mr Dawson was directing the issue to the relevant lines of accountability.

Professor Bradley thanked Ms O'Brien for the work she has completed and understands the workforce pressures.

Ms O'Reilly invited Ms Bride to discuss the statutory function assurances on her programme of care:

iii. Learning disability

H425 noted:

- Recruitment is challenging within learning disability due to high profile in media
- Adult safeguarding lead has tendered resignation need to recruit, this is an essential post
- Service Manager has been secured
- Senior Social work post in Muckamore has now been recruited
- There are currently no Social Work posts within Learning Disability which could impact the Discharge of Statutory Function negatively
- There is no Business Support available which is a huge deficit as the data gathered cannot be analysed.
- Data is gathered manually and this needs to be improved
- As previously discussed MCA workforce is an issue with a lack of medical cover for Form 6 completion
- Only 3 ASW on daytime rota – this poses potential risk for the team. H425 expanded by stating she had attempted to address this by adding it to the Job Description that progression was possible within two years. This has been challenged by the Union.
- No additional resources have been put in place and there is lack of medical cover
- An action plan has been put in place and H425 is working through this with the Steering Group as she envisages not meeting the December 2020 deadline Muckamore
- Lack of community placements in Muckamore and Iveagh Two Business Cases have been submitted
- Progress has been made in Muckamore regarding resettling delayed population
- Cherry Hill Scheme continues to resettle individuals
- A contract has been developed with Bradley Court
- Preliminary discussions have taken place with RQIA as a number of patients would be better suited to residential supported living placements, suggesting a new build within the hospital to accommodate. This is due to the patients not wanting to leave Muckamore site
- Forensic patients resettlement has been paused
- Admissions to Muckamore are a contentious issue but there have been few admissions within the last year and they were successfully managed
- Good partnership with colleagues in Mental Health
- Extensive work has been carried out by the Community Teams leading to fewer admissions
- Blue light meetings have been introduced as urgent Multi Disciplinary Teams
- A Draft Operational Policy has been drafted for Intensive Treatment Team and funding needs to be secured

Ms Karp asked if Muckamore site being used for patient resettlement was a safe option. H425 stated that clinical team support and aftercare issues are being addressed regarding these plans. The issue of Belfast Trust being the landlord or a private landlord was touched on and will be progressed as discussions continue with RQIA. Ms Traub added that the Department have written to Belfast Trust to develop a proposal. She explained the need

to plan for the patients but also discussion is necessary to plan. Ms Traub stated that other Trusts will be involved in these discussions.
Ms O'Reilly asked if the families had been involved in discussions, H425 confirmed working in partnership with families was important and families had been consulted with regard to resettlement.

Historical CCTV
The team have monitored the CCTV and Disciplinary action can now be actioned accordingly.

H425 concluded by stating it has been a difficult year with staffing issues and RQIA reports, but the Multi Disciplinary Team worked extremely hard to lift these. A lot of changes and additional Audits have been put in place and RQIA feedback was positive. Covid 19 has presented challenges regarding face to face contact and Day Centres not opening, ongoing Paris issues and new documentation for APP forms and staffing shortages continue to add stress to the Department.

Professor Bradley thanked H425 for the work she has completed and highlighted the successfully resettlements. H425 is pleased to report that additional staff have been put in place to address resettlement.

Ms Karp thanked H425 for her comprehensive overview.

Ms O'Reilly asked Ms Traub if she has enough staff, Ms Traub will consider if the Trust has sufficient Leadership capacity and will discuss with the Executive Team.

Ms O'Reilly accepted the Report and Ms Diffin will report to Trust Board.

Adult Safeguarding
Ms Shaw reported that Caroline Brogan and Ann Pearse have written a detailed report regarding this. There are currently five levels and the Trust delivers Level two training. There is scope to deliver multi level training across the Trust. There is a small team in place but this work requires additional funding.
Ms O'Reilly asked Ms Diffin to discuss assurance regarding Adult Safeguarding. Ms Diffin reported there is a gap in the provision of training and is now working with Ms McKnight to scope this.

Ms McKnight acknowledged the work completed to date regarding the scoping paper and this has highlighted the need to prepare a Business Case. She discussed the importance of staff training and a strategic consistent approach to Adult Safeguarding is now required. Ms McKnight reported the Trust are in receipt of a number of Reports including Home Truths along with Ministerial Statement. Ms McKnight will attend the Interim Transformation Board which will be Chaired by Sean Holland. ***NIASPS has been stood down, Belfast LASPs will continue***. An Action Plan is required to capture current policies and procedures, the recommendations of the report and look within the Trust to review how we currently meet the needs.
Ms McKnight expressed her disappointment regarding the exclusion of statistical data within the DSF Report as she believes it is fundamental to give a clear picture of challenges faced. Ms McKnight stated the importance of quality data analysis and monthly returns are made presently.

Ms O'Reilly thanked Ms McKnight and agreed that action needs taken.

Professor Bradley thanked Ms McKnight and Ms Shaw for the reports they had submitted. He raised the issue around the number of leavers, Ms Diffin clarified that staff retention was preferable but some staff prefer Agency work due to rotation. Ms Diffin suggested introducing this to the Trust in order to give staff more flexibility and greater clarity of the Social Work role within Family Support to assist the recruitment matching process. Professional Bradley suggested an option of contract work for these roles as a possibility.

Summary
Ms O'Reilly thanked Ms Diffin and the Team for their contributions to the DFS Report. She stated the Report demonstrates the need for wider governance and accountability around Social Work and Social Care and how we integrate both.

Ms O'Reilly summarised the following:

- The work force issues should be dealt with as discussed to ensure quality and safety.
- She discussed the complex issues around Adult Safeguarding, she noted that problems were reported regarding over dependency on processes and highlighted the importance of a positive outcome for Service Users and Families.
- She believes that Adult Safeguarding is about positive risk taking and how to understand the difference between Vulnerable Adults in Learning Disability, Vulnerable Adults in Older People and Vulnerable Adults in Mental Health and a clear understanding of vulnerability is required moving forward in order to improve Quality of Life.

Ms O'Reilly is happy for Ms Diffin to report to Trust Board and she will support her regarding the assurances made to the Trust Board.

Ms O'Reilly concluded the meeting by thanking everyone for their hard work and attendance at the Social Care Committee meetings.

Belfast Health and Social Care Trust
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Social Care Committee - Adults

20th May 2021 11.15am
Teams Teleconference

Minutes

Present:

Ms Anne O'Reilly, Non-Executive Director (Chair)
Professor Martin Bradley, Non-Executive Director
Ms Nuala McKeagney Non-Executive Director

In Attendance:

Ms Carol Diffin, Director of Children's Community Services/Executive Director of Social Work
Ms Gillian Traub, Interim Director ASPC
Ms Tracy Reid, Divisional Social Worker ACOPS
Ms Mary O'Brien, Divisional Social Worker, MH
Ms H425 Divisional Social Worker LD
Ms Natalie Magee, Co-Director ACOPS
Ms Christine Wilkinson, Divisional Social Worker Elderly Programme of Care
Ms Ursula McCollum Governance Manager
Mr Peter McNaney, Chairman (joined the meeting late)

1. **Apologies:**

Dr Cathy Jack, Chief Executive
Ms Miriam Karp, Non-Executive Director
Mr Aidan Dawson, Director Specialist Hospitals and Women's Health and Mental Health
Ms Tracy Kennedy, Co-Director Learning Disability
Ms Julia Lewis, Co-Director Mental Health and CAMHS

2. **Chairman's Business**

Ms O'Reilly welcomed everyone to the meeting explaining it is a formal committee to review the Discharge of Statutory Functions Report. Ms O'Reilly explained there are four Adult Service Areas and this work is complex.

a. **Conflicts of interests**

There were no conflicts of interests reported

3. **Minutes of Previous Meeting**

The minutes of the previous meeting of the Social Care Committee (SCC) held on 29th September 2020

The minutes of the previous meeting were agreed as an accurate record.

4. **Matters Arising**

There were no Matters Arising from the Previous Reports

5. **Discharge of Statutory Functions Report 1 April 2020 – 31 March 2021**

Individual Service Area Reports

Learning Disability

H425 outlined the update from Learning Disability Services. Key issues highlighted;

- The Domiciliary Care waiting list has been reduced from 20 to 12 with an aim to continue reducing this
- As of 31st March 2021 all DOLS in MAH have been completed with 36 awaiting panel and 40 with capacity. Re-scoping and now 422 still to complete along with 23 referred through for Review Tribunal. There is a MCA action plan in place which includes MCA training, steering group, scoping of service users, data base and triaging. Noted central MCA team input with DOLS/medical assessments regarding legacy cases.
- Iveagh - Delayed discharges there are two patients whose discharge has been delayed, also noting the JR proceedings and the business cases. HSBC and DOH are aware. Future management of service remains under review and the business cases are being progressed
- Issues around lack of suitable accommodation for those being discharged from MAH, H425 advised there are currently 43 patients in residence, six patients have been discharged between April 2020 to March 2021. Three patients are currently on trial leave and only one patient in active treatment in MAH. Accommodation plan being developed up until 2023 which includes further engagement with potential providers. Business cases to be reviewed and an onsite proposal to be considered.
- Recruitment: ASG Lead has been appointed. PSW funding has been agreed and the business plan will be submitted. H425 advised Team Leader posts will now be retained as SW. Noted lack of business support and difficulty getting suitable backfill. An 8A PSW is to be recruited, temporary expressions of interest to be issued.

Summary of actions of areas where the division has not met DSF functions during 2020-2021 and risks identified and remedial action taken to address the situation are Blue Light meetings to consider alternatives in community for admissions if mild or moderate learning difficulties . Resettlement plans to reduce inpatients. Proposal to open new admission beds on MAH site.

H425 advised the future plan include an agreed combined DSF data set. Establish SW DSF meetings with SM, ASG and ASMs to discuss data set, analyse and identify actions. Require business support including admin and PSW.

H425 advised in relation to Muckamore Abbey the improved governance arrangements include ASG and PP embedded in all meetings across the site from local level through to executive team; weekly MDT ASG meetings. Learning is shared through different forums and ASG huddles / ASG forum is being held.

Practice improvements include aide memories / checklists / flow charts and procedural manual ASG notice boards to be implemented./ additional support / supervision / training / procedural manual to be produced. .

Preventative work will include shared learning, commissioned work from ARC and keeping yourself safe.

Audits will be conducted on a monthly and quarterly period. Training to be implemented for all professionals across the site.

ACOPS

Ms Tracy Reid, provided an update from. Key points highlighted:

Noted decrease in number of joint protocol cases which appears to be a regional trend and the HSCB agree that the most appropriate vehicle to take this forward regionally is through the new Adult Protection Board.

Ms Reid noted there is on-going challenges in relation to PSNI investigation times.

Domiciliary Care Provision update provided, graph and details on power point presentation.

New areas where the division has not adequately discharged DSF during 2020-2021;

Non- essential Annual Reviews were stood down by DOH from April 20 – Jan 21 due to COVID pandemic pressures and restrictions. All cases have been risk stratified with essential visits and reviews for high risk cases maintained. Telephone contact is being maintained with service users and families.

CREST Vacancies/ Caseloads / Care Reviews. Currently a total of vacant cases in at **936** (**56.6%** of overall caseload). CREST Practitioner has been deployed to the MCA Team, which will leave **54%** vacant caseload (**508** cases). The current plan to reduce the risk is for current staff resource to be directed to Homes on Escalation and urgent reviews required. Communication to be sent to families and care home providers to provide a single of point of contact into service to escalate any concerns. Also, a daily review of duty log and allocation of priority cases. This information regarding activity is analysed on monthly basis.

Hospital social work historical cases, there are currently 5000 unclosed cases in hospital social work. Redeployment and staff shortages due to Covid-19 have affected this service. Action Plan in place to reduce risk and progress monitored implementation of new closure processes and assurance systems, additional admin time and professional resource.

Ms Reid provided an update for the divisional social worker assurances with QMS, Governance and accountability structure. Noting the risks within this are currently 1400 staff in ACOPS, Social Care Assurance and second Divisional Social Worker.

Ms Reid provided an update in regards to Meadowlands adult safeguarding, the 9 24/7 facilities adult safeguarding.

Ms Reid provided an update on the recent transfer of Valencia into mental health services along with an update to the review of safeguarding with ACOPS service managers training and pathways & processes.

Mental Health & CAMHS

Ms Mary O'Brien provided an update for Mental Health and CAMHS.

Issues / actions agreed at DSF meeting in October 2020 are currently up to date.

Ms O'Brien advised while the Division has adequately fulfilled its Delegated Statutory Functions the following concerns should be highlighted.
The high level of non-designated S/W posts across the Division (approximately 50% of all S/W posts)
Continuing difficulties faced by the ASW service in fulfilling requirements under the Mental Health Order. Remedial actions taken place to address include:
review of current workforce across the Division to clarify and discern the required number of designated S/W posts to fulfil DSF on an ongoing basis. This work will be part of the task and finish group chaired by the Department of Social Services.
Exploration of developing an ASW hub to provide peer support, learning and to centralise the service in keeping with the recent draft Regional ASW Quality Standards.
RESWS joint working arrangement developed with BHSCT has now been extended to all Trusts.
ASW Paris implementation as of the 1st June 2020 enabling the development of data collation, management and analysis enhancing information infrastructure and reporting capacity. This will aid current and future workforce planning regarding the ASW service based on capacity and demand.
Ms O'Brien advised in regards to the MCA Legacy cases work continues to ensure all legacy cases with be authorised in full compliance with DOLs. Current challenges are vacancies across community social work, staff not having the two years' experience required for this role and competing priorities and demands. With the current number of remaining outstanding legacy cases there are concerns regarding Section 269 come 31st May 2021. The MCA Team are working collaboratively with colleagues in Learning Disability and Older People Services and co-ordinating an action plan to address outstanding legacy work and dedicating all available resource to this work as a priority. The MCA Team are recruiting 10 additional staff to undertake legacy work with interviews scheduled for 17th May 2021. Further, the Trust have offered overtime opportunities across the workforce and uptake has been good.

Ms O'Brien provided an update on current safeguarding processes.

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No other issues raised

Next Meeting Date: Thursday 9th December 15:45 – 18:00

Date:	Information w/e Wednesday 12/08/2020
Lead:	Gillian Traub
Email:	Gillian.Traub@belfasttrust.hscni.net
Tel:	07824 877634
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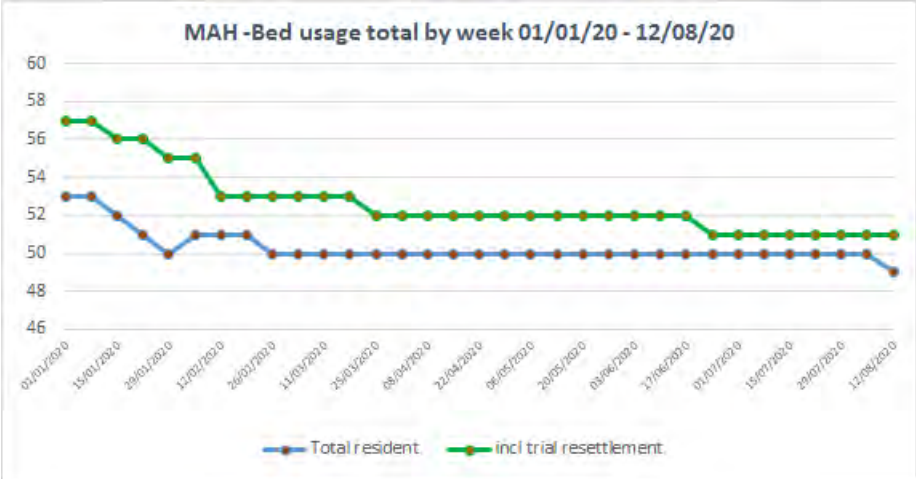
Tel:	02895048192

Weekly Report Number - 74

1) Key Patient Activity Issues

1.1 MAH Inpatient Numbers

The number of patients in residence has reduced to **49** as a patient commenced trial resettlement on 12 August 2020. The number of patients on trial resettlement has therefore increased to two patients. **Two** patients remain on extended home leave at the request of families. The graph below displays the number of inpatients resident in Muckamore Abbey Hospital and the number of patients on trial resettlement.

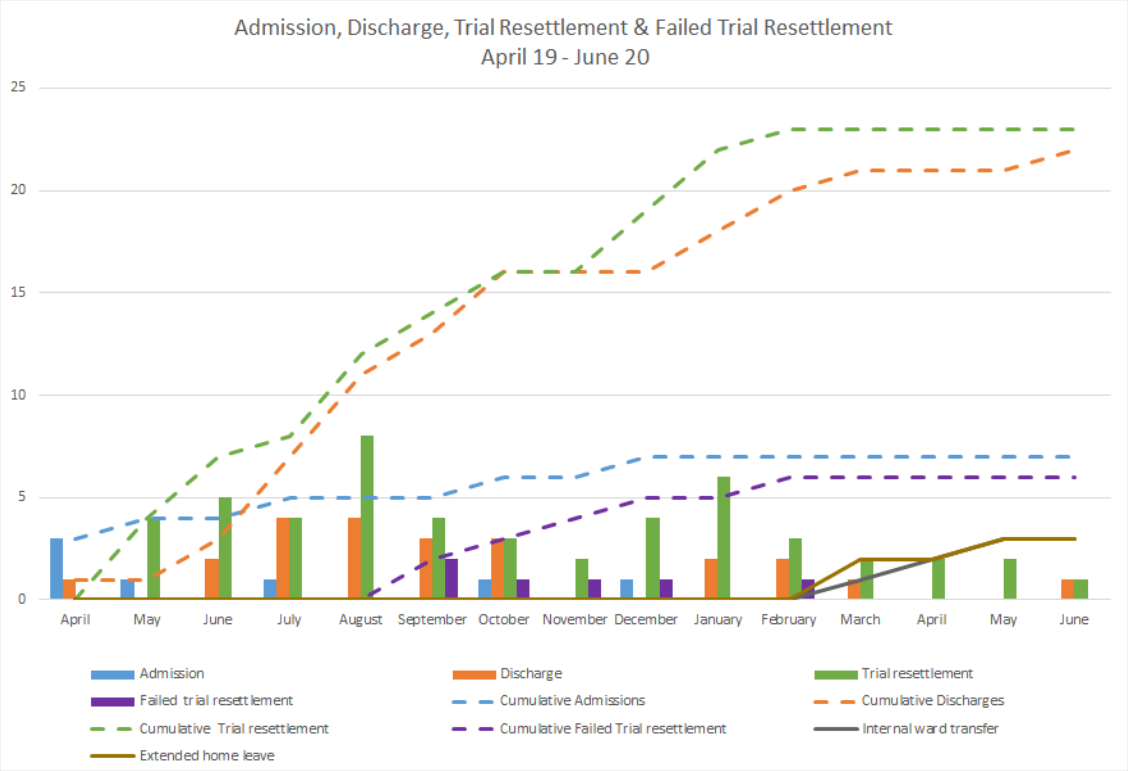


Patients in Muckamore Abbey Hospital by Trust of Residence are as follows :

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	21	0
Belfast HSC Trust	18	1
South Eastern HSC Trust	8	1
Southern HSC Trust	1	0
Western HSC Trust	1	0
Total	**49**	**2**

1.2 Monthly MAH Admissions, Trial Resettlements and Discharges

The graph below plots the monthly, and year to date, number of patients admitted, discharged, on trial resettlement or having returned from an unsuccessful trial resettlement.



Admission: admitted during month

Discharge: discharged during month

Trial resettlement: pts on TR on last day of month (not included if discharged/failed trial resettlement during the month)

Failed TR: Returned to MAH during the month

Cumulative Admissions: Number of actual patients

Cumulative Discharges: Number of actual patients

Cumulative Trial resettlements: Number of actual patients

Cumulative failed TR: Number of actual patients

Internal ward transfer: No of pts transferred within the month

Extended home leave: Pts on EHL on last day of the month

1.3 Failure Rate of Resettlement – 2020/21 updated

The failure rate of resettlement in the year 2019/20 was 23%. The table below shows the year to date position for 2020/2021 :

	2020/21			
	Successful Resettlement - patient discharged	**Failed Resettlement** - patient returned	**Ongoing Resettlement**	**Success Rate**
BHSCT	1	0	1	**100%**
NHSCT	0	0	0	**N/A**
SEHSCT	0	0	1	**N/A**
WHSCT	0	0	0	**N/A**
Total	**1**	**0**	**2**	

(2) Current Safeguarding Referrals

2.1. Patient on Patient Adult Safeguarding Referrals – w/e 12 August 2020

There were 5 patient on patient ASG referrals reported during the period, and 1 which was referred promptly on the same day but which did not transfer into last week's Safety Report.

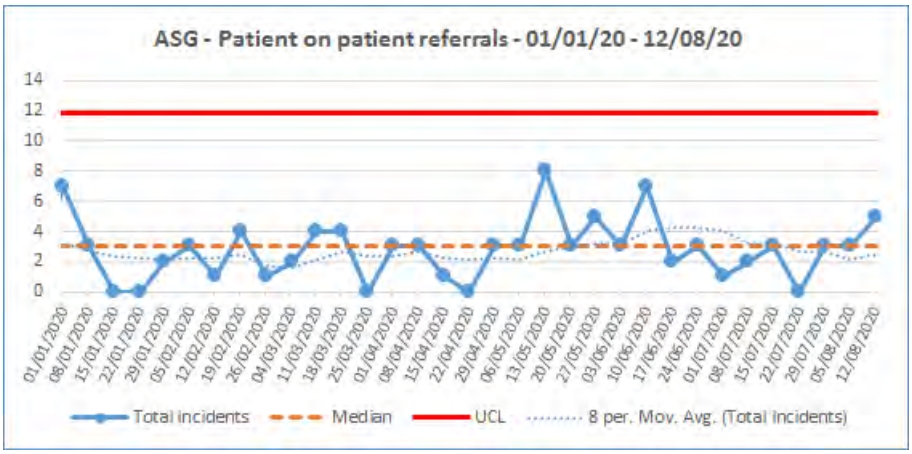
previous period

Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
Ardmore	Dining room	1	05/08/2020	12-1pm	same day	+1 day	ASGR(PP)	Physical

12/08/2020

Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
Sixmile A	Own bedroom	1	06/08/2020	2-4pm	same day	+1 day	ASGR(PP)	Emot/Psyc
Cranfield 2	Nurse station	2	09/08/2020	2-4pm	same day	+3 days	ASGR(PP)	Physical
Cranfield 2	Nurse station	3	09/08/2020	2-4pm	same day	+3 days	ASGR(PP)	Physical
Cranfield 2	Dayroom	4	09/08/2020	2-4pm	same day	+3 days	ASGR(PP)	Physical
Ardmore	N/R	5	10/08/2020	6-8pm	same day	+2 days	ASGR(PP)	Physical

Trend Analysis for Patient on Patient ASG Referrals, Jan 2020 to date :



2.1 Staff on Patient Adult Safeguarding Referrals – w/e 12 Aug 2020

There were 3 staff on patient ASG referrals reported during the period, and one recorded from a previous period which had been previously referred (historic).

previous period (historic)

Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
Conicar (old)		1	n/k	n/k	08/08/2020	same day	previously referred	Physical

12/08/2020

Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
Sixmile A	Corridor	1	05/08/2020	n/k	+1 day	same day	ASGR(PP)	Sexual
Sixmile A	Dayroom	1	05/08/2020	12-4pm	+1 day	same day	ASGR(PP)	Physical
Cranfield 1	Office	2	07/08/2020	12-4pm	same day	same day	ASGR(PP)	Physical

Conicar – this referral arose following comments from a patient alerting staff to incidents which they remembered taking place when they were a child.

(3) Weekly governance review - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.

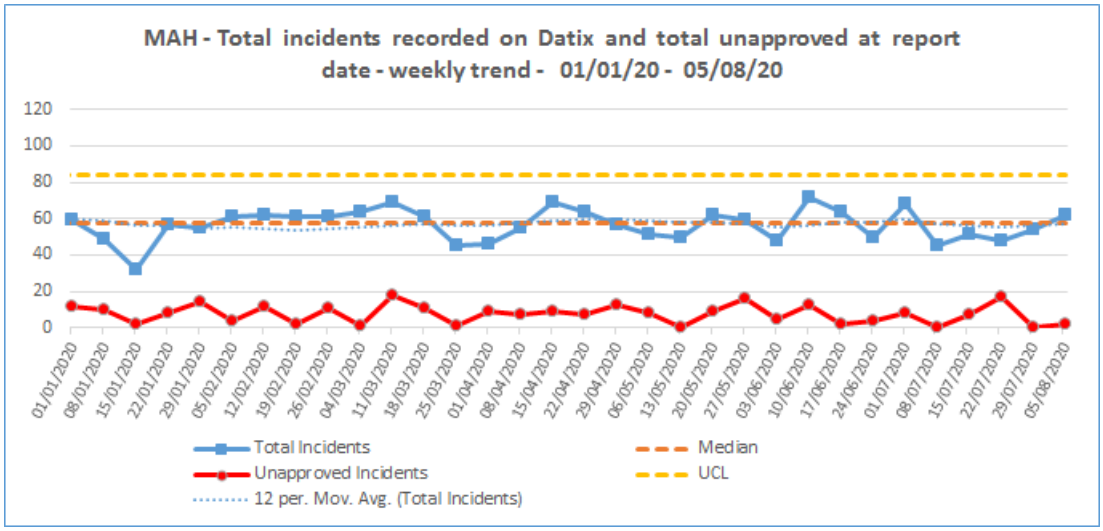
3.1 Incidents

Incident reporting relates to the period week ending 05 Aug 2020, as approved at 12 August 2020.
A total of **62** incidents was recorded, of which 2 across all wards / areas remain unapproved. This analysis covers the **60** approved incidents.

The following table shows approval status by ward / location of incident:

Approval status 30/07/20 - 05/08/20 (app. 12/08/2020)	Ardmore	CF 1	CF 2	CF ICU	Erne	Sixmile A	Sixmile T	Moyola Day Care	Total
Unapproved, not viewed	0	0	1	0	0	0	0	0	1
Unapproved, viewed	0	0	1	0	0	0	0	0	1
Approved, investigation ongoing	0	3	0	0	0	1	0	0	4
Approved, investigation complete	13	15	3	1	6	10	7	1	56
Total	**13**	**18**	**5**	**1**	**6**	**11**	**7**	**1**	**62**

The chart below shows incidents recorded on Datix from 01 Jan 2020 to date.



Only the **60** 'approved' incidents can be further categorised by **those affected in the incident, by severity, by day of the week and by category/ type of incident.**

a) Those Affected

Those affected 30/07/20 - 05/08/20 (app. 29/07/2020)	Organ-isational	Patient	Staff	Total
Medication/Biologics/Fluids - Administration to Patient - Failure to administer	0	1	0	1
Insufficient numbers of healthcare professionals	1	0	0	1
Administrative Processes (Excluding Documentation) - Other administration incident	0	2	0	2
Fire Alarm Activated by Automated Devices (false alarms) - Other false activation of detector	1	0	0	1
Other self harming behaviour	0	1	0	1
nappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	0	1	0	1
Physical contact	0	4	26	30
Physical threat (no contact)	0	3	10	13
Sexual (including harassment and indecent exposure)	0	0	2	2
Witnessed Slips/Trips/Falls (includes faints) - Standing up/sitting down	0	1	0	1
Suicide attempt/gesture (not overdose)	0	1	0	1
Use of tobacco products	0	1	0	1
Verbal Abuse	0	0	1	1
Suspected Slips/Trips/Falls (un-witnessed, Includes faints) - Walking	0	1	0	1
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	0	1	0	1
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	0	1	0	1
Witnessed Slips/Trips/Falls (includes faints) - While at play/recreational activity	0	1	0	1
Total	**2**	**19**	**39**	**60**
	3%	32%	65%	

Highlighted incident types with >3 incidents per category

Incidents are discussed at Ward level PIPA Meeting and weekly Live Governance chaired by the Clinical Director.

b) Severity

The classification of the approved incidents for the period is shown in the table below.

Incidents by Severity 30/07/20 - 05/08/20 (app. 12/08/2020)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total
Totals:	**31**	**27**	**2**	**0**	**0**	**60**
	52%	45%	3%			

c) Incidents by Day by Location

Incidents by day of the week - 30/07/20 - 05/08/20 (app. 12/08/2020)	Ardmore	CF 1	CF 2	CF ICU	Erne	Sixmile A	Sixmile T	Moyola Day Care	Total
Thursday	1	3	0	0	1	2	1	0	8
Friday	4	2	0	0	0	2	2	0	10
Saturday	1	1	0	0	1	4	0	0	7
Sunday	1	2	0	0	0	0	0	0	3
Monday	0	1	3	0	1	1	1	0	7
Tuesday	4	4	0	1	2	1	2	1	15
Wednesday	2	5	0	0	1	1	1	0	10
Total	**13**	**18**	**3**	**1**	**6**	**11**	**7**	**1**	**60**

Highlighted locations with >3 incidents in a day

d) Type / Location / Severity

Incidents by Severity 30/07/20 - 05/08/20 (app. 12/08/2020)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total	% incidents
Ardmore	**6**	**5**	**2**	**0**	**0**	**13**	**22%**
Witnessed Slips/Trips/Falls (includes faints) - Wheelchair related	1	0	0	0	0	1	
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	0	1	0	0	0	1	
Physical contact	2	2	2	0	0	6	
Physical threat (no contact)	3	2	0	0	0	5	
Cranfield 1	**7**	**11**	**0**	**0**	**0**	**18**	**30%**
Other self harming behaviour	0	1	0	0	0	1	
Fire Alarm Activated by Automated Devices (false alarms) - Other false activation of detector	1	0	0	0	0	1	
Physical contact	5	8	0	0	0	13	
Physical threat (no contact)	1	2	0	0	0	3	
Cranfield 2	**1**	**2**	**0**	**0**	**0**	**3**	**5%**
Witnessed Slips/Trips/Falls (includes faints) - Standing up/sitting down	0	1	0	0	0	1	
Physical contact	1	1	0	0	0	2	
Cranfield ICU	**1**	**0**	**0**	**0**	**0**	**1**	**2%**
Other documentation incident	1	0	0	0	0	1	
Erne 1	**3**	**3**	**0**	**0**	**0**	**6**	**10%**
Suspected Slips/Trips/Falls (un-witnessed, Includes faints) - Walking	1	0	0	0	0	1	
Physical contact	2	3	0	0	0	5	
Sixmile Assessment	**8**	**3**	**0**	**0**	**0**	**11**	**18%**
Physical threat (No contact)	5	0	0	0	0	5	
nappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical	1	0	0	0	0	1	
Use of tobacco products	1	0	0	0	0	1	
Insufficient numbers of healthcare professionals	1	0	0	0	0	1	
Witnessed Slips/Trips/Falls (includes faints) - While at play/recreational activity	0	1	0	0	0	1	
Physical contact	0	2	0	0	0	2	
Sixmile Treatment	**5**	**2**	**0**	**0**	**0**	**7**	**12%**
Administrative Processes (Excluding Documentation) - Other administration incident	1	0	0	0	0	1	
Suicide attempt/gesture (not overdose)	1	0	0	0	0	1	
Medication/Biologics/Fluids - Administration to Patient - Failure to administer	1	0	0	0	0	1	
Sexual (including harassment and indecent exposure)	1	1	0	0	0	2	
Verbal Abuse	0	1	0	0	0	1	
Physical contact	1	0	0	0	0	1	
Moyola Day Care	**0**	**1**	**0**	**0**	**0**	**1**	**2%**
Physical contact	0	1	0	0	0	1	
Totals:	**31**	**27**	**2**	**0**	**0**	**60**	
	52%	45%	3%				

Moderate Incidents

Inappropriate/Aggressive Behaviour towards Staff by a Patient
Ardmore Ward – 4 August 2020
A patient ran towards staff in her pod. Staff had to lock themselves in the patient's activity room for safety. The patient then proceeded outside again and ran down to another ward where she reached the back door. The patient was not adhering to verbal re-direction therefore staff implemented physical intervention to escort her back to her pod. The patient continued to come out of her pod and staff had to re-engage hold again and escort her into her pod where staff continued with physical intervention. The patient was offered PRN medication but

continued to refuse it. The patient was sitting on her sofa and throughout physical intervention slid down the sofa. Staff encouraged the patient to sit back in her seat. Staff remained in hold while the patient was attempting to sit back in the seat but then the decision was made to exit the room as staff were not able to continue with these holds safely. The patient ran after staff as they were exiting and pulled one of the staff members by the back of her head and pulled forcefully.

Emergency response and physical intervention hold was implemented to remove the patient's hold on the staff member's hair and safely escort her back to her sitting room where staff remained in hold. The patient continued to refuse her oral medication. PRN I.M haloperidol 5mg and promethazine 25mg was administered. Staff were able to release their holds shortly after when they escorted the patient to her bedroom. Physical intervention was implemented again as the patient attempted to hit staff. Physical intervention implemented intermittently for 1 hour and 20 minutes, in total the longest period was 40 minutes. The patient was spitting at staff and attempting to kick out at staff during physical intervention.

Outcome of review/investigation
Emergency alarm pulled, prompt staff response using physical intervention intermittently. PRN for agitation given via I.M as patient declined oral. The staff injured were reassured and supported with a hot debrief with the Nurse in Charge. The patient has a history of displaying this type of behaviour. Care plan reflects positive measures to support the patient and reduce occurrence of these incidents. Staff member offered Staff Care and referred to Occupational Health Fast Track physiotherapy. Staff member currently on sick leave.

Inappropriate/Aggressive Behaviour towards Staff by a Patient
Ardmore Ward – 4 August 2020
Day care staff member and her colleague returned with a patient to the ward. Both of the staff members approached the nurse to handover regarding the patient's engagement in day care. As the staff were talking to the nurse in front of the nursing station, behind the computer, the patient approached them from the day space to follow their conversation. The patient started to have a positive conversation with a member of day care staff and was touching her face in a friendly manner. Daycare staff responded and continued to give the hand over.

After a few minutes, with no trigger, the patient attacked the day care staff member aggressively. The patient was pulling and twisting the daycare staff's hair with both hands and dragged her to the floor. The patient started kicking her whilst she was on the floor. The day care staff member's back was against the patient's wheelchair when the nurse approached to intervene. The nurse pulled the alarm and staff responded. When staff were attempting to remove the daycare staff's hair from the patient's hands the patient bit the nurse on the right elbow continuously until the patient released the day care staff member's hair. When the patient let go of the staff member's hair and elbow, she dropped into a non-epileptic seizure for around 15 minutes before she came back round.

Outcome of review/investigation
Emergency alarm pulled, staff quickly intervened and attempted to de-escalate with no effect. Use of emergency technique. Ward doctor held one to one conversation with patient. The patient has a history of displaying aggression towards others – care plan reflects positive measures to support the patient and reduce occurrence of these behaviours. Hot debrief and reflection, staff supported by colleagues and senior management.

Other Documentation Incident (PICU) – as described in table above
Inappropriate/Aggressive Behaviour towards a Patient by Staff - Physical threat (No contact)

Sixmile Treatment Ward – 5 August 2020
Patient A advanced towards staff member A threatening to hit him. MAPA blocking technique implemented. Patient A alleged that staff member A had hit him. Staff member B then assisted staff member C to utilise MAPA techniques to escort the patient to the Low Stimulus room (Bedroom 6). Patient A made an allegation that Staff member A had hit him. Patient A declined to have a body chart completed.

Outcome of review/investigation
This patient has a diagnosis of a learning disability and has a history to challenging behaviour. During episodes of aggression this patient may target certain staff members. This patient is currently undergoing a change to his medication. This patient can experience low mood and feeling of self-loathing and this can cause patient to act in a negative way towards himself. Staff should adhere to the Positive Behaviour Support plan. Staff familiar with this patient should continue to support him.

3.2 Medication Incidents
There were two medication incidents reported during the period, w/e 05 August 2020 (reported one week in arrears).

Administrative Processes
Sixmile Treatment Ward – 31 July 2020
Patient A did not receive prescribed Sodium Valporate 200mg. Medication had been postponed due to patient A waking late. Staff member forgot to administer the drug. On Call GP contacted and updated. Service Manager updated.

Outcome of review/investigation
Patients on the ward had been verbally abusive towards staff throughout this day. Staff member involved had been a victim of several hours of verbal abuse from patients that day and this may have contributed to this forgetting to administer this medication.This staff member understands the importance of appropriate administration of medication and the need to seek support and communicate with those on the ward by way of support.

Administration to Patient - Failure to administer x 1
Sixmile Treatment
04/08/2020
Patient missed a morning dose of Omeprazole due to an oversight. The patient was written up for a stat dose. Verbal reassurance provided.

Outcome of review/investigation
Medication was missed as the kardex was not fully checked - all trained staff to ensure they check the kardex in full to ensure all prescribed medications are given. Error quickly noted and patient prescribed a stat dose to ensure administration of drug took place.

3.3. Use of Rapid Tranquilisation during Physical Intervention.

=0 use of rapid tranquilisation reported during the period w/e 12 August 2020.

3.4. Use of Prone Restraint

=0 use of prone restraint reported during the period w/e 12 August 2020.

3.5 Use of Supine Hold

=0 use of supine hold reported during the period w/e 12 August 2020.

3.6 Incidents of Physical Intervention (PI)

There were 35 incidents involving the use physical intervention w/e 12 Aug 2020, equating to 52% of all incidents.

Use of Physical Intervention 06/08/2020 - 12/08/2020 (based on 13/08/2020)	NO - None used	YES - Holding only	YES - Dis-engagement only	YES - Dis-engagement and Holding	Total	% use of P.I. by location
Ardmore	1	9	0	0	10	90%
Cranfield 1	4	9	2	9	24	83%
Cranfield 2	10	0	0	0	10	0%
Sixmile Assessment	7	2	4	0	13	46%
Sixmile Treatment	5	0	0	0	5	0%
Erne	4	0	0	0	4	0%
General walkways, grounds etc	1	0	0	0	1	0%
Total	32	20	6	9	67	
	48%	30%	9%	13%		

Highlighted locations with >3 incidents of use of P.I. in a location

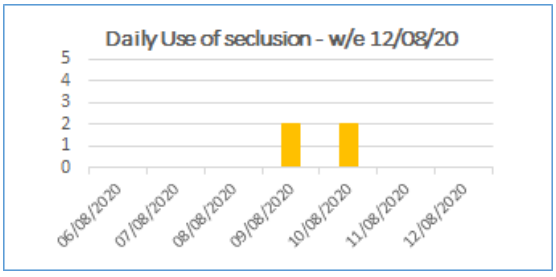
3.7 Seclusion and Voluntary Confinement

3.7.1 **Seclusion**

Seclusion was utilised on **4 occasions** in this period**,** in the management of 1 patient in Cranfield 1:

- Shortest duration of voluntary confinement – **33 minutes**
- Longest duration of voluntary confinement – **1 hours 12 minutes**
- Earliest commencement of confinement was **17:57pm**
- Latest conclusion of confinement was **00:14am**

Instances of Seclusion per Day of Week



Analysis by Patient of Seclusion

12/08/2020				
Patient ID	**Ward**	**Seclusion Area**	**Reason**	**No. of seclusions**
P322	CF 1	Cranfield ICU	Agression	4

Number of Episodes

No episode ended later than **00:14am** and the earliest episode started at **17:57pm**.

12/08/2020					
Time Seclusion Ended	7am - 12noon	12 noon - 5pm	5pm - 11 pm	11pm-7am	**Total**
No. of Seclusions	0	0	3	1	4

Length of Time of Seclusion

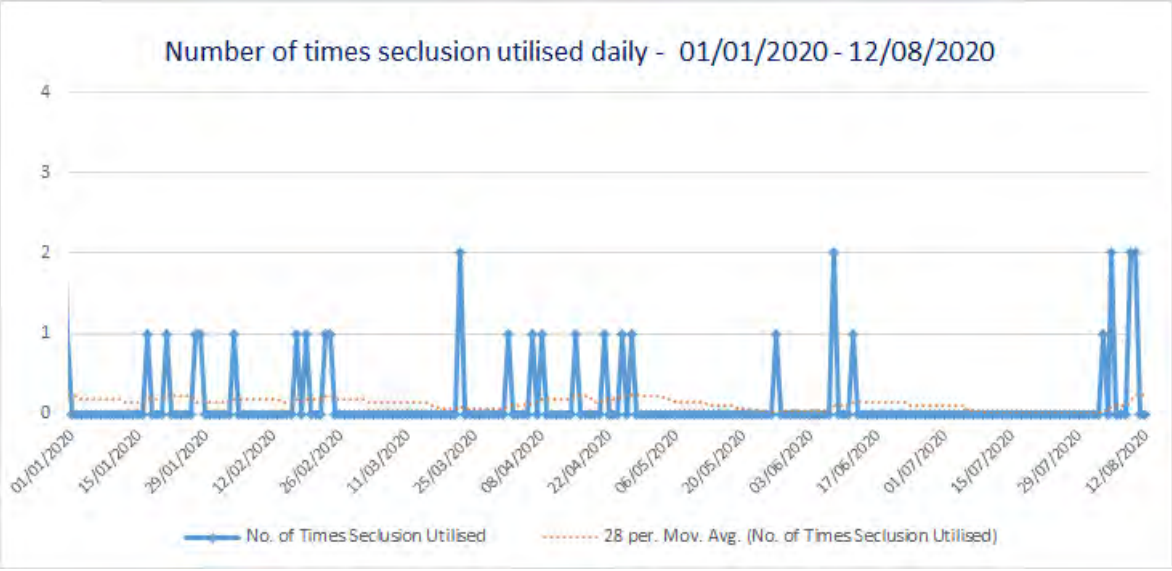
In terms of the length of time seclusion, the table below details for each patient the length of time confinement lasted on each occasion by time band. The average time was **2 hours 33 minutes** for the period.

12/08/2020							
Pt. ID.	**<30mins**	**30 mins - 1 hr**	**1 - 2 Hrs**	**2 - 3 Hrs**	**3 - 4 Hrs**	**> 4 Hours**	**Total**
P322	0	2	2	0	0	0	**4**
Total	0	2	2	0	0	0	**4**

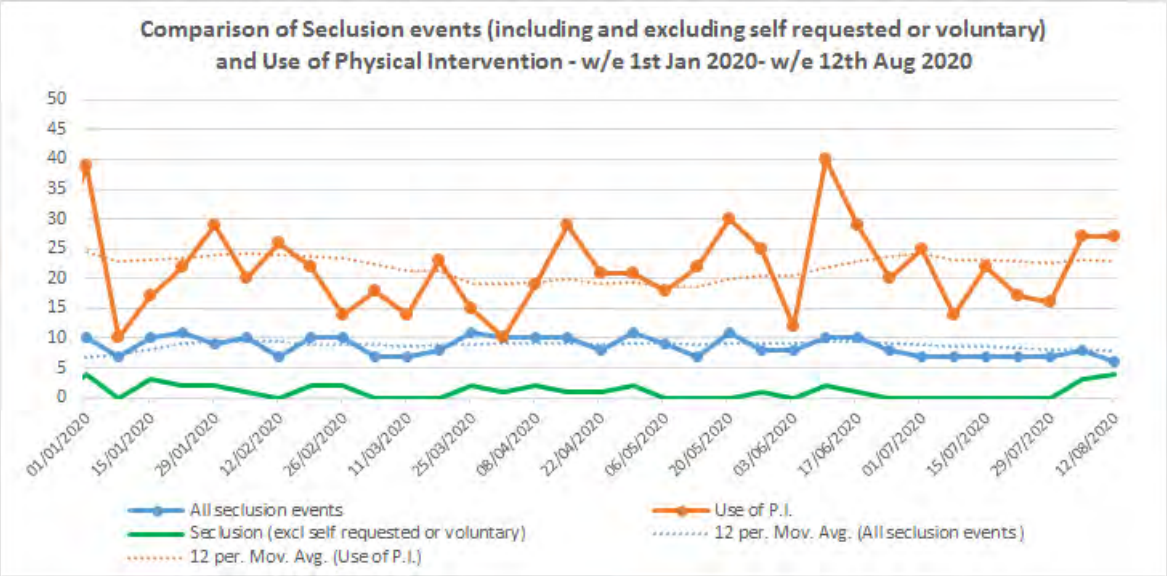
Observation Compliance

Seclusion Observation compliance - w/e 12/08/20				
Total seclusions	15 min obs	4 hr medical assess	1 hr medical assess	Issue
4	4 of 4	n/a	n/a	

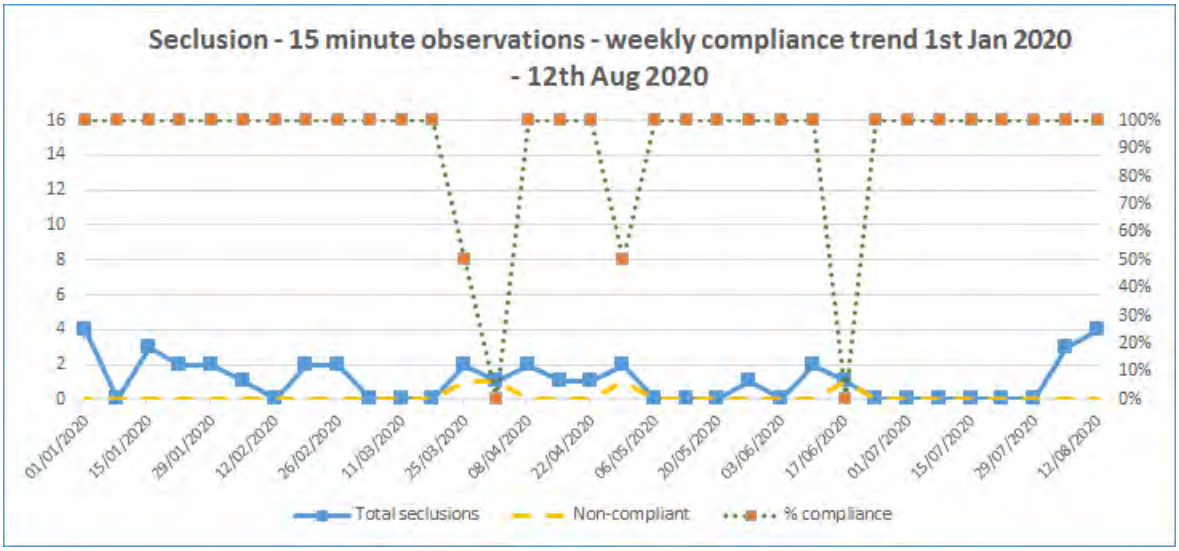
Daily Seclusion Trend (excludes voluntary confinement)



Comparison of Seclusion Events and Use of Physical Interventions

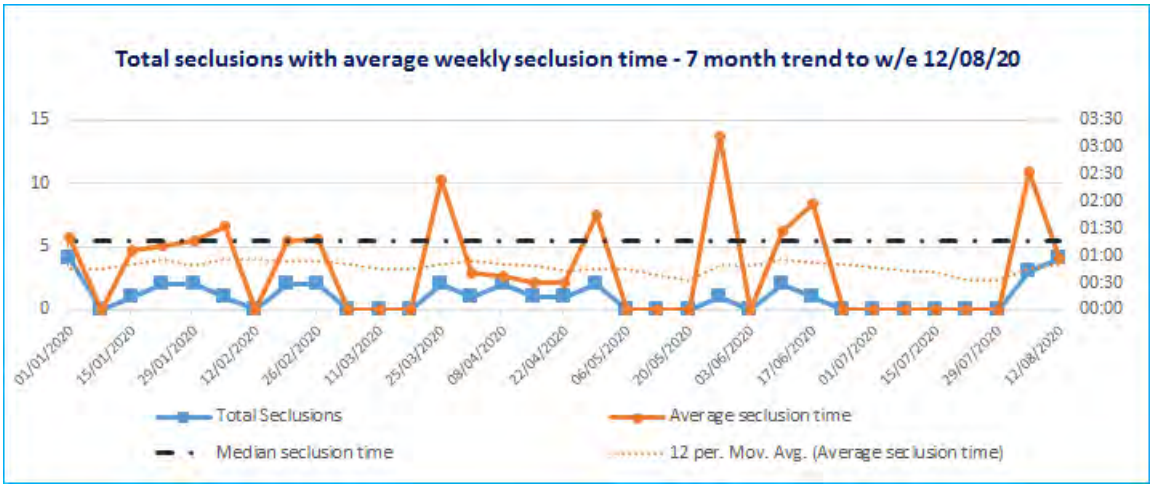


Seclusion Review Compliance



Seclusions with Average Weekly Seclusion Time

The graph below shows the trend of average weekly time in seclusion, per seclusion event :

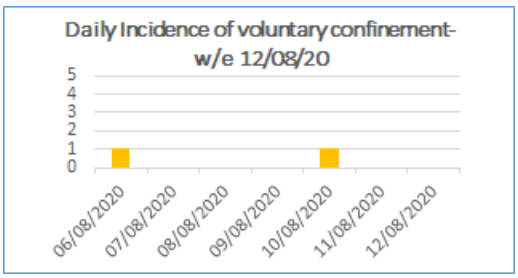


3.7.2 Voluntary Confinement

Voluntary Confinement was utilised on **2 occasions** in this period**,** in the management of 1 patient in Sixmile Assessment:

- Shortest duration of voluntary confinement – **45 minutes**
- Longest duration of voluntary confinement – **1 hour 10 minutes**
- Earliest commencement of confinement was **09:35am**
- Latest conclusion of confinement was **11:50pm**

Instances of Voluntary Confinement per Day of Week



Analysis by Patient of Voluntary Confinement

12/08/2020				
Patient ID	**Ward**	**Confinement Area**	**Reason**	**No. of VC's**
P60	Sixmile A	Patients bedroom	Voluntary	2

Number of Episodes

No episode ended later than **11:50pm** and the earliest episode started at **09:35am**.

12/08/2020					
Time Vol Confinement Ended	7am - 12noon	12 noon - 5pm	5pm - 11 pm	11pm-7am	**Total**
No. of VC's	2	0	0	0	2

Length of Time of Voluntary Confinement

In terms of the length of time voluntary confinement occurred, the table below details for each patient the length of time confinement lasted on each occasion by time band. The average time was **57 minutes** for the period.

12/08/2020							
Pt. ID.	**<30mins**	**30 mins - 1 hr**	**1 - 2 Hrs**	**2 - 3 Hrs**	**3 - 4 Hrs**	**> 4 Hours**	**Total**
P60	0	1	1	0	0	0	**2**
Total	**0**	**1**	**1**	**0**	**0**	**0**	**2**

Observation Compliance

Voluntary confinement Observation compliance - w/e 12/08/2020				
Total Vol Confinement	15 min obs	4 hr medical assess	1 hr medical assess	Issue
2	2 of 2	n/a	n/a	

3.8 Complaints

No new complaints received. No update

3.9. Risk Register Position

No change.

3.10. CCTV Viewing
(*References to Cx relate to camera numbers, e.g. C28)*

Please note that all CCTV viewing is now reviewed prior to publication in the Safety Report. On a weekly basis, an Assistant Service Manager and a Designated Adult Protection Officer will review the CCTV viewing reports to determine if any action is required – this is a new step, called the CCTV Viewing Quality Assurance (QA) Review Process.

The QA Review Process was completed on 18 August 2020 for the viewing reports included below, and comments are included.

Ardmore 2 **17/07/20** **09:00-15:00**	***Feedback from Safety Report 73*** Busy shift. 6 patients observed. Good ratio of staff to patients. Staff interacting with patients who appeared to respond well to this. Staff engaged in structured activity with 1 patient in activity room (completing jigsaws). Patients' general nursing needs responded to. Busy shift, staff responsive to patients' needs and interacted well with patients. 1 staff member providing 1:1 with patient in flat 1. Staff member observed eating patient's breakfast (C62 10:11). 2nd breakfast for patient was produced @ 10:22 C62, which patient ate some of. ***QA Meeting*** *The eating breakfast incident will be reviewed by ASG and Senior Manager and discussed with the Ward Manager.* ***Outcome*** *Staff member spoken to in presence of Ward Manager. Explained they had challenges in developing a therapeutic relationship with the patient. Patient on this occasion requested staff to take her breakfast with her. Same accommodated and facilitated appropriate patient/staff interaction.*
Ardmore 1 **21/07/20** **21:00 – 21:25 V1** **21:25 – 23:50 V2** **01:00 - 07:00 V3**	***Feedback from Safety Report 73*** **V1** - Only 1 patient observed, the rest must have gone to bed. Staff observed in day space and in nurses station. One female patient knocked on Nurses Station door at 21:06 on C2. As there was no answer, same patient climbed over nurse's station counter and communicated for 16mins through glass shutter. Due to short time I spent viewing ward, I was unable to grasp activities in much detail. Patients were already in their rooms. V**2** – Quiet night. Nursing staff members sitting in main day space. Only one patient observed who sat on smoking room engaged in her own activities – iPad/phone. Cameras failed early on in shift. Fault was immediately reported by Admin staff. Viewer remained and attempted to turn system on + off with no success. **V3** - Appeared to be a very quiet night shift. 3 nurses based themselves in day space area (C14). They were observed leaving day space at regular intervals to check bedroom corridors (C11 – 02:30, 03:30, 04:36, 05:30, 06:00). Patient leaves her bedroom and comes into day space at 05:30 and sits on relaxation chair. Staff interact with patient on 1:1 basis. Patient appears relaxed. She leaves at 05:45 and goes back to bedroom, then returns to day space at 06:16 and remains there. Staff engage with patient on 1:1 basis. Staff observed not wearing masks C14 @ 05:45. ***QA Meeting*** *To speak with Ward Manager and camera footage to be reviewed.* ***Outcome*** *Patient is not allowed to access staff office due to previous incidents of challenging behaviour. Day staff were completing paper work from day duty and conversed with patient through the door. Patient generally likes to update staff with facts from her magazines. No staff would have been allocated to this patient at this time.*
Erne 2 **22/07/20** **21:00 – 07:00**	3 patients observed, staff responded to patient who was unsettled and lying on dining room floor. 2nd patient agitated - staff responded to patient appropriately trying to settle him. Patients appeared to be all in their rooms by 22:30. Needs of patient responded to in preparation for bed.
Ardmore 2 **23/07/20** **15:00 – 21:00**	**Viewer 1** - Ward was calm initially. Staff were chatting to their colleagues. Two patients sitting quietly. At 15:30 one female patient became extremely agitated, this lasted for approximately 30mins. Staff were involved in managing and monitoring a female patient who was agitated. (C25 15:30) female patient was agitated, kicking and trying to grab out at staff. At 15:34:18 patient grabbed female nurse by her hair and neck and forced her back against

	wall. C28, day space, 15:34:27, she hit female nurse on head. 3 staff attempted to restrain patient, who then ran off and attacked another patient. 2 nurses tried to restrain patient, by holding her by the arms, but patient got away and continued kicking and thumping walls. After a number of attempts to calm patient down she accepted a drink at 15:7, c26 and calmed down. Staff remained closeby to observe her further. Although sufficient staff were present, they did not carry out MAPA. 2 or 3 staff tried to restrain patient, but as 2 staff had something in their hands they were unable to properly carry out MAPA. Ward furniture should have been removed to further avoid injury. Patient presented a very difficult situation for staff and patients concerned. Disturbed patient attacked a fellow patient in a wheelchair and physically attacked staff. MAPA intervention may have managed this situation earlier. Staff tried to calm patient down by offering her a drink. Nurses tried to communicate with patient. Shortly after incident (C25 15:52), patient had calmed down and she and staff nurse involved, hugged. A post incident review would be useful here. A very difficult situation for staff to manage and adapt practice. Typically an aggressive episode like this affects all patients and staff alike. Attempts to diffuse a situation can reduce some potential incidents. ***QA meeting*** ***CCTV footage to be viewed by ASG and Senior Manager.*** **Viewer 2** – Observed staff team actively engaged with patients in day space and bedroom corridors. One patient was unsettled and required 3-5 staff to monitor and ensure patient's well-being. As above when patient became unsettled and presented a risk to herself and others, staff responded appropriately and promptly. The staff team worked well as a group to safely manage the situation to ensure the safety of both the individual patient and other patients on the ward. (C32, 27, 25, 28, 38, 40, 41, 51, 17:00 – 17:45). As previously noted, staff were observed working well as a team to manage and support a patient who became unsettled on the ward.	
Ardmore 1 **24/07/20** **15:00 – 21:00**	Generally a quiet shift. 3 patients observed throughout. One patient mostly in bedroom, second patient in day space and third patient in smoking room (C19). Staff members appeared responsive to needs of patients – patient in smoking room regularly checked and brought snacks and fluids. General nursing care needs provided – nutrition and fluids. Patient also assisted with personal care needs. Verbal engagement observed between staff members and patients. Patient in smoking room engaged in own activities – using iPad and iPhone.	
Sixmile Treatment **25/07/20** **21:00-07:00**	Ward appeared busy and interactive. Patients generally engaged in own activities such as listening to music, using iPhone/iPad and chatting together while making coffee in the life skills room. Staff members also observed positively interacting with patients – chatting, supervising while patients prepared food. Staff members visible in day space area and appeared to respond to needs of patients – food/snacks provided, supervision provided while patients used washing machine. Patients also appeared to spend time in bedrooms and garden area. Calm atmosphere on ward.	
Cranfield 2 **26/07/20** **07:00 – 15:00**	Staff group appeared busy around the ward, having team meeting and going in and out of patients' bedrooms. 2 patients observed. A staff member sat in main day space with patient who appeared agitated at times.	

	Ward appeared calm and interactive. Patients engaged in activities such as using iPads/ spending time in garden/going for walks. Staff members observed positively engaging with patients. Staff members appeared to engage positively with 2 patients on ward. Main staff group appeared to be assisting patients in bedroom areas. Breakfast provided to one patient – staff member assisted patient with this. Staff members visible in main day space and responsive to needs of patients. Staff observed bringing food to some patients' rooms, sitting alongside patients while they ate in dining area and assisting some patients while promoting a level of independence. Staff members appeared to work well as a group and were visible and promptly responsive to the needs of patients.
Cranfield 1 **27/07/20** **07:00–10:00 V1**	Four patients observed. All patients assisted with personal care tasks. Good level of engagement observed between staff and patients. Busy ward as patients getting up and moving about. Patients' personal care needs attended to by staff appropriately.
Sixmile Treatment **27/07/20** **21:00 – 07:00**	Ward calm and interactive in early part of shift. Patients observed positively engaging with each other, having coffee/toast supper together while chatting. Staff members also so observed verbally engaging with patients. Patients observed intermittently throughout night. Staff members visible on ward and responsive to patients' needs of patients. Patients checked on a regular basis throughout the shift. As noted only 1 patient awake at 06:20 and observed for very brief period.
Erne 1 **28/07/20** **21:00 – 07:00**	Only 2 patients observed this night shift. 1. Patient in dining room at 21:15, nurse observed engaging 1:1 with patient and accompanying him to his bedroom at 21:30. 2. Patient in apt 2 was regularly checked by staff. Staff observed regularly checking bedroom corridors throughout the shift. Patient in Apartment 2 was sleeping on a mattress on the bedroom floor at the doorway. Got up at 03:35, took off his clothes, went across to room opposite and came out dressed. Then went to apartment day space and was pacing up and down. Two staff responded, changed the patient's bed and removed old laundry. Observed patient through glass door in day space pacing up and down. Nurse sat with patient at table for a short period. Patient became more settled. Staff continued to observe patient. Staff observed cleaning and wiping services.
Cranfield 2 **29/07/20** **21:00 – 07:00**	Quiet shift. Staff members observed assisting patients with personal care needs in preparation for going to bed. One patient observed who engaged in own activities (iPad) and spent time in garden area before going to bed at 01:00. Staff members visible in ward area and responsive to the needs of patients – ensuring their care and dignity when required and in a prompt manner. Staff visible in main day space, ward area throughout shift. Patients checked on a regular basis.
Moyola Day Care **01/08/20** **12:00 - 14:00**	This two hour period Day Services appeared to be very quiet. Staff member and 2 patients in kitchen. Staff member was assisting and supervising 2 patients cooking a meal. Very good interaction observed. Nurse in group room (C37) on PC, no patients. Appears good engagement between staff member and 2 patients she was supervising in the kitchen.
Cranfield 1 **02/08/20** **21:00-00:06 V1** **00:06-07:00 V2**	**Viewer 1** - Evening shift. Staff observed with patients in TV room, staff base and bedroom corridors. C22, 33, 35 fm 21:04 – 21:08 – 1 patient was unsettled and required intervention and monitoring by staff. This was provided in a timely manner by staff members. C33, 35, 22 fm 21:04 – 21:08 - 1 patient was unsettled and required staff to intervene for his own and staff safety, holding him by his upper arms. Patient went down on floor. A further intervention was required when the patient went into the staff base. There was no clear camera view for this.

	Viewer 2 – Quiet night shift. All patients in bedrooms, regularly checked by staff during the night. Only 1 patient awake at 06:20, but returned to bedroom having been checked by staff member. Patient appeared happy to do so. ***QA Meeting*** ***To be viewed by ASG and Senior Manager.***

(4) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback

4.1. Safety Brief
Ongoing on a daily basis on each ward, using agreed template.

4.2. Safety Quality Visits
The Assistant Service Managers have virtual catch up with ward teams.

4.3 Weekly Live Governance meetings ongoing
Chaired by Clinical Director and involving all wards.

4.4 Monthly ward clinical improvement groups
These have been stood down during the coronavirus pandemic.

4.5 Patient Experience Feedback
This work is currently paused as part of containment measures for the coronavirus pandemic.

(5) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.

5.1. Staff Counsellor Sessions – 12 Sessions offered per week.

This service continues to offer support to staff.

5.2 Information from MAH Senior Nursing Team

The Senior Nursing Team continues to maintain a focus on workforce recruitment and retention. In addition the Senior nursing Team has been contributing to Resettlement discussions focussing on how to make the process even more patient focussed.

5.3 Lead Nurse/ASM recruitment
Appointment of 2 lead Nurse /Assistant Service Managers . One successful candidate from within Belfast Trust and the other from an external Trust.

(6) Emerging issues

Covid-19 Update at Time of Report Submission
Patient who had been tested for Covid-19 on 8 August and who had two negative test results has since returned to their ward following a period of isolation and remains well.

On 18 August 2020 three further patients from separate wards within Muckamore Abbey Hospital were tested for Covid-19. IPC advice sought and patients nursed in isolation. Visiting was stopped during this period. All tests returned negative and patients returned to the wards.

On 19 August 2020, MAH was advised that a family member who had been visiting a patient had tested positive for Covid-19 having last visited on 15 August. IPC advice sought, patient moved to isolation . No testing of patient in line with protocol unless symptoms develop and to remain nursed in isolation for 14 days from 15 August 2020.

Staff Absence in Erne Ward
Increased staff absence in Erne Ward. A range of options are being reviewed. Estates review of building environment in relation to standards for facilities of people with Learning Disability and wheelchair users has been commissioned with the initial survey expected in September.

Review of Leadership and Governance Muckamore Abbey Hospital 2012 – 2015
The report was published on the evening of 5 August 2020. Staff Briefings took place on 5 ,6 , 11 and 14 August and conversation with patients in Sixmile Ward on 6 August 2020.

RQIA Whistleblowing
A number of concerns have been raised with RQIA anonymously in relation to Erne recommendations in a clinical care plan for two patients in Erne Ward, and the communication of the same to staff. RQIA have been provided with a response which includes that specific action plans have been formulated by the MDT in relation to both patients which were initiated on 23 and 24 July 2020 respectively. Care plans have been fully updated for Patient 1 and are in the process of being updated for Patient 2.

Request for admission from WHSCT
A request has been made from the WHSCT for a Northern Trust patient to be admitted to the MAH site. It is understood that this patient requires a high level of staffing support to maintain safety**.** An Initial meeting to discuss this case took place on 14 August 2020 with a further meetings on 21 August 2020.

Trade Unions
Trade Unions are highlighting concerns regarding the increasing number of physical assaults on staff and support to staff and discussion with the management team are ongoing. A meeting is planned to take place on 27 August with Trade Union colleagues.

(7) Media and communications – FOIs, media enquiries etc.

As at 10 August 2020:

- No media enquiries outstanding
- No constituency enquiries outstanding
- No Departmental enquiries outstanding
- 7 FOI requests outstanding (1 started as media but transferred to FOI)

(8) Financial Governance

BSO Internal Audit have provided a final audit report with an outcome of 'Satisfactory' and on 14 April 2020, RQIA wrote to the Trust to advise that the Improvement Notice had been lifted. An Action Plan is now in progress.

An unannounced Finance Audit was completed on 15 July 2020. Generally there was a satisfactory outcome to how Patient finances are managed in line with Hospital Policy and Procedure. Meeting to take place 27 August with ASMs to discuss learning and to agree individual ward level presentations.
(9) Next Steps/forward look – wider strategy update
Review of Leadership and Governance Muckamore Abbey Hospital 2012 – 2017 Following publication of this review, it is planned to seek feedback from those who participated in the review process in order to inform an overall factual accuracy response from the Trust to the Review.
(10) Other Issues requiring escalation for advice and senior decision making
None.

Belfast Health and Social Care Trust

caring supporting improving together

Complaints / Compliments

Annual Report

2019-20

Working together Excellence Openness & Honesty Compassion

Belfast Health and Social Care Trust
caring supporting improving together

COMPLAINTS /COMPLIMENTS ANNUAL REPORT 2019-20

WORKING TOGETHER **EXCELLENCE** **OPENNESS & HONESTY** **COMPASSION**

Introduction

This report gives an overview of complaints and other feedback received from patients, their carers and family members by Belfast Health and Social Care Trust from 1st April 2019 to 31st March 2020.

The Belfast Trust is one of the largest integrated health and social care Trusts in the United Kingdom.

We deliver treatment and care to approximately 358,000 citizens in Belfast and provide the majority of regional specialist services to all of Northern Ireland.

We have an annual budget of £1.6bn and a workforce of approximately 21,500 staff (full time & part time). Belfast Trust also comprises the major teaching and training hospitals in Northern Ireland.

Our vision is to become one of the safest, most effective and compassionate health and social care organisations in the United Kingdom.

The Trust received a total of

1,646 formal complaints during the past year,

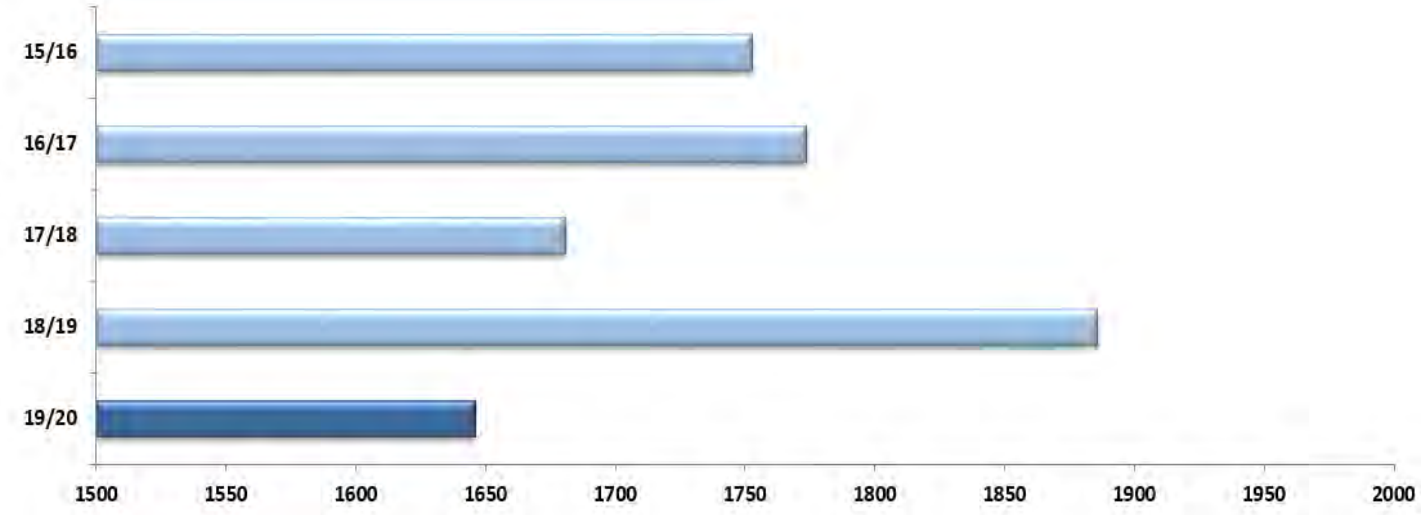
and 7,012 formally reported compliments about our services.

Although most patients have positive experiences of our services there may be times when treatment or care do not meet expectations especially when something has gone wrong or fallen below standard.

We are focused on making sure that lessons from complaints are taken on board and followed up appropriately, sharing these lessons across other Service Areas and Health and Social Care Trusts where the learning can be applied in settings beyond the original ward / department.

By listening to people about their experience of healthcare, the Trust can identify new ways to improve the quality and safety of services and prevent similar problems happening in the future.

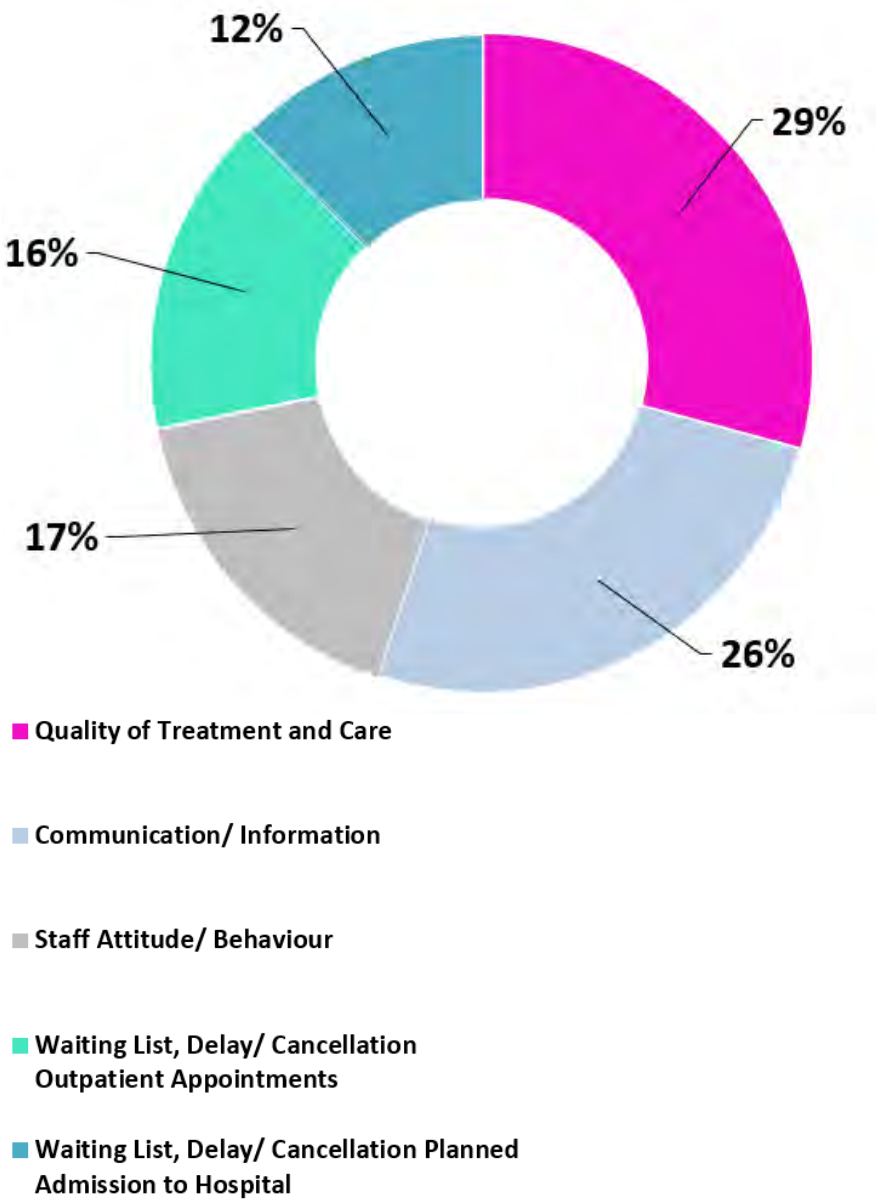
Formal Complaints received during the past 5 years*



* See further details on Page 6

What you said

The most frequent reasons for complaints about our services during 2019-20 are shown below:



How we listen

Anyone who uses any of our services can complain. You can also complain on someone else's behalf (you will generally need their written consent to do so).

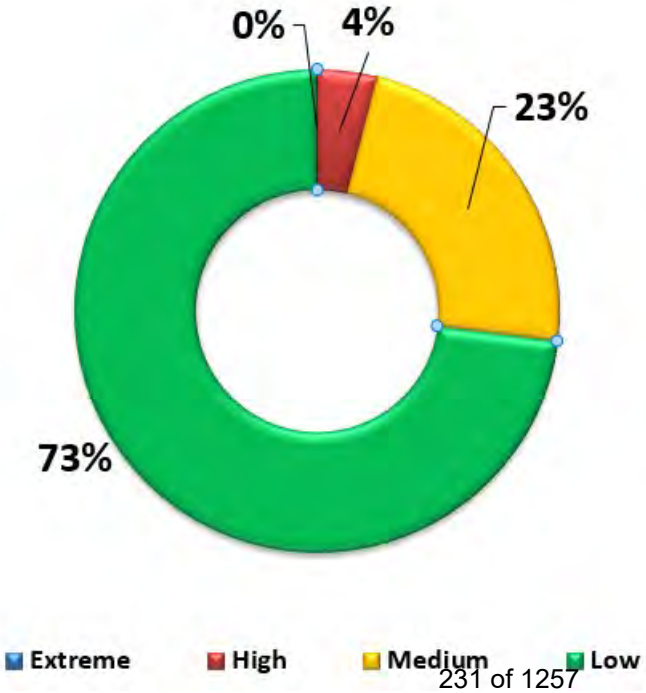
Your complaint will be investigated thoroughly and confidentially. We aim to respond to your complaint in full within 20 working days, to address your concerns and let you know of any actions taken as a result.

Some complaints may however take longer to resolve than others. We will contact you to explain if this is the case with your complaint, and we will continue to keep in touch with you while we work to provide you with a response.

All complaints received by the Trust are assessed against the Trust's risk evaluation matrix and are **graded** as either Low, Medium, High or Extreme risk by the Complaints Team in conjunction with the relevant Service Area(s).

This grading determines the most appropriate action to be taken in response to the complaint, including the type of investigation to be undertaken, and notification of the issues identified to senior staff.

The chart opposite shows an overview of the complaints received during 2019-20 by their grade.



How we improve

We use a number of different approaches within the Trust to gain information and identify areas for improvement in relation to how we deal with complaints. During 2019-20 these included:

- Amending the Trust Complaints Policy to enhance **Professional Assurance** processes used across the Trust to identify and respond to potential concerns identified in complaints relating to staff who provide treatment and care to patients / service users.

- Continuing to monitor **Key Performance Indicators** in order to track significant aspects of complaints management. These include time taken to provide responses; complaint subjects; and numbers of complaints resolved by staff within their wards / departments (ie rather than requiring patients to use the formal complaints procedure to address concerns). Data is produced regularly to inform progress in these areas,

- Our **Service User Experience Feedback Group** (whose members include Non-Executive Directors, Medical Director, Service Directors and Co-Directors along with representatives from Patient Client Council, Personal and Public Involvement, and Nursing and User Experience teams) continued to meet throughout the year to review and monitor complaints / other forms of Service User Feedback and to identify shared learning for the Trust and beyond.

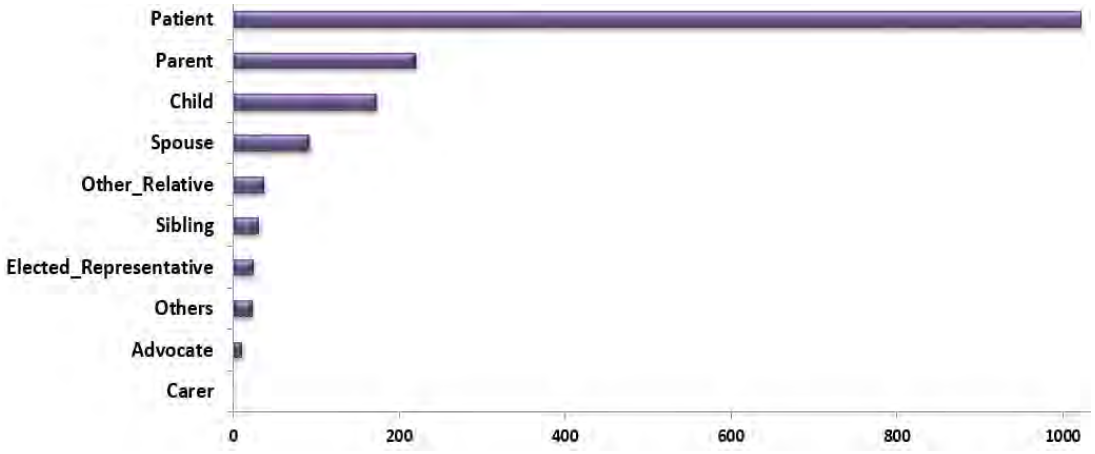
- **Shared Learning templates** continued to be produced regularly by Trust Service Areas. These describe anonymised patient experiences that have highlighted ways in which our delivery of treatment and care can be improved. These templates are shared widely both within the Trust and to other HSC organisations to help avoid similar problems being encountered by other service users.

- Internal **Performance Reports** were provided to our Trust Board 4 times during the year. These reports included details of reasons for complaints; distribution of complaints across Service Areas and clinical specialties; and statistics about the timeframes within which our responses are provided.

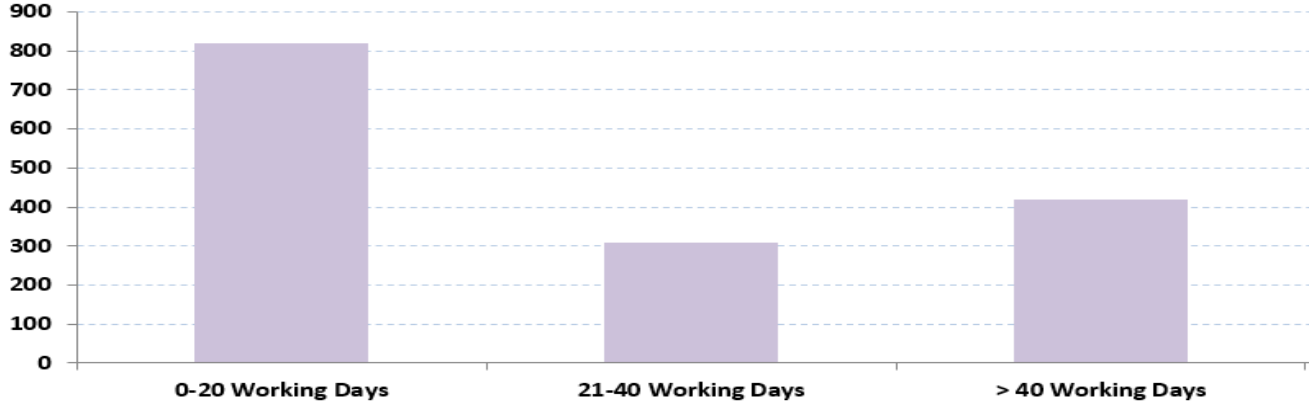
Who Complains?

In 2019-20, 62% of complaints were made by the person directly affected.

The chart opposite shows who raised complaints on behalf of others during this time.



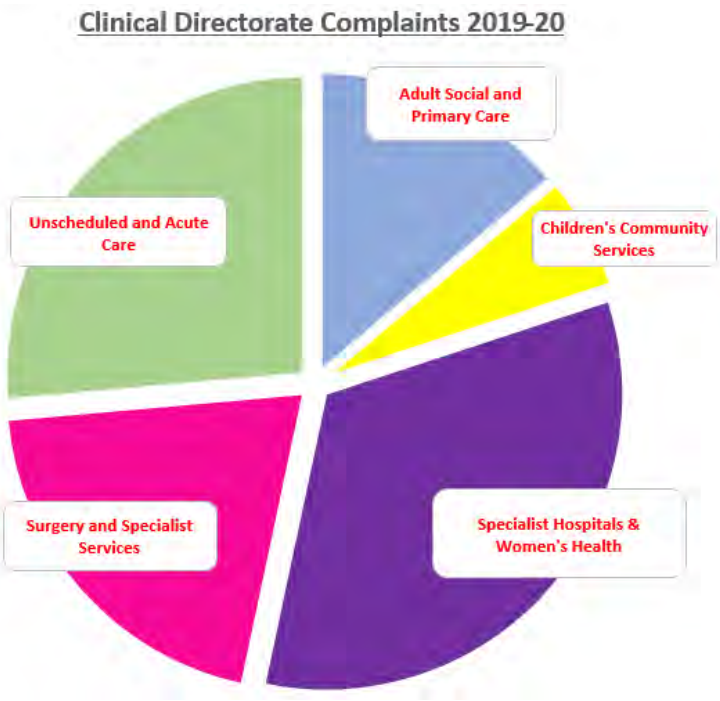
How we respond - timeliness of complaint responses 2019-20*

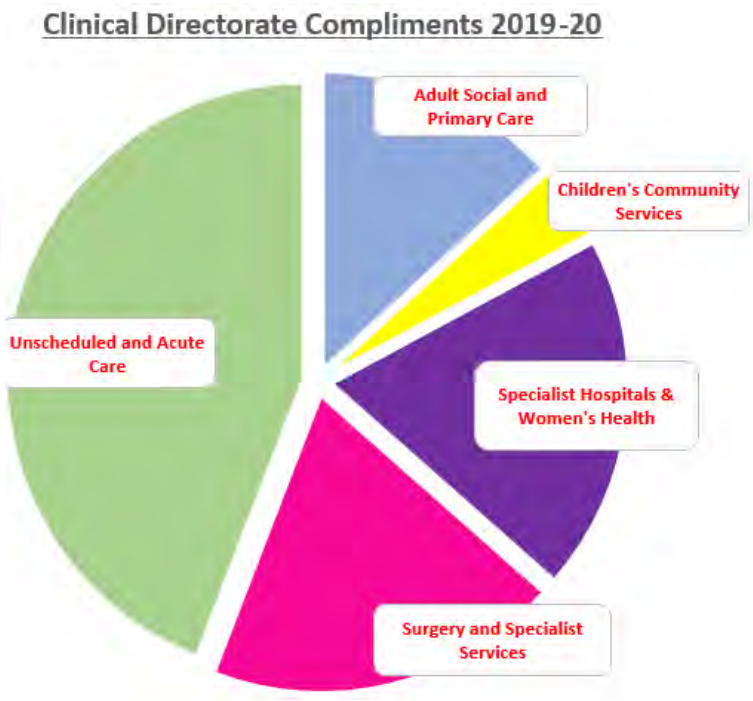


Although we aim to respond to complaints within 20 working days, complex complaints (particularly those that involve a range of services / departments / organisations, or where independent expert opinions are sought) can require additional time to investigate. While we continue to seek improvement in the timeliness of our replies, we feel that this must not be at the cost of providing a **quality response to complainants.*

What you said

The services provided by Belfast Health and Social Care Trust are organised into Directorates. Each year complaints and compliments are received about the clinical specialties and departments within these groupings, and the charts below show a comparative overview of these complaints grouped by Clinical Directorate during 2019-20.

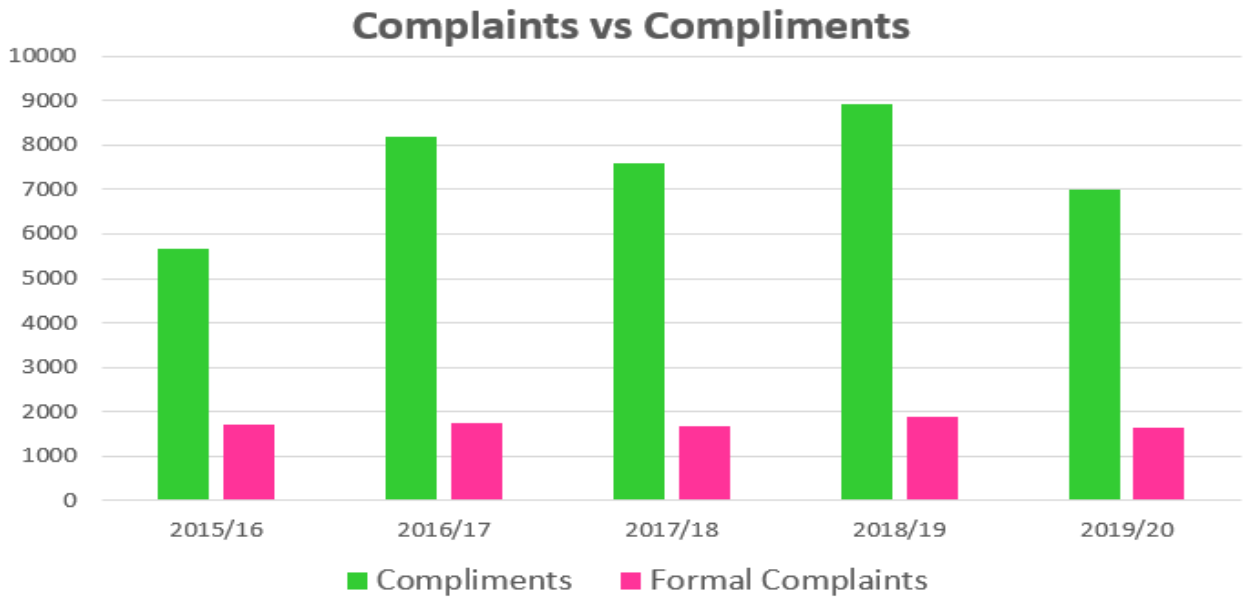




Compliments

Throughout the year the Trust continued to receive compliments about many aspects of our services.

A total of **7,012** compliments were formally recorded during 2019-20 and the table below shows the numbers of both complaints and compliments received over the past 5 years.



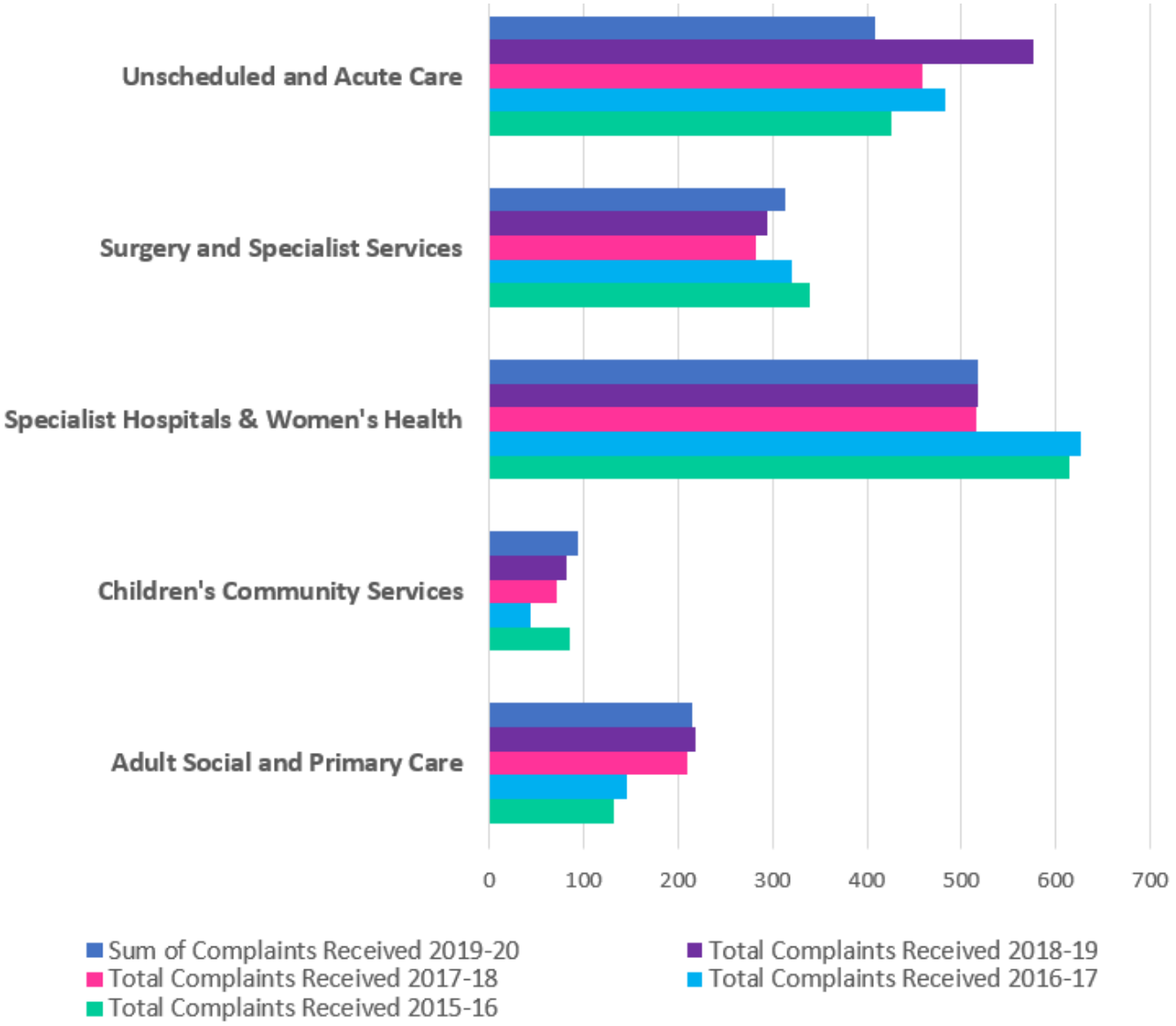
Compliments are always appreciated as they provide our patients and clients with an opportunity to share their positive experiences with our staff members, and allow the Trust to learn from areas of good practice and share what is working well in one area across others.

As such we encourage service users to tell us when they have been happy with their experiences. Compliments can be shared with us by phone, face-to-face with staff, in writing, or by email via a dedicated mail box:

compliments@belfasttrust.hscni.net

Complaints

The numbers of complaints received by each area are typically proportionate to their activity levels and to the nature and complexity of the services provided, with larger clinical Directorates receiving greater numbers of complaints. The distribution of **complaints across** the clinical **Directorates** over the past 5 years is shown below



Complaints during COVID-19

The final weeks of the 2019-20 year saw Trust services starting to be significantly impacted by coronavirus and the associated measures implemented to protect our patients, staff and the wider public.

We greatly appreciated the patience and support of both existing and new complainants as we all worked to deal with unprecedented changes at this time. Service Area staff faced extraordinary challenges in seeking to re-organise and re-design the delivery of care in order to ensure capacity for patients with COVID-19, as well as those requiring urgent care for other conditions. Within the central complaints team itself, a number of staff were redeployed to support the provision of support and advice for those bereaved during coronavirus.

Clearly these factors impacted on our capacity as an organisation to be able to respond to complaint issues in as timely a manner as we would otherwise have wished, however processes were put in place to monitor and escalate complaints raising high risk issues, as well as those for which responses were outstanding for long periods of time, so that work could continue in these areas as a priority, in addition to the ongoing efforts to progress our other complaints.

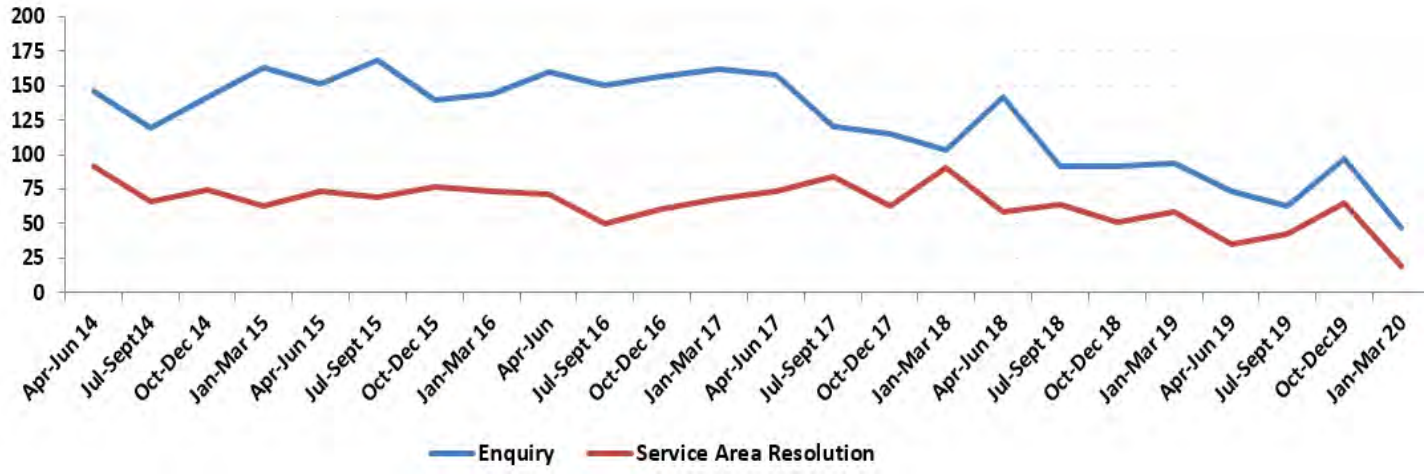
The Trust also established a Governance Triage Panel to assess any high risk complaints that may have been proposed for suspension (due to the effect of COVID-19 on the capacity of Service Areas to investigate) and determine whether this was appropriate, or whether urgent investigation was required. Due to the commitment and effort of staff however, the investigation of all high risk complaints continued for all cases despite the COVID-19 impact.

General Enquiries & Frontline Resolutions

"**General Enquiries**" received by the Complaints Team are not subject to the HSC Formal Complaint Procedure, and can generally be resolved relatively quickly. Examples include: enquiries about position on the waiting list, clients unable to contact specific wards/departments, or clients who request that their concerns are not raised as a formal complaint.

The Trust also continues to promote the resolving and recording of complaints and concerns at service level e.g. in wards and departments. These cases are also monitored by the Complaints Team under a heading of "**Service Area" or "Frontline" Resolution**".

The chart below shows the number of enquiries and service area resolutions recorded from 2014-2020:



Complaints Awareness Training is made available to all staff to encourage and facilitate the resolution of patients' concerns at this frontline level. However all service users may subsequently request that their concerns are further investigated formally by the Trust under the Health and Social Care Complaints Procedure.

Ombudsman Cases

If patients are not fully satisfied with the outcome from the Trust's complaints processes they can choose to subsequently raise their concerns with the Northern Ireland Public Services Ombudsman.

The Ombudsman's office assesses each complaint and decides whether the issues raised warrant further investigation.

Ombudsman reports received during 2019-20 saw a total of 9 complaints relating to the Trust upheld (these included cases where the Ombudsman investigations had commenced in previous years).

The Trust produces action plans to ensure that all recommendations arising from Ombudsman reports are implemented. We also promote and review the sharing of learning from Ombudsman recommendations, in this way we make certain that any service improvements are put in place not only in the area where the complaint originally arose, but also in other areas where there is potential for similar issues to arise.

How we Listen and Learn

Trust staff continue to work hard to ensure that concerns or criticisms raised by patients or their loved ones are dealt with in an effective way. In particular we continue to try to make the process of raising a complaint **easy** for complainants; and to ensure that investigations into patients' issues are **fair**, **thorough** and completed in a **timely** manner. We also strive to ensure that appropriate **actions** are taken in response to complaint investigation findings in a way that fully resolves the matter for the complainant, and identifies learning and potential improvements that can be shared across the Trust.

- Learning from the issues raised in complaints continues to be included in the Trust's wider "**Shared Learning**" system. This system makes sure that key improvements are identified (for example following complaints or incidents experienced in wards and departments) and that details are provided across the Trust and to other Northern Ireland healthcare organisations to avoid similar issues happening elsewhere.

- The Complaints Department supports our managers and staff working in wards and departments to help ensure that comprehensive and full responses are provided to all complaints in an appropriate and timely way.

  In order to improve the timeliness of our response to complainants, we further enhanced our focus on long outstanding complaints during 2019-20, highlighting cases where investigations and responses had been ongoing for significant periods of time. We also encouraged and supported staff to resolve complaints at an early stage - increasing the numbers of complaints addressed informally within wards and departments, and also increasing the numbers of formal complaints addressed within 5 workings days.

- Although we have a focus on making sure our complaint replies are provided in as timely manner as possible, we feel that this must not be at the cost of the **quality of the responses.** As such, the Trust continued to review complaint response letters during 2019-20 to help ensure that all the issues or questions raised by complainants are responded to, and that the content and language used in the letters meets the standards our staff would hope for themselves in a response being received by their own loved ones. This included regular reviews of representative samples of complaint response letters by the Medical Director and Chief Executive to **Quality Assure** and inform improvements in our correspondence with complainants.

- The Trust also continues to use a range of **Key Performance Indicators (KPIs)** to monitor Service Area performance and to ensure specific focus on and review of important issues. These include not only the time taken to respond to complaints when raised, but also common issues of complaint (particularly communication and provision of information, and staff attitude and behavior). The indicators are discussed at regular Trustwide meetings attended by senior staff, and learning / areas of good practice are shared between Service Areas to inform improvement in other wards / departments.

  KPI 1: Increase the number of complaints resolved ≤ 5 working days

  KPI 2: Increase the number of complaints resolved ≤ 20 working days

  KPI 3: Reduce the number of complaints resolved > 40 working days

  KPI 4: Reduce the number of complaints regarding staff attitude / behaviour

  KPI 5: Reduce the number of complaints regarding communication / information

  KPI 6: Increase the number of complaints resolved on the frontline

  KPI 7: Reduce the number of complaints being re-opened / re-visited

Learning from Complaints

The Trust endeavours to ensure that where any patient had an experience within our care that did not meet the standards that we expect, this experience is reviewed and any learning is identified and used to inform changes in the way that we deliver our services. This learning is shared across Trust wards / departments where relevant to help avoid other patients experiencing similar issues in the future.

Some examples of how complaints have led to improvements within the Trust during 2017-18 include the following:

Complaint 1

A patient was hospitalised following Polytrauma and discharged 22 days later. The patient and family subsequently complained about inadequate preparation for this discharge from hospital, and felt that a more comprehensive package should have been put in place.

The learning from this complaint was shared with the Multi Disciplinary Team.

Staff within Trauma & Orthopaedics were required to attend study sessions in relation to safe discharge planning and documentation.

A Quality Improvement Project, led by the Multi Disciplinary Team, was also initiated to promote safer discharge.

Patients within Trauma & Orthopaedics will now be given a discharge information package, with Multi Disciplinary Team input throughout their inpatient stay. This package will also identify services that have been contacted, following Multi Disciplinary Team assessment of the patient's needs. The package will stay at the patient's bedside and will enhance communication with the family.

Complaint 2

A patient complained that her privacy and dignity were not maintained while attending for a diagnostic test.

During the CT scan, an initial planning scan was done to assess which level to start and stop the scan. At this initial stage it was apparent that artefact from clothing (eg zips, buttons, belt, buckle, heavy materials etc) was present on the scan. It was essential that this was removed from the area to be scanned, in order to achieve the best quality images. Unfortunately, as the scan had already commenced it was vital that the patient remained in the same position. Otherwise a repeat scan would be required which would have resulted in an additional unnecessary radiation dose.

As a result, a new information poster (see overleaf) was designed for patients advising them on what to wear for an imaging scan and patients are now issued with double gowns.

This poster is now displayed in all Imaging Departments across the Trust.

This complaint has been a source of learning for the team in the Mater Imaging Department as well as the wider Imaging team. The key points of this complaint have been shared with all Imaging staff in our fortnightly newsletter as well as the learning from it.

A MESSAGE FROM OUR X-RAY TEAM

HSC Belfast Health and Social Care Trust
caring supporting improving together

We sometimes request that patients wear a gown to reduce the appearance of artefacts, such as zips or buttons which can make x-rays difficult to interpret. In some areas we do not have the facility to get patients changed into gowns e.g. fracture clinic/x-ray department. It may prove useful and potentially reduce your waiting time or if you do not want to wear one of our gowns, to please wear the following clothing when coming to your x-ray.

X-Ray of the pelvis, hip or femur

Please try to avoid jeans or trousers with metal zips, buttons, belts or buckles across the pelvis area. Jogging bottoms and leggings should be fine.

X-Ray of the shoulder / humerus / chest

Please wear tops without buttons, sequins/beads or zips. T-shirts should be fine. If possible, please do not wear a bra with metal fastenings, sports bras are ideal.

X-ray of the knee / lower leg

Please wear shorts or trousers that roll up comfortably above your knee. Skirts and leggings should also be fine.

Please remove jewellery that may interfere with the examination. For example, rings for hand x-rays and necklaces for shoulder x-rays.

Thank you for your cooperation.

What we will be doing in 2020/21

We want to be sure that complaints we receive continue to be appropriately investigated; responded to in reasonable timeframes and in a manner that reflects the key Trust values; and to make certain that learning from complaints is used to inform potential improvements for the future to help make our services the safest, most effective and compassionate they can be.

Key pieces of work will be taken forward during 2020/21 to achieve these aims:

⇒ Ensuring Trustwide implementation of enhanced professional assurance processes, and reviewing these processes during the year to ensure their effectiveness. This includes developing and implement a robust system for escalation of concerns in relation to Professional Staff across all staff groups within Service Areas.

⇒ Establishing an audit mechanism for review of Complaints Handling processes in the central complaints team in order to improve complaints management processes

⇒ Fully implementing a feedback process to allow complainants to tell us about their experience of complaining, and using this feedback to identify actions that will improve our ways of working.

⇒ Continuing to highlight learning from complaints and Ombudsman cases, and use this to identify how things can be done better to improve service delivery throughout the Trust.

⇒ Continuing to provide training to support improvements in how we respond to complaints.

⇒ Continuing to promote the resolution of complaints on the frontline within wards and departments, and working to reduce the length of time taken to investigate and respond to complainants (particularly where responses have not been issued after 40 working days).

We will also continue to promote collaborative working on a number of levels to progress these areas:

⇒ between Directorates & the central Complaints Team, including improvements in the data and information provided by the Complaints Team to staff.

⇒ between the Trust and external bodies (e.g. Northern Ireland Public Services Ombudsman, Patient Client Council, Department of Health).

⇒ Between the Trust's complaints central complaints department and those in other NHS Trusts

We will also continue work to improve our systems for recording and collating compliments received by wards and departments as part of the Department of Health's regional reporting requirements.

The Complaints Team can be contacted at:

Belfast Health and Social Care Trust - Complaints Department

Musgrave Park Hospital

7th Floor McKinney House

Stockman's Lane

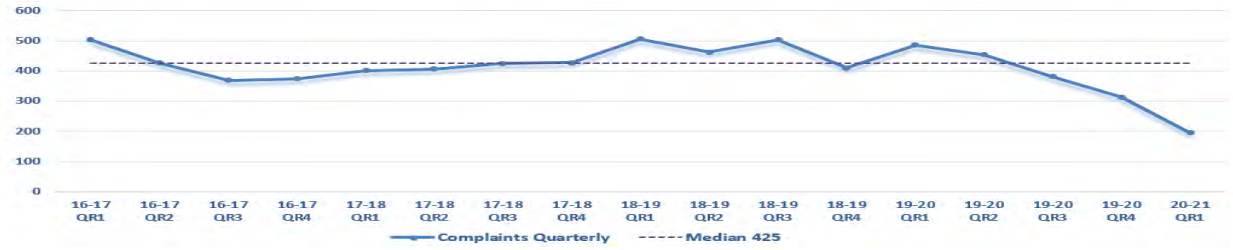
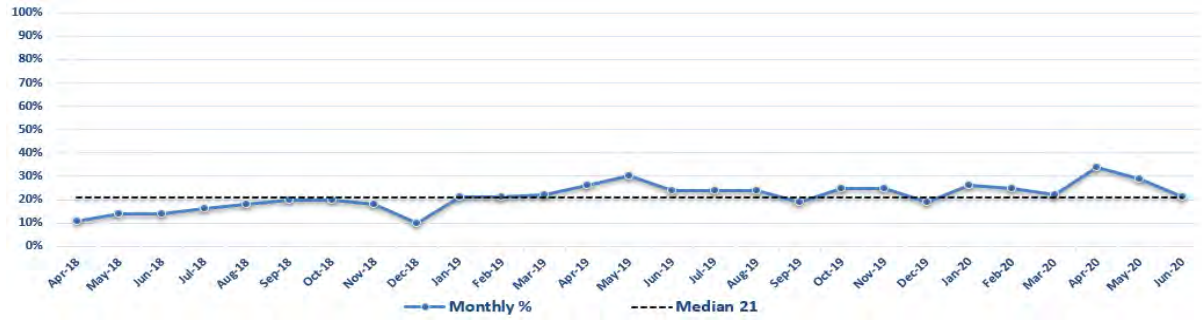
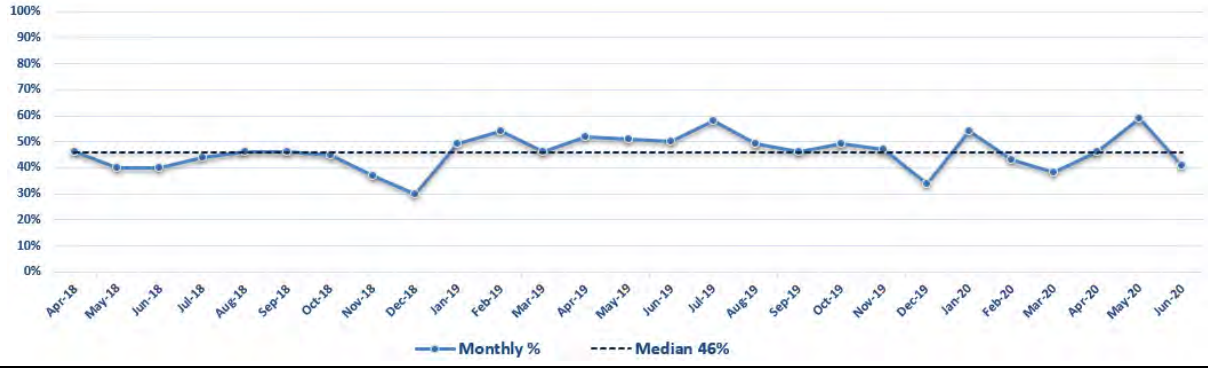
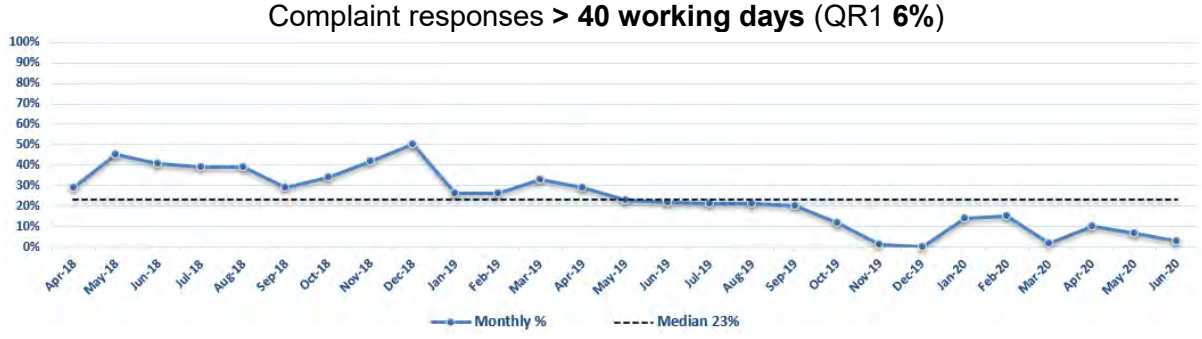
Belfast BT9 7JB

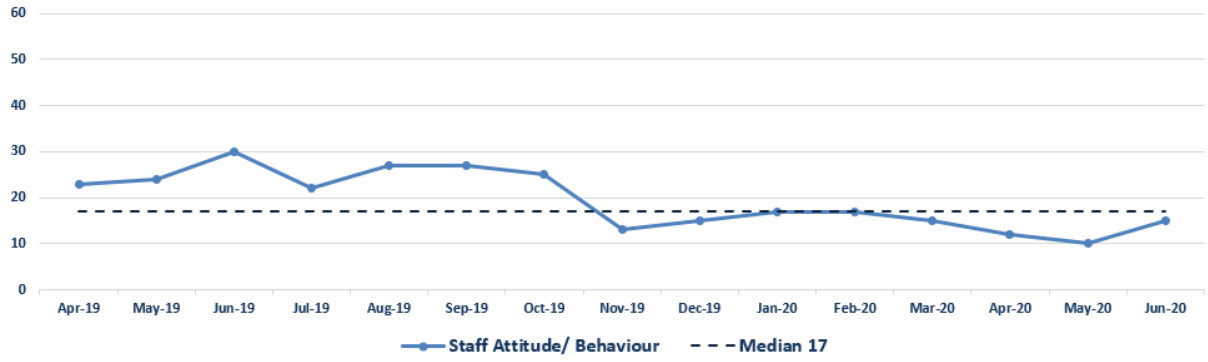
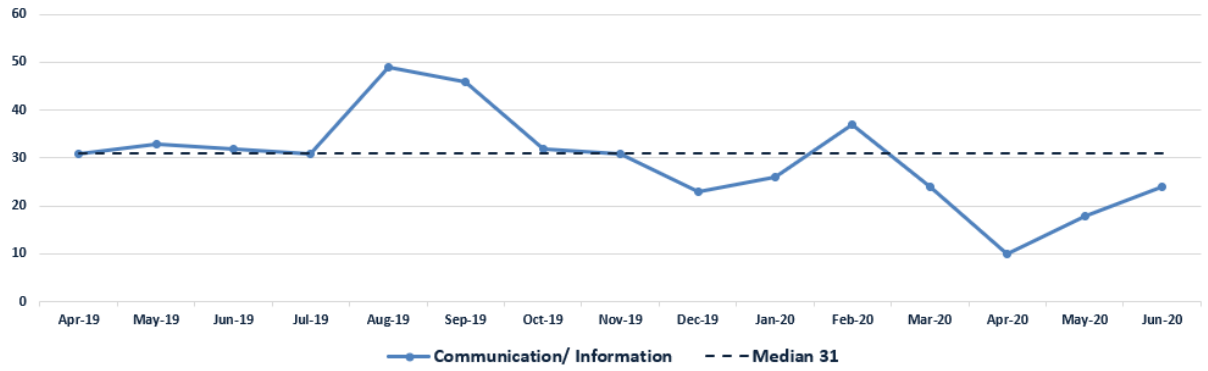
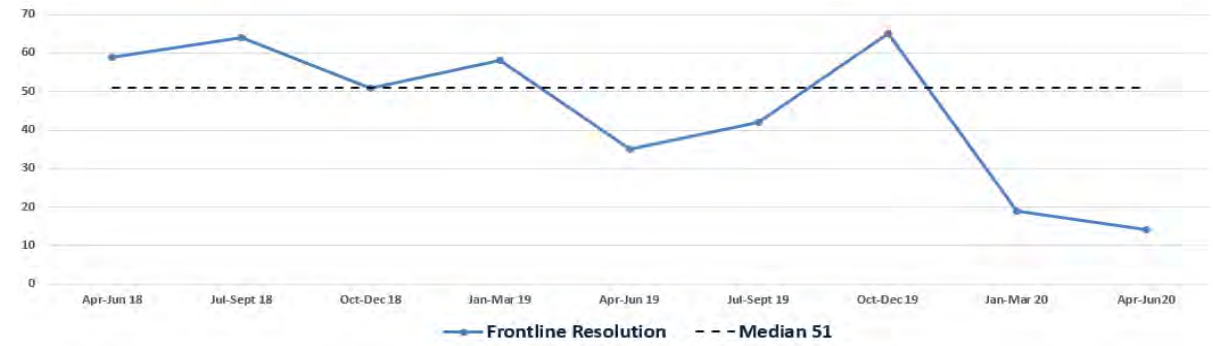
Email: complaints@belfasttrust.hscni.net compliments@belfasttrust.hscni.net

COMPLAINTS & COMPLIMENTS

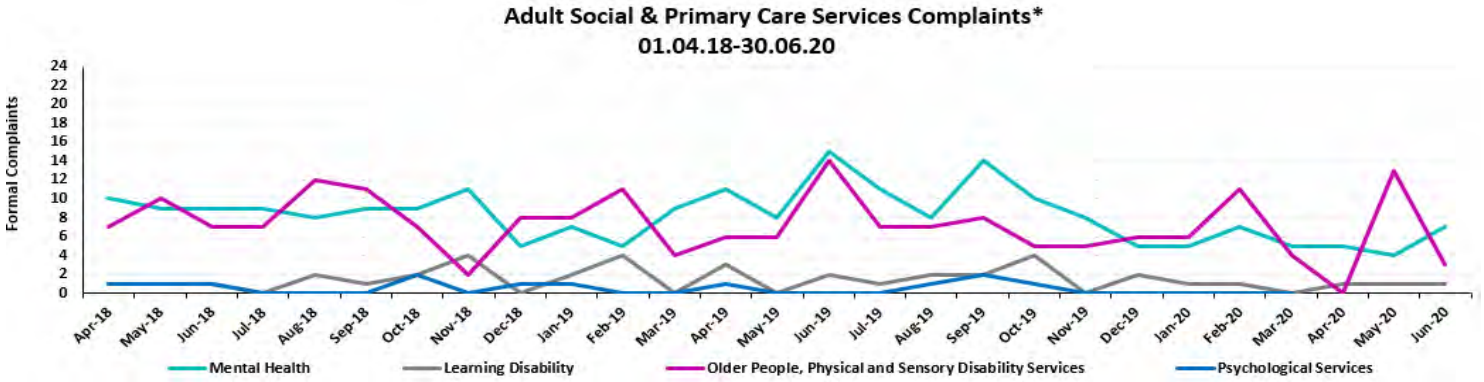
SUMMARY REPORT APRIL TO JUNE 2020

Data as at 17.08.20

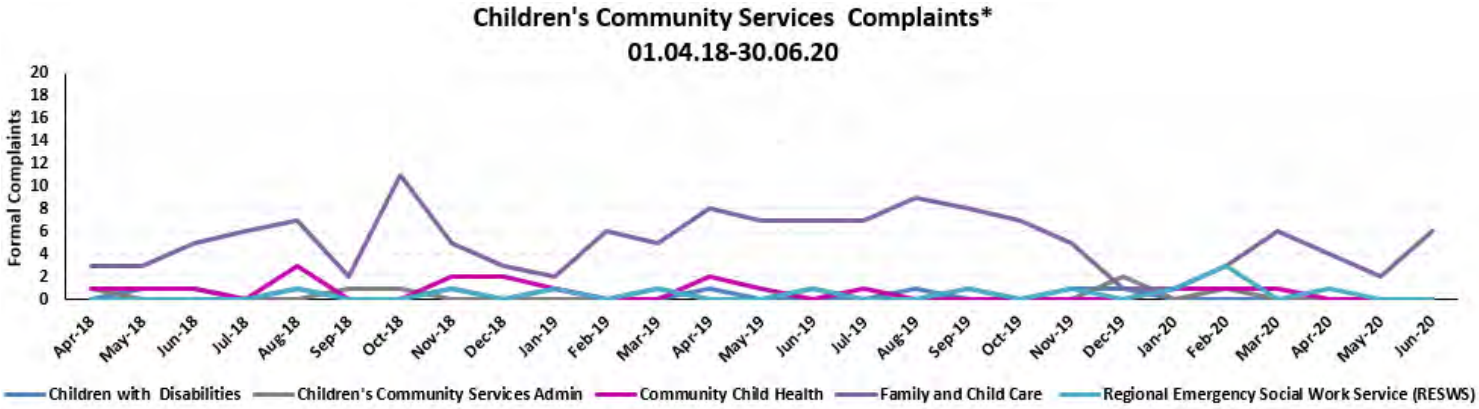
	April to June 2020		
1	**196** formal complaints with consent were received in Q1 20-21. This reflects a reduction of **40%** on the preceding quarter - this is potentially a result of public disinclination to raise complaints during the COVID-19 peak, and a consequence of fewer interactions with patients / service users due to downturn in many services during these months. **16** complaints were graded High Risk during this quarter and none were graded as Extreme.  **44** (22%) formal complaints received in Q1 20-21 were COVID-19 related.	
2	**KPI 1**	*Increase number of complaints resolved ≤ 5 working days*	Complaints resolved **≤ 5 working days** (QR1 **27%**) 
3	**KPI 2**	*Increase number of complaints resolved ≤ 20 working days*	Complaints resolved within **20 working days** (QR1 **49%**) 
4	**KPI 3**	*Decrease number of complaints resolved > 40 working days*	Complaint responses **> 40 working days** (QR1 **6%**) 

5	KPI 4	*Reduce number of complaints related to staff attitude/ behaviour*	Complaints related to **staff attitude** 
6	KPI 5	*Reduce number of complaints related to communication/ information*	Complaints related to **communication / information** 
7	KPI 6	*Increase number of complaints resolved at the frontline*	Complaints resolved at the **frontline** 
8	KPI 7	*Reduce number of re-opened complaints*	**36** formal complaints were **revisited** during the quarter compared with 72 for the same quarter in 2019-20.

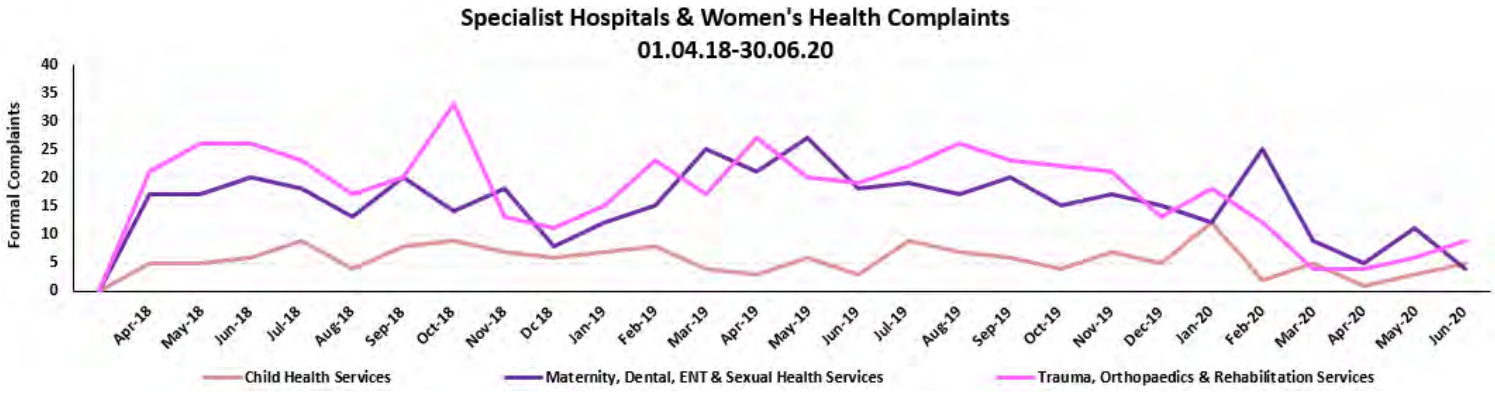
Complaints by Division: April 2018 – June 2020

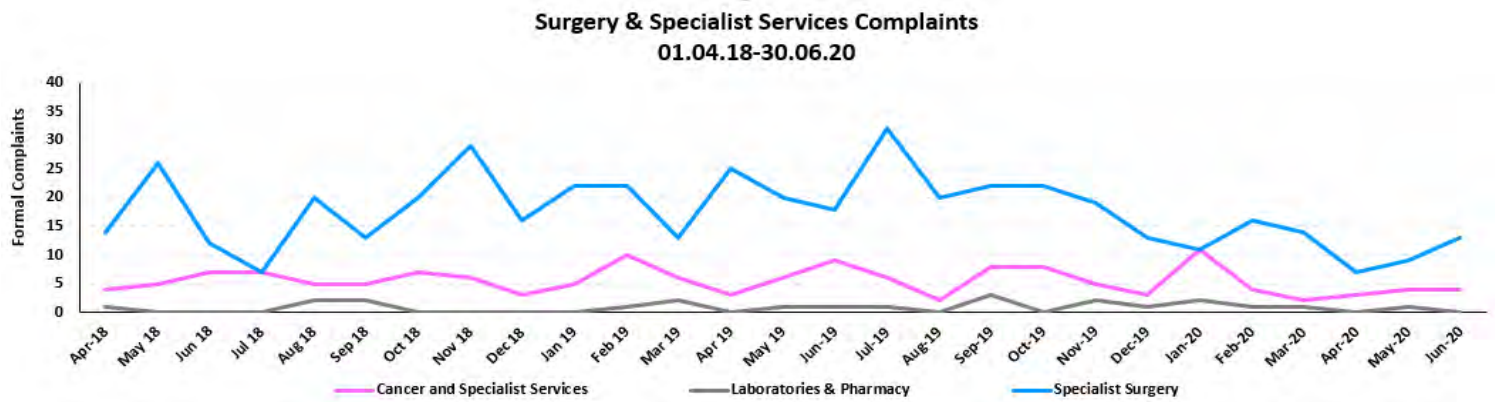


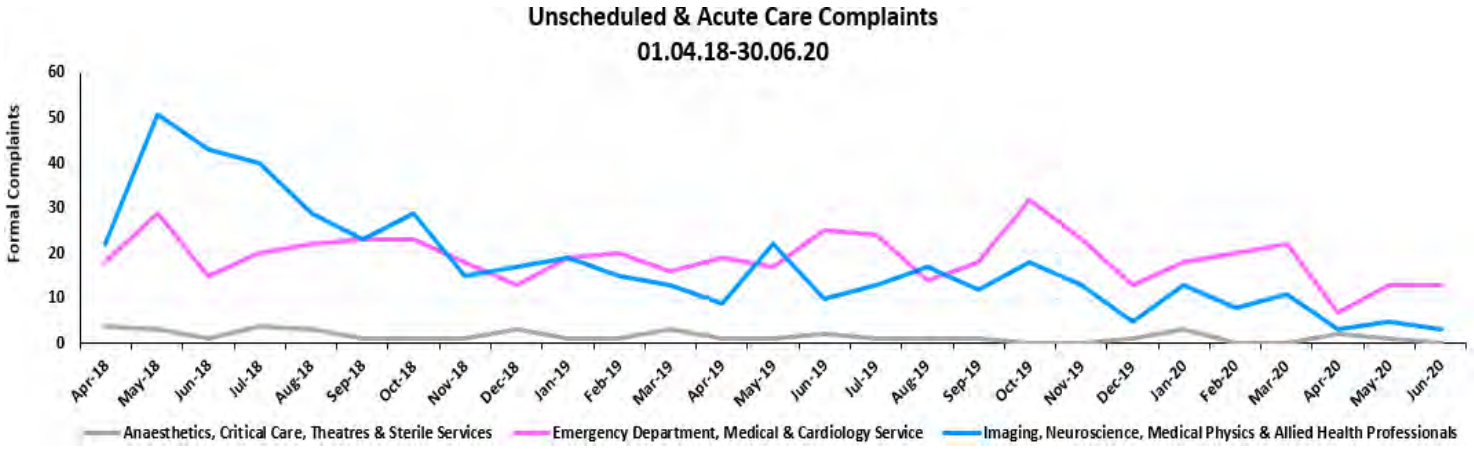
Please note there were no complaints in respect of Psychological Services in Q1 20-21.



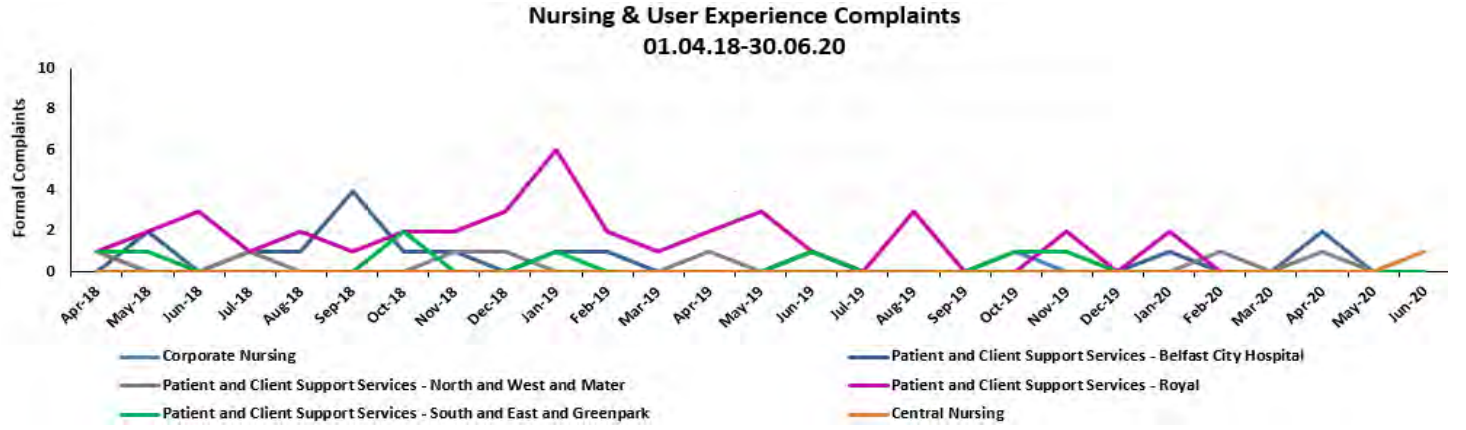
Please note there were no complaints in respect of Children with Disabilities, Children's Community Services Admin or for Community Child Health in Q1 20-21.

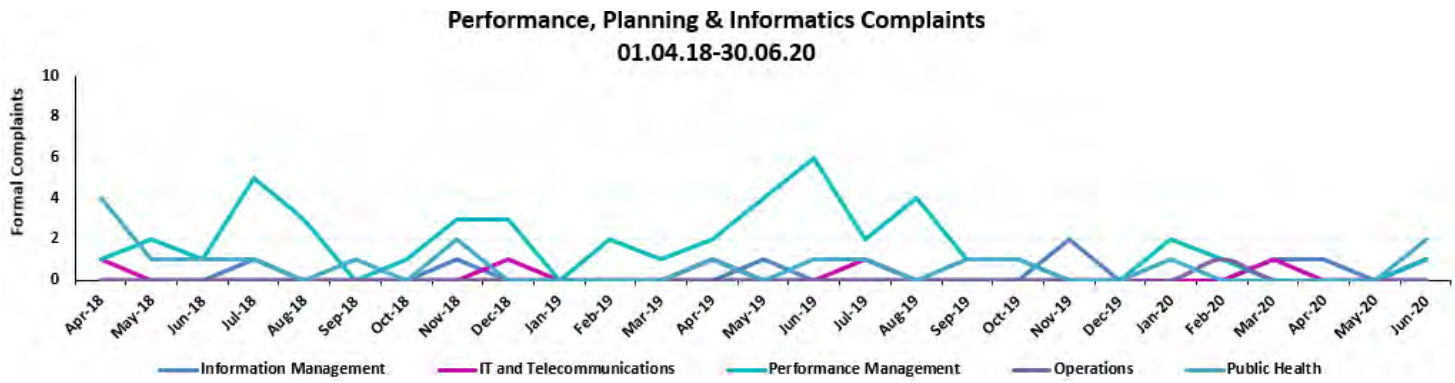





Unscheduled & Acute Care Complaints
01.04.18-30.06.20
Formal Complaints
Anaesthetics, Critical Care, Theatres & Sterile Services
Emergency Department, Medical & Cardiology Service
Imaging, Neuroscience, Medical Physics & Allied Health Professionals

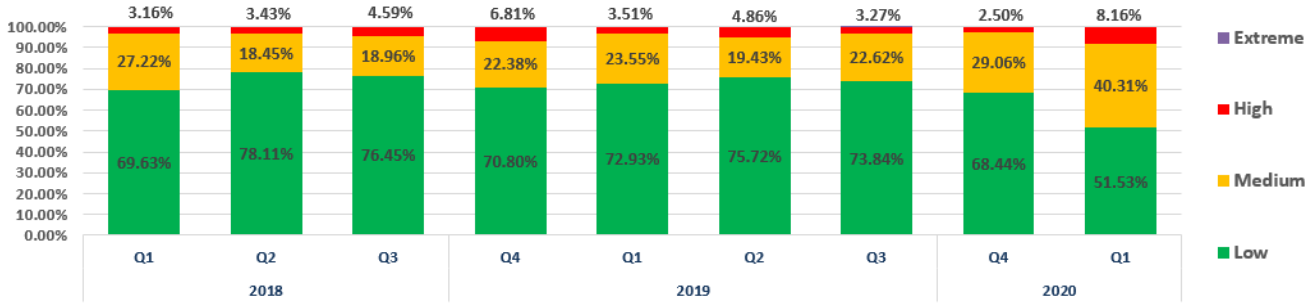

Finance, Estates & Capital Development Complaints
01.04.18-30.06.20
Formal Complaints
Accounting and Financial Services
Capital Development
Estates


Nursing & User Experience Complaints
01.04.18-30.06.20
Formal Complaints
Corporate Nursing
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
Central Nursing


Performance, Planning & Informatics Complaints
01.04.18-30.06.20
Formal Complaints
Information Management
IT and Telecommunications
Performance Management
Operations
Public Health

Formal Complaint Grading:

Formal complaints are graded* according to the Regional Risk Matrix. Complaints Managers routinely review the initial grading, in conjunction with the Service Area, throughout the complaints process and grading may change following investigation. A total of **16** High Risk, and **0** Extreme Risk complaints were received during the Quarter.



High Risk Summary – Quarter 1 2020-21

Directorate	Division	Specialty	Subjects	Description
Adult Social and Primary Care	Adult Community & Older People's Services	Commissioned Services	Aids/ Adaptions/ Appliances, Quality of Treatment & Care	C26668 - Complaint regarding placement of complainant's father (now deceased – COVID-19) in a care home where complainant has stated concerns existed in relation to PPE.
		District Nursing	Quality of Treatment & Care, Staff Attitude/ Behaviour	C26656 - Complaint regarding care provided to complainant's father (now deceased) – patient injured during catheter insertion at home. Patient was subsequently transferred by ambulance to RVH ED but died later that night.
		PHD and Sensory Support	Professional Assessment of Need, Communication/ Information, Quality of Treatment & Care	C26715 - Complaint re transfer of complainant's mother to a residential care home where patient contracted COVID-19 and also experienced a fall which resulted in a severe head injury and consequent admission of patient to hospital. Patient had previously fallen while an inpatient in BCH (resulting in a broken wrist) and again in the care home in which she had initially been placed.
		Older Peoples Services	Quality of Treatment & Care Communication / Information Quantity of Treatment & Care	C26839 - Complaint regarding treatment and care provided to complainant's father (now deceased – COVID-19) in Mount Lens Care Home. Complaint raises issues in relation to procedures in the event of patient falls; hygiene; food and nutrition; and communication and guidance for the family.
Specialist Hospitals & Women's Health	Trauma, Orthopaedics & Rehab Services	Trauma (Fractures)	Waiting List, Delay/ Cancellation Planned Admission to Hospital	C26605 - Complaint regarding death of complainant's wife following infection developed under leg cast – review appointment cancelled by patient due to patient being unwell.
	Child Health Services	Children's Hospital (RBHSC)	Quality of Treatment & Care, Staff Attitude/ Behaviour, Communication/ Information	C26799 - Complaint regarding treatment and care provided to patient's son (now deceased) in the Children's Haematology Unit.
	Maternity, Dental, ENT & Sexual Health Services	Maternity Services	Quality of Treatment & Care Communication / information	C26664 - Complaint regarding treatment and care provided to complainant in relation to early pregnancy loss.

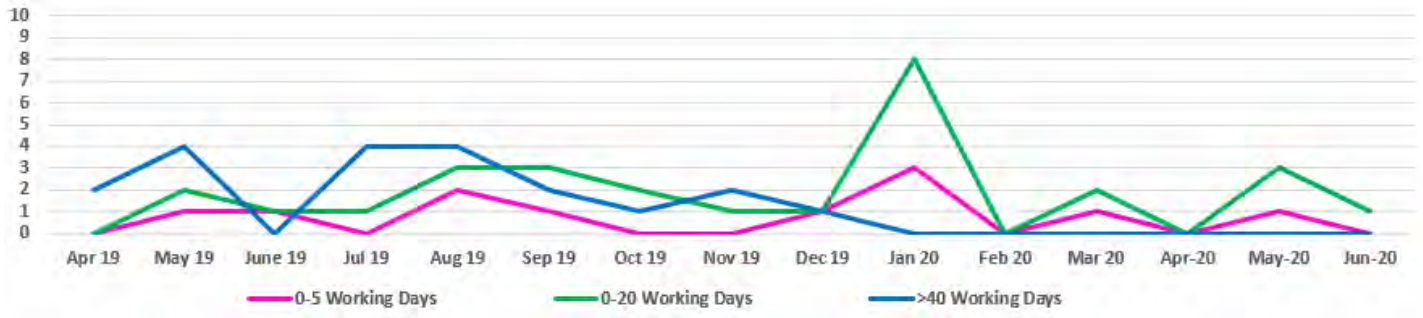
Directorate	Division	Specialty	Subjects	Description
Surgery & Specialist Services	Cancer & Specialist Medicine	Medical and Clinical Oncology	Quality of Treatment & Care, Staff Attitude/ Behaviour, Communication/ Information	C26793 - Complaint regarding treatment and care provided to patient (now deceased) in BCH Cancer Centre. Complaint raises queries in relation to clinical decision making, and cites NICE Guidelines and private medical opinion to challenge aspects of the patient's treatment.
	Surgery	Surgery	Quality of Treatment & Care	C26827 - Complaint regarding death of complainant's mother following surgery in RVH.
			Quality of Treatment & Care	C26565 – Complaint regarding broad range of issues (52 questions) with care provided to complainant's sister (now deceased aged 43 years) in RVH Wards 6A and 6D, and MIH Ward F, Recovery Ward and ICU. Family believe delays in treatment caused death of patient.
	Cancer & Specialist Medicine	Medical and Clinical Oncology	Quality of Treatment & Care Communication / information Staff attitude / behaviour	C26729 - Complaint regarding decision-making process in relation to chemotherapy treatment for complainant's mother-in-law (now deceased).
Unscheduled and Acute Care	Emergency Dept, Medical & Cardiology Services	General Medicine	Quality of Treatment and Care, Other	C26814 - Complaint re treatment & are provided to complainant's wife (now deceased) during the year prior to her death. Complaint raises concerns in relation to cardiology and respiratory services as well as issues with GP and SEHSCT.
			Quality of Treatment & Care Communication / information	C26688 - Concerns raised regarding decision-making in relation to critical care / ventilation for complainant's mother (now deceased – COVID-19) in Ward E, MIH.
			Quality of Treatment & Care	C26571 - Complaint re treatment & care provided to complainant's mother (now deceased, aged 57 years) by ED, General Medicine and General Surgery. Patient developed septic shock following bowel surgery which resulted in ICU admission and subsequent death. Complaint also raised issues regarding treatment and care and delayed results on the part of the patient's GP, and a lack of communication from general medicine.
			Quality of Treatment & Care	C26674 - Complaint re treatment and care provided to complainant's father (now deceased). Family state that failures in treatment and care (including delayed cancer diagnosis, catheterisation of patient against family's wishes, and delay in commencing antibiotics on ward) contributed to patient's death.
		Emergency Departments	Quality of Treatment & Care	C26734 - Complaint re treatment & care provided to complainant's son (now deceased) in MIH ED. Patient was discharged from ED but re-presented 2 days later when an inoperable brain tumour was diagnosed. Patient died the following day.
			Quantity of Treatment & Care	C26763 - Complaint regarding treatment and care provided to complainant's brother (now deceased) in RVH ED. Patient was discharged from ED to await a previously requested urgent ENT appt. Patient died 2 weeks later*

** case not included in formal consented complaints figures for Q1 as consent only received Jul 20*

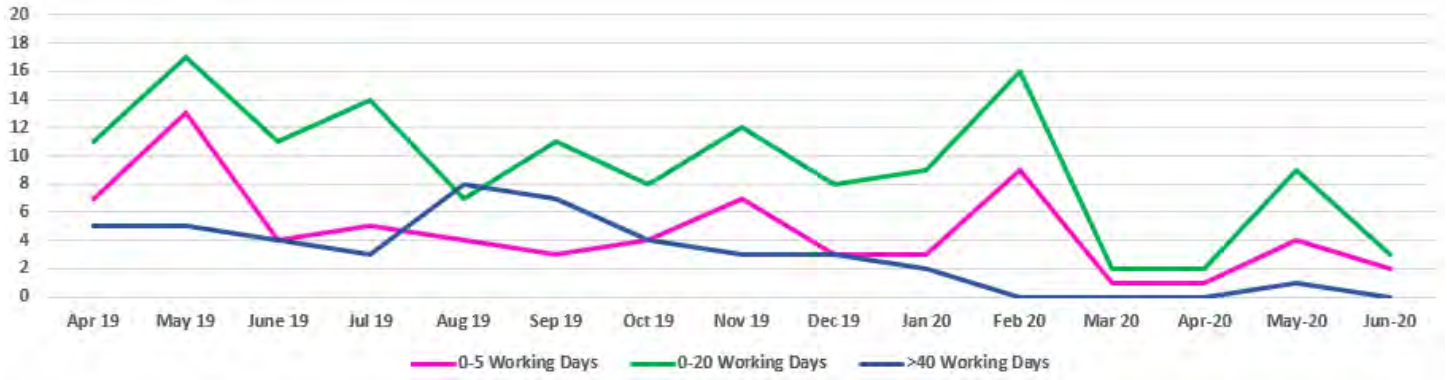
KPI 1: Increase in number of complaints resolved ≤ 5 working days
KPI 2: Increase in number of complaints resolved ≤ 20 working days
KPI 3: Decrease in complaint resolved > 40 working days

Specialist Hospitals & Women's Health – Response Times

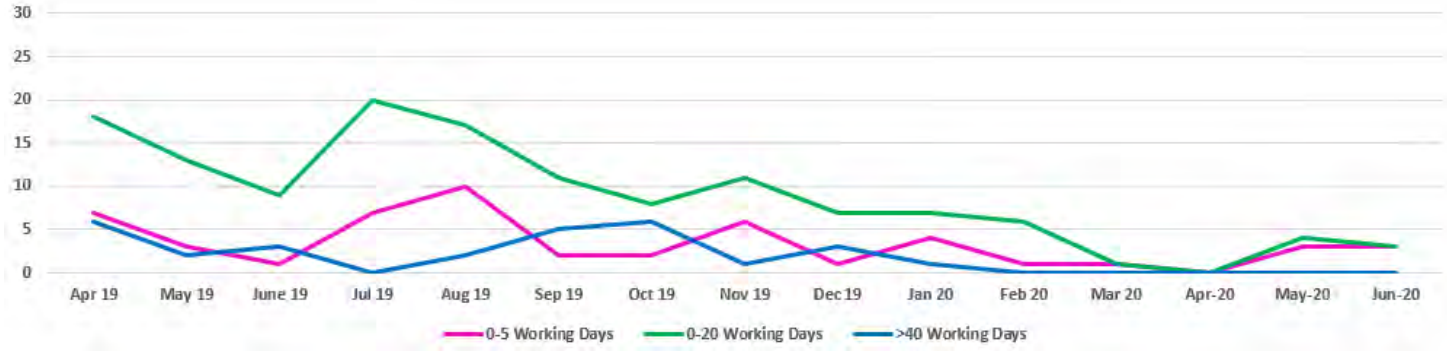
Child Health Services Q1 20-21:



Maternity, Dental, ENT & Sexual Health Services Q1 20-21:

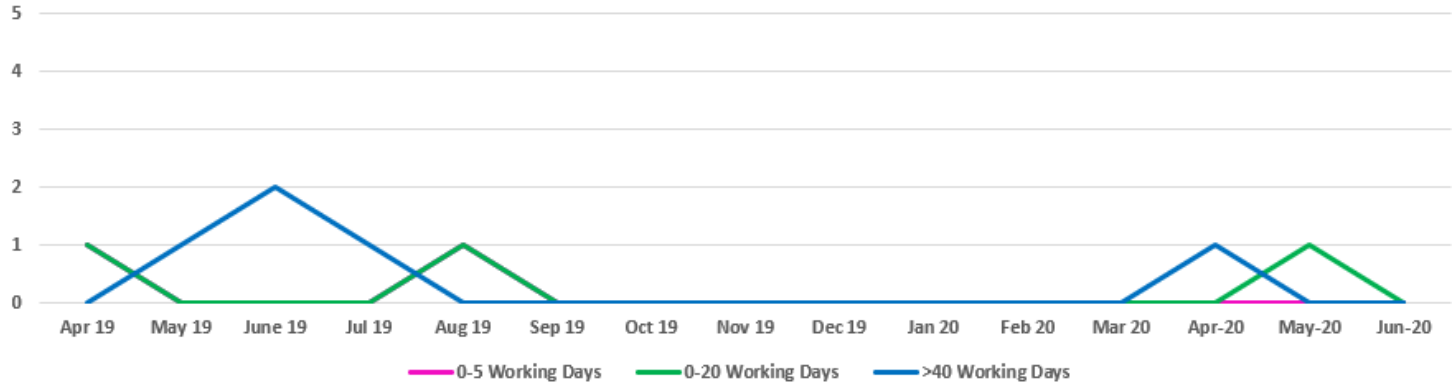


Trauma, Orthopaedics & Rehabilitation Services Q1 20-21:

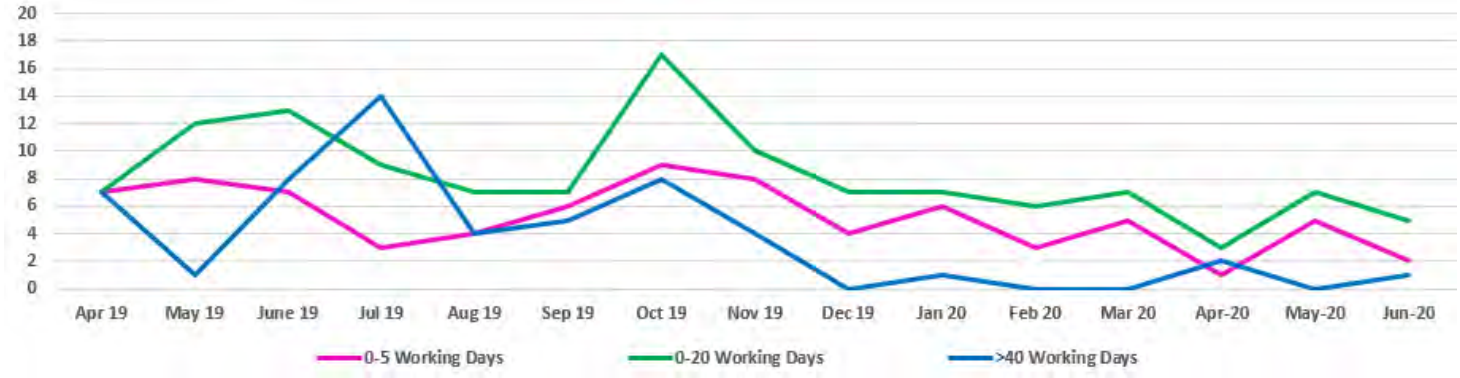


Unscheduled and Acute Care – Response Times

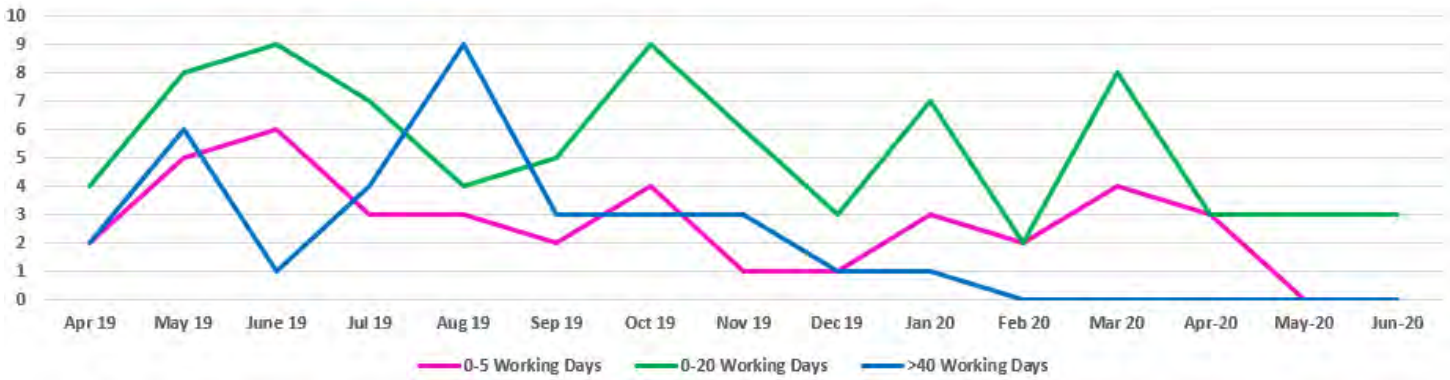
Anaesthetics, Critical Care, Theatres & Sterile Services (ACCTSS) Q1 20-21:



Emergency Departments, Medical & Cardiology Services Q1 20-21:



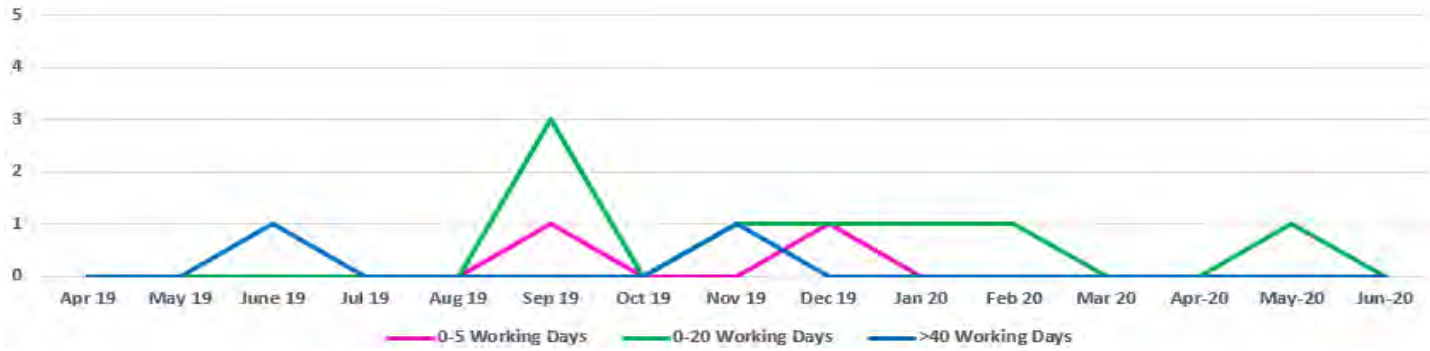
Imaging, Neuroscience, Medical Physics & Allied Health Professions Q1 20-21:



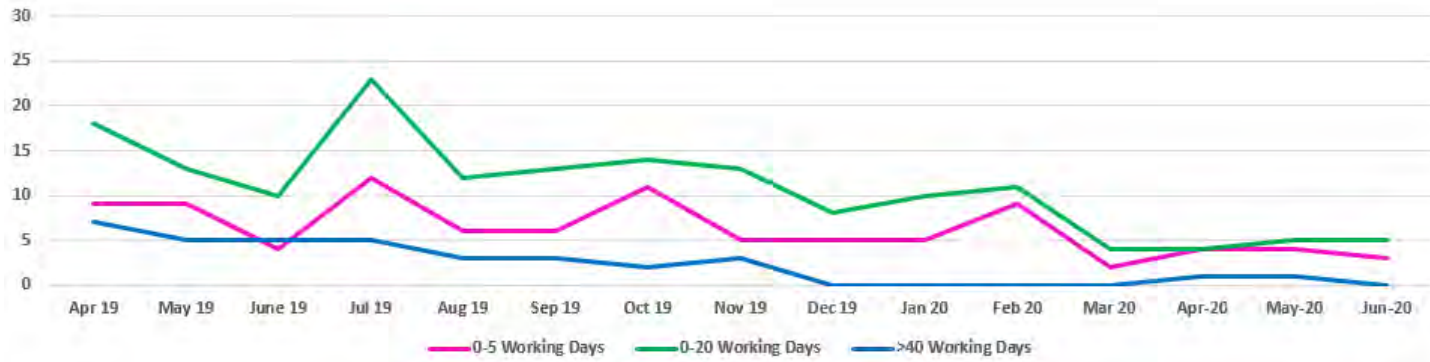
Surgery and Specialist Services – Response Times

Cancer & Specialist Services Q1 20-21:

Laboratories & Pharmacy Q1 20-21:

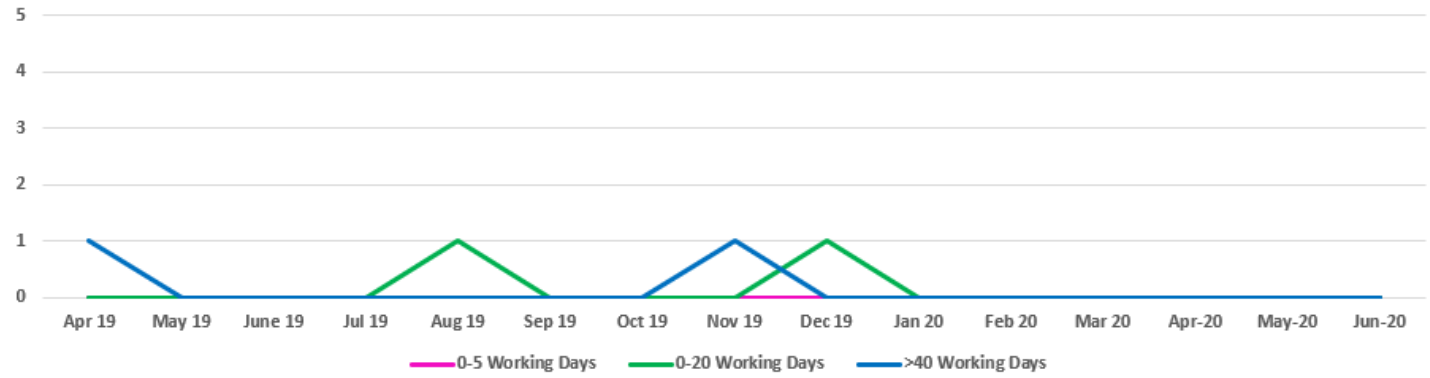


Specialist Surgery Q1 20-21:

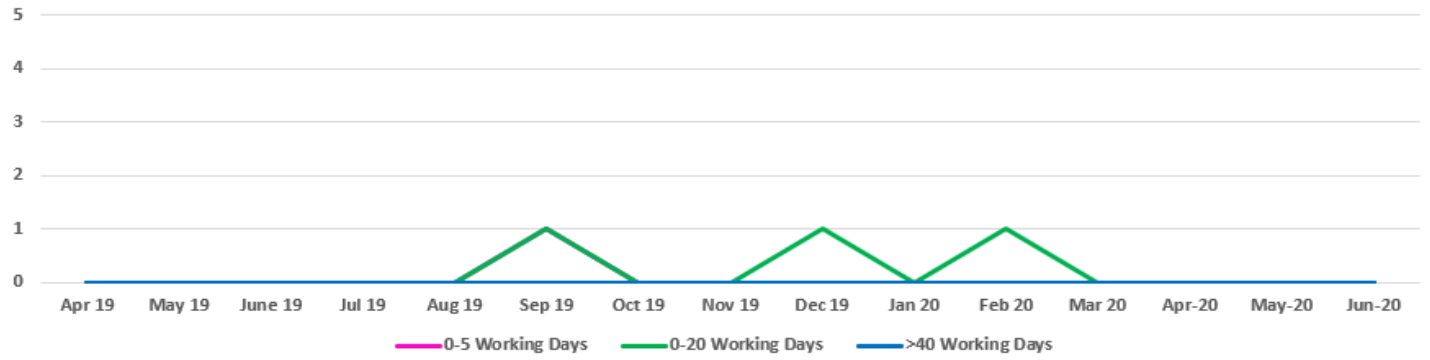


Children's Community Services – Response Times

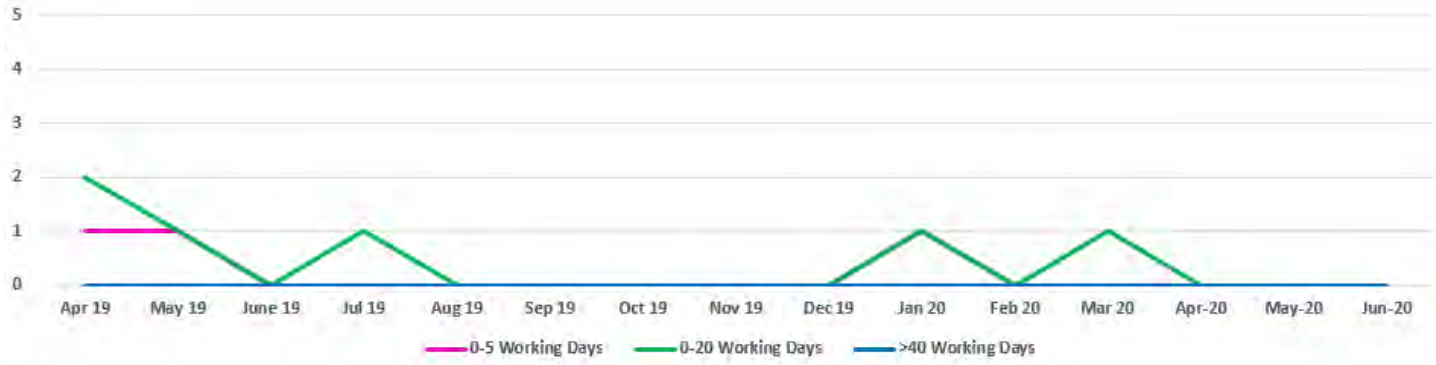
Children With Disabilities Q1 20-21:



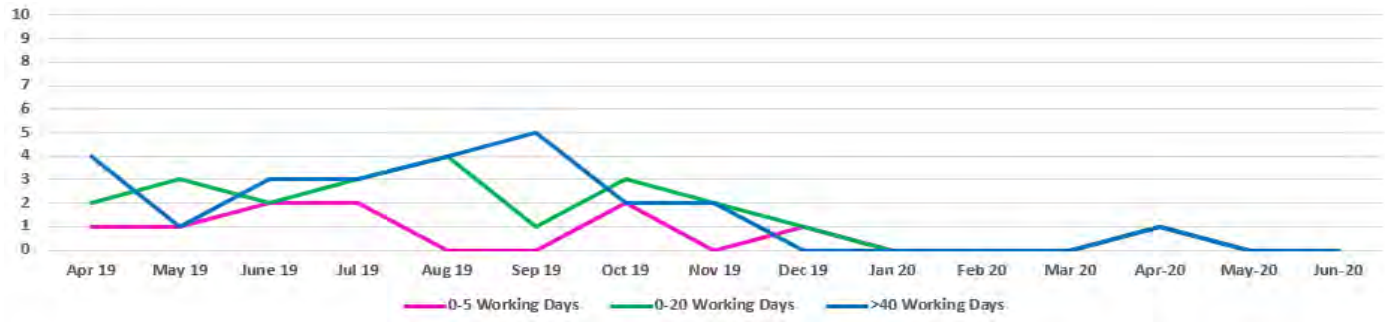
Children's Community Services Admin Q1 20-21:



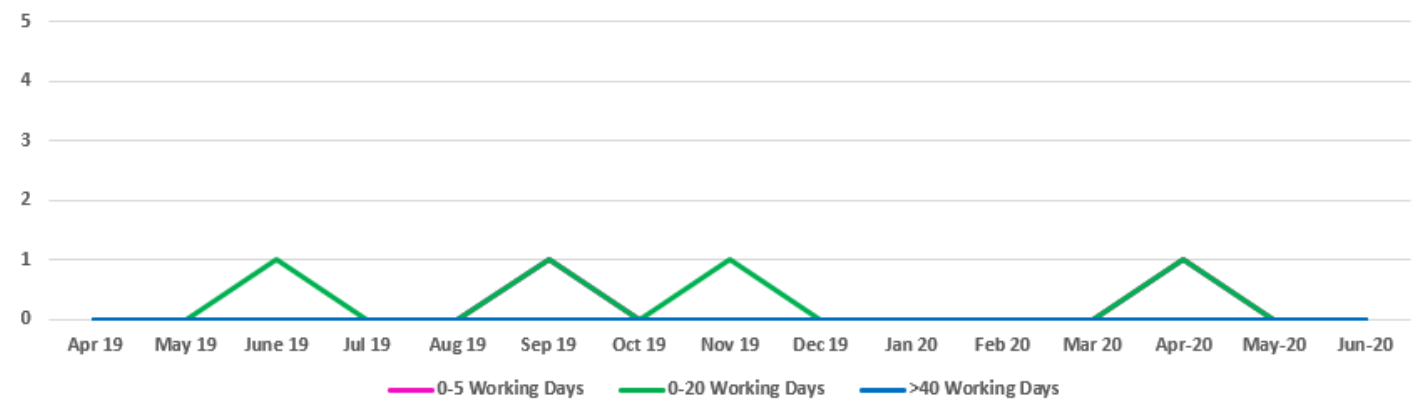
Community Child Health Q1 20-21:



Family & Child Care Q1 20-21:

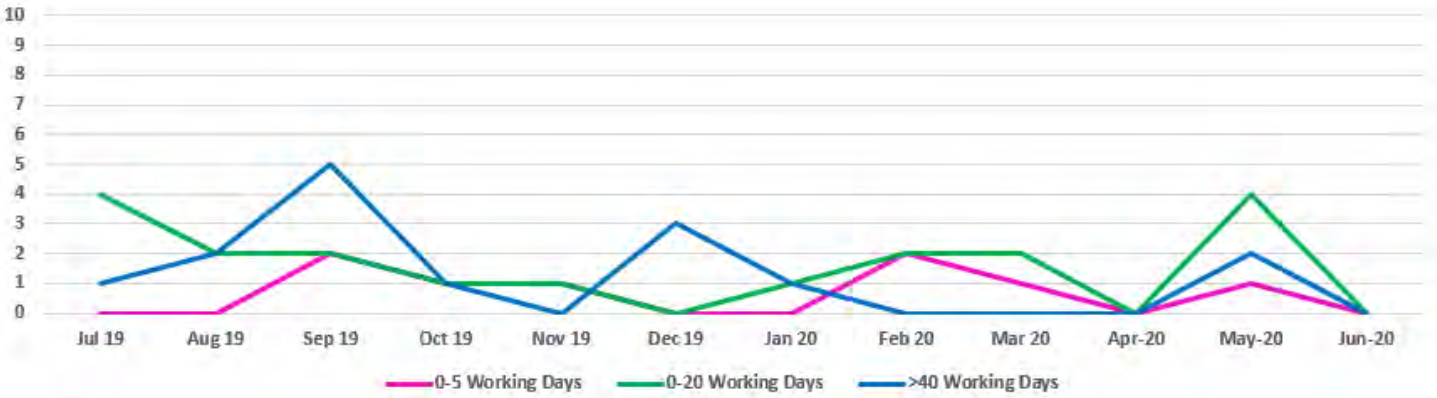


Regional Emergency Social Work Service (RESWS) Q1 20-21:



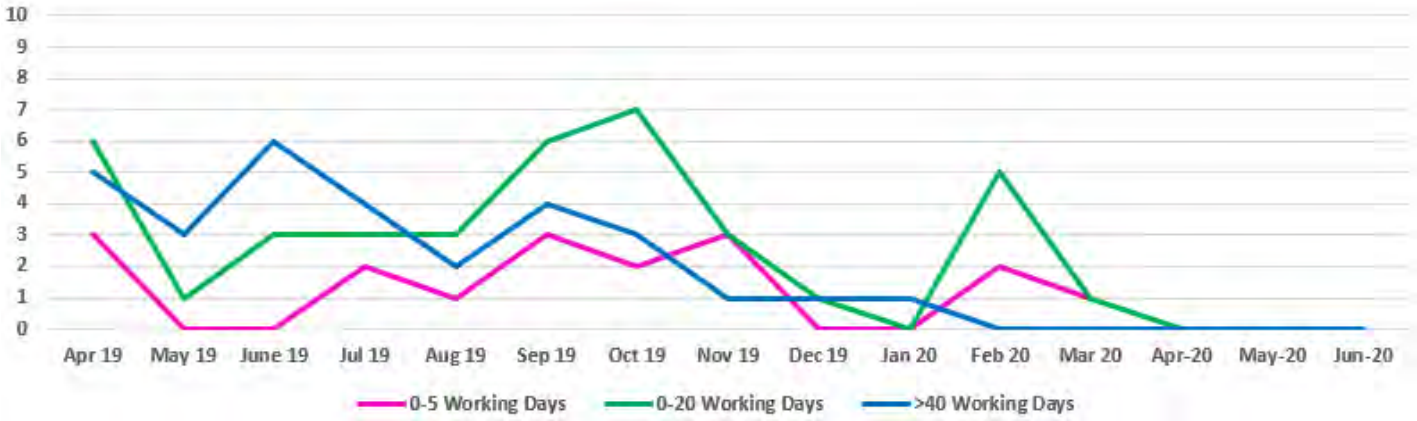
Adult Social and Primary Care – Response Times

Older People, Physical & Sensory Disability Services (ACOPS) Q1 20-21:

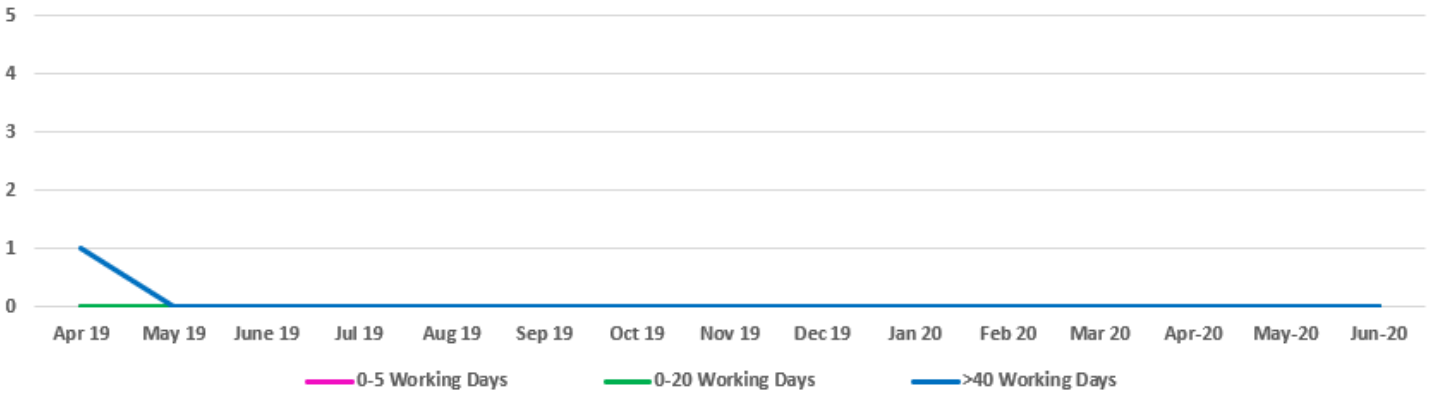


Learning Disability Q1 20-21:

Mental Health Q1 20-21:

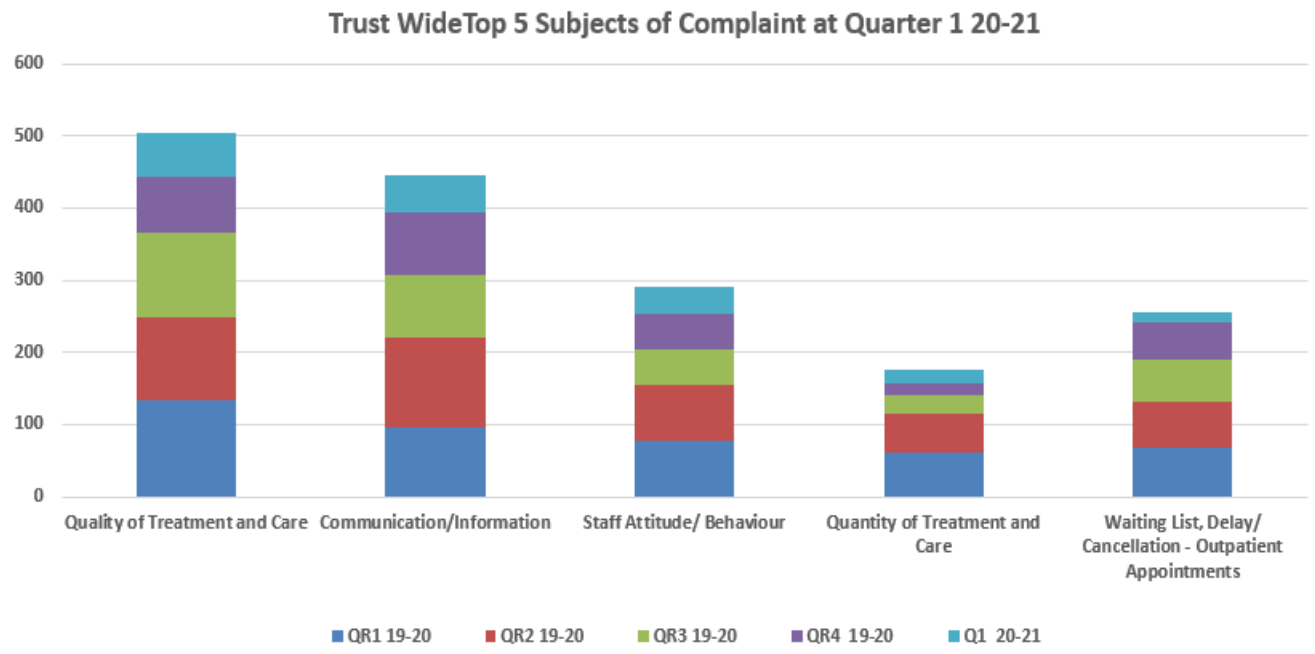


Psychological Services Q1 20-21:



KPIs 4 & 5 - Subjects of Formal Complaints:

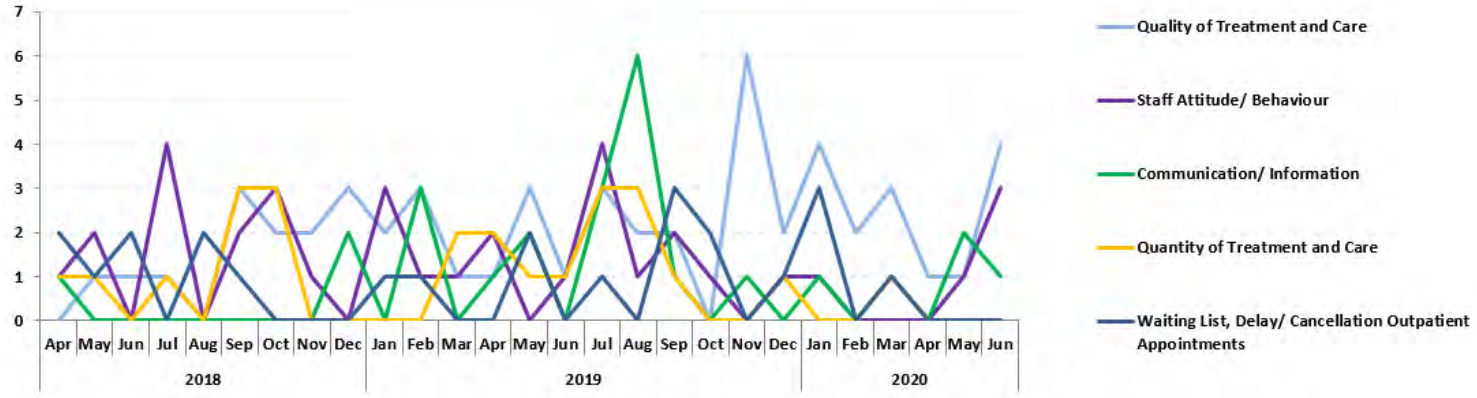
Top 5 Subjects Trust wide Q1 (251 Subjects raised in QR1 across 196 Complaints)	QR1 19-20	QR2 19-20	QR3 19-20	QR4 19-20	Q1 20-21
Quality of Treatment and Care	133	115	117	77	62
Communication/Information	96	125	86	87	52
Staff Attitude/ Behaviour	78	76	51	49	37
Quantity of Treatment and Care	60	55	26	17	19
Waiting List, Delay/ Cancellation - Outpatient Appointments	68	64	57	52	14



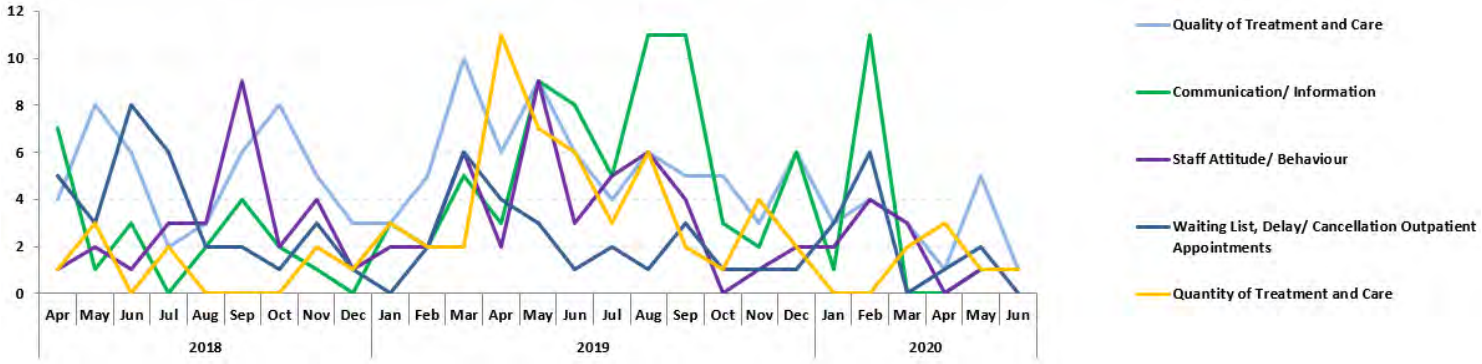
KPI 4 & 5 - Subjects of Formal Complaints by Division:

Specialist Hospitals & Women's Health Divisional Top Subjects 01Apr18 – 30Jun20

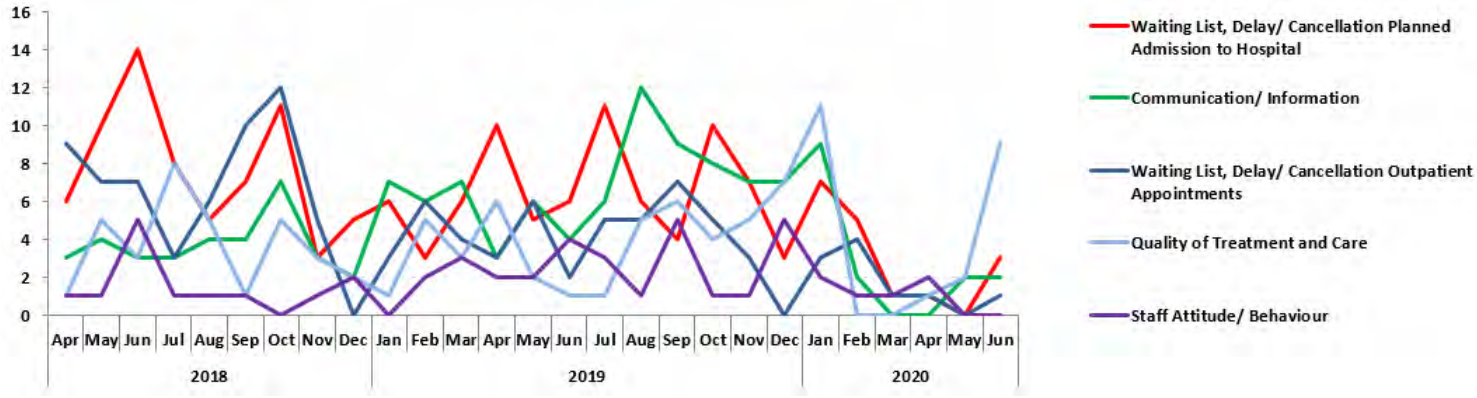
Child Health Services



Maternity, Dental, ENT & Sexual Health Services

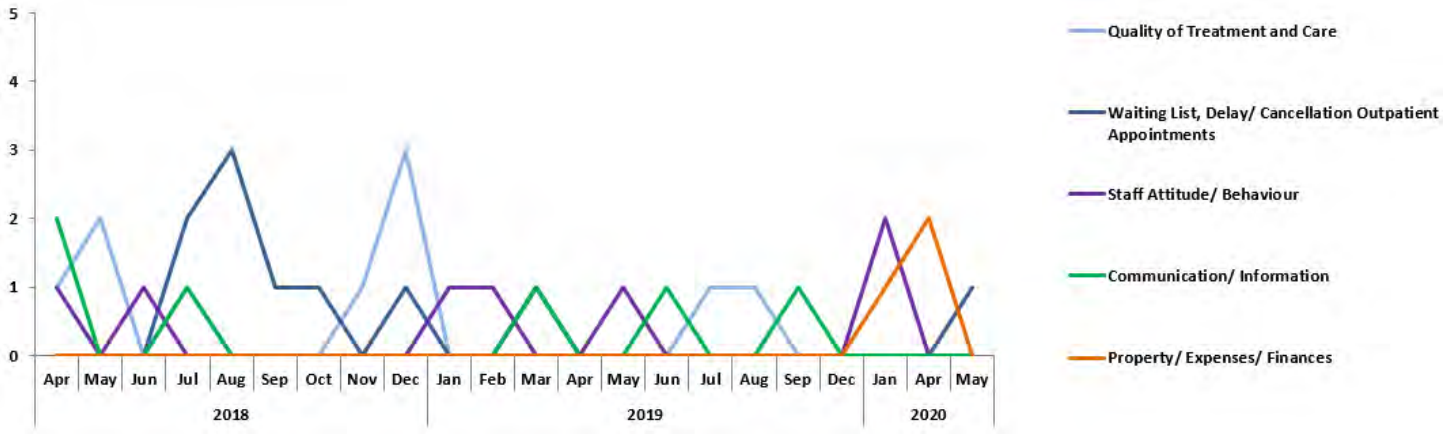


Trauma, Orthopaedics & Rehabilitation Services

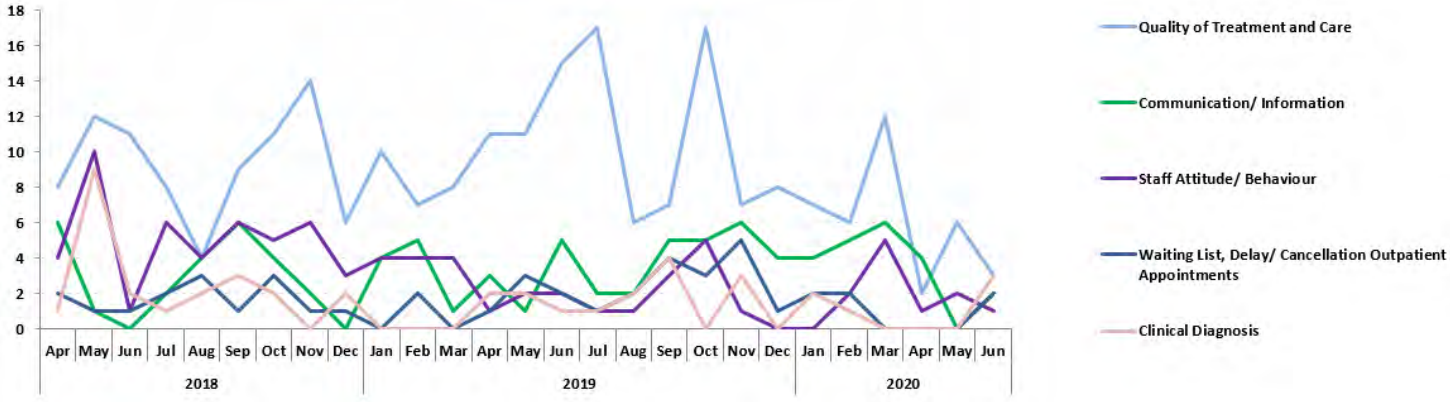


Unscheduled and Acute Care – Divisional Top Subjects 01Apr18 – 30Jun20

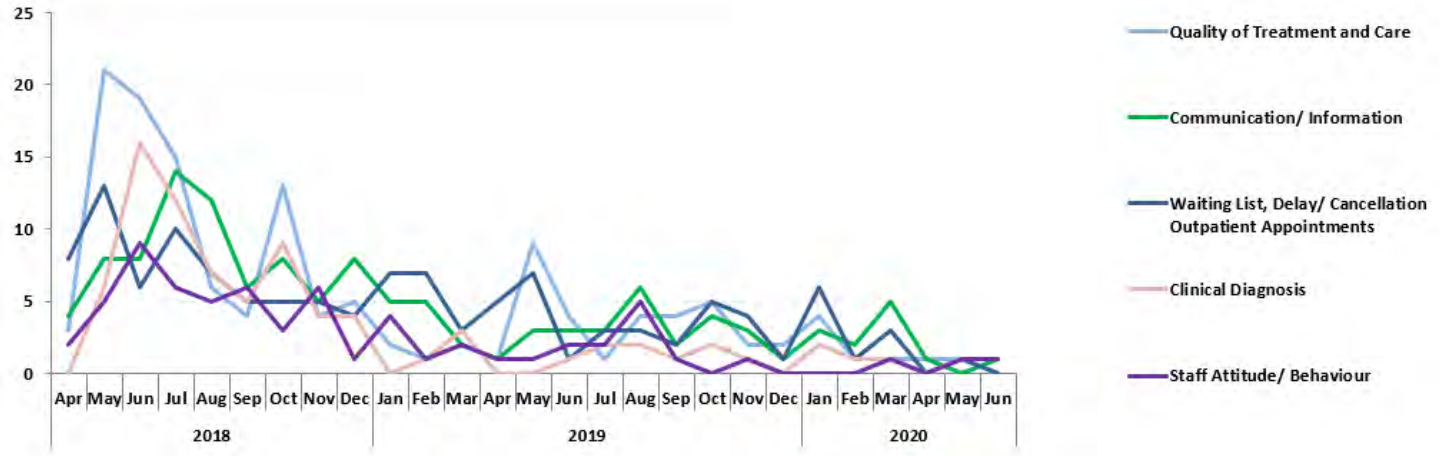
ACCTSS



Emergency Dept, Medical & Cardiology Services

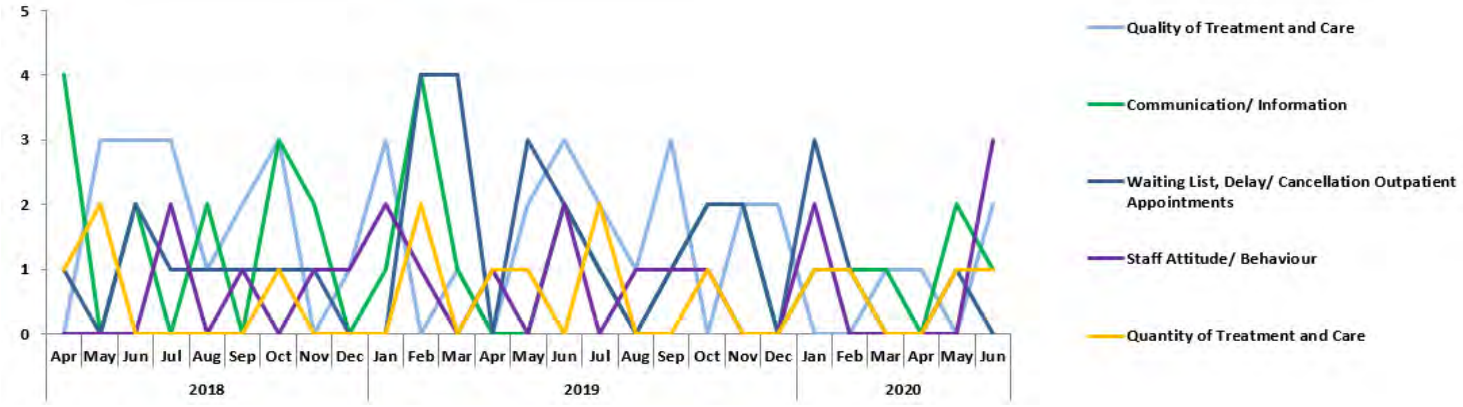


Neurosciences, Imaging, Medical Physics and Allied Health Professions



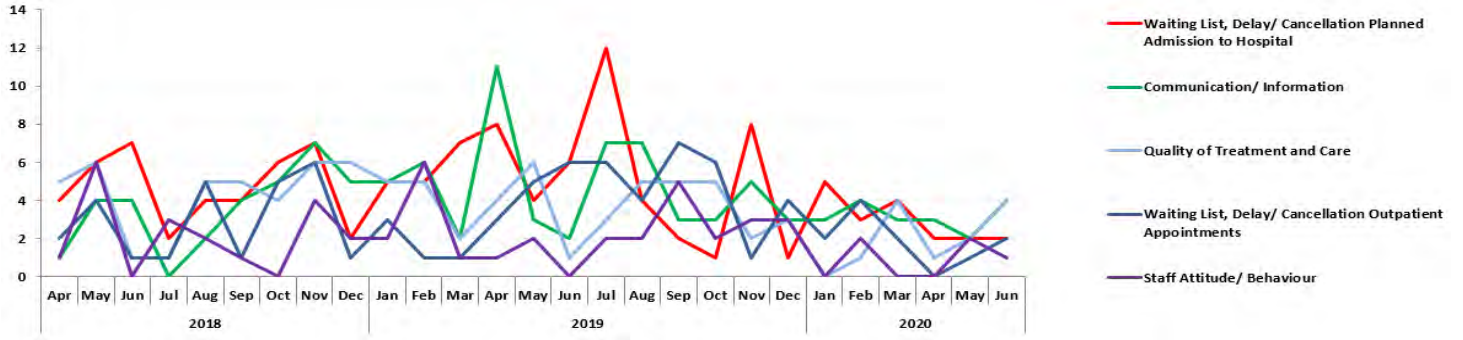
Surgery and Specialist Services – Divisional Top Subjects 01Apr18 – 30Jun20

Cancer & Specialist Medicine

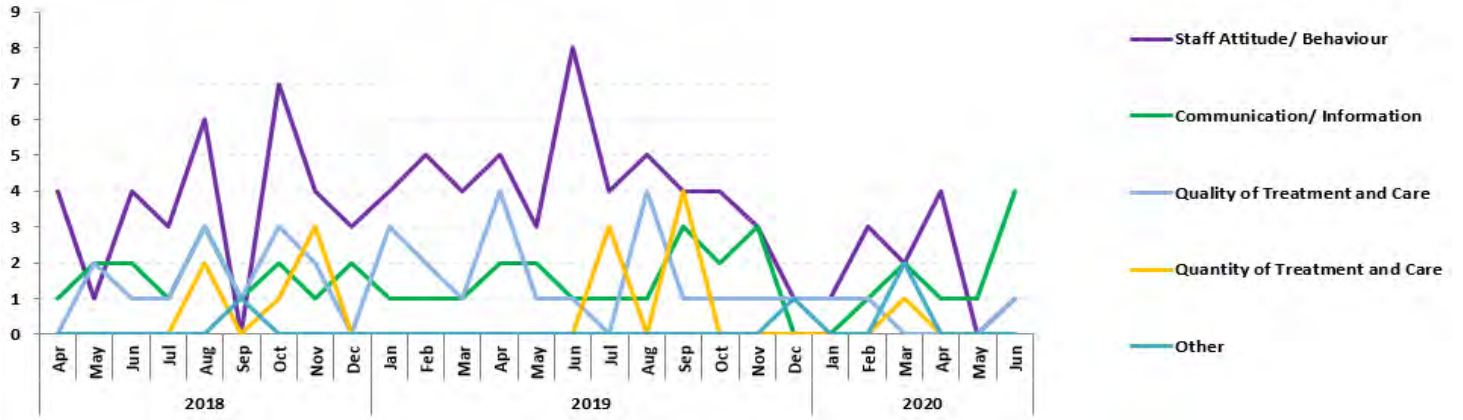


Laboratories & Pharmacy

Surgery

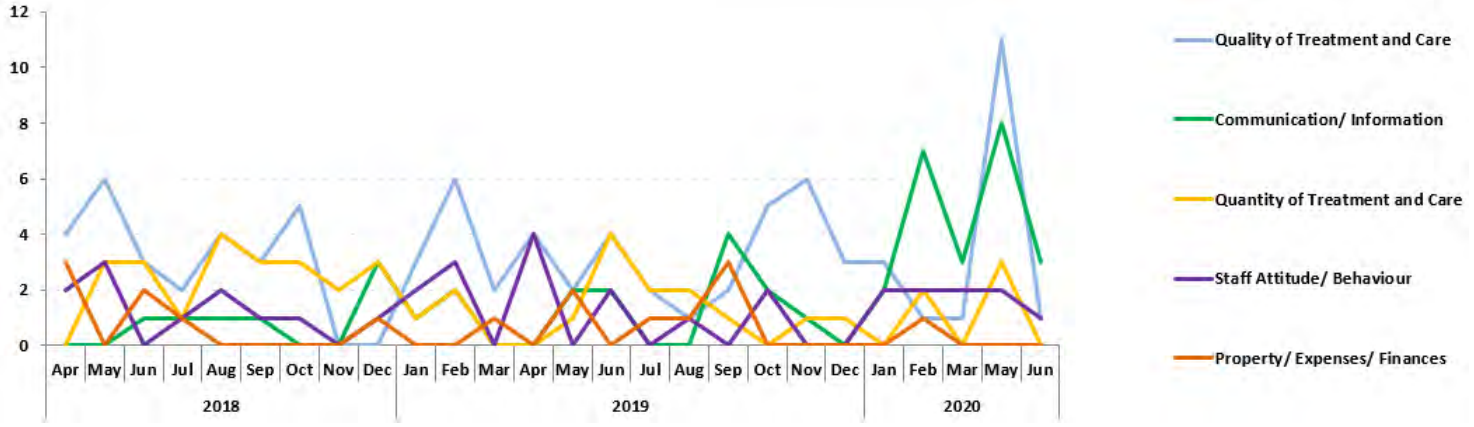


Children's Community Services –Top Subjects 01Apr18 – 30Jun20

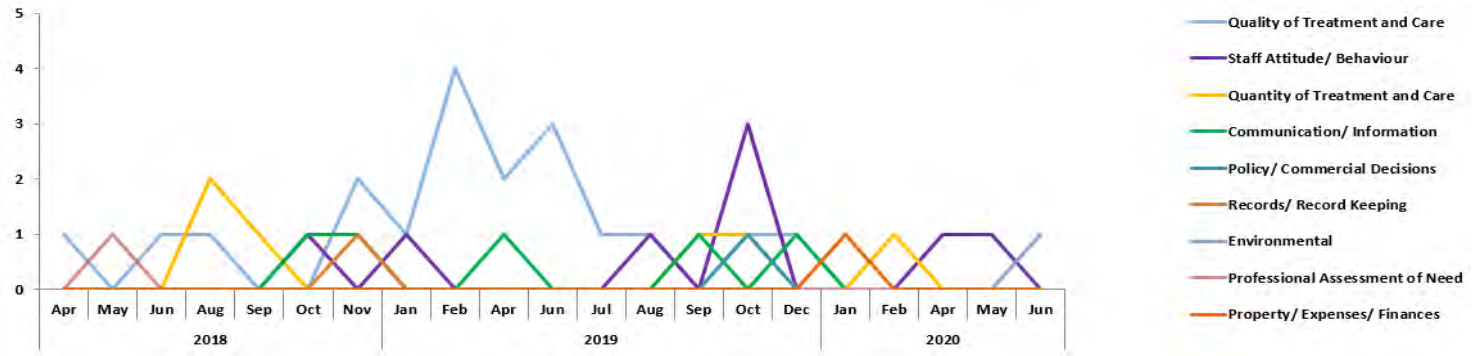


Adult Social and Primary Care – Divisional Top Subjects 01Apr18 – 30Jun20

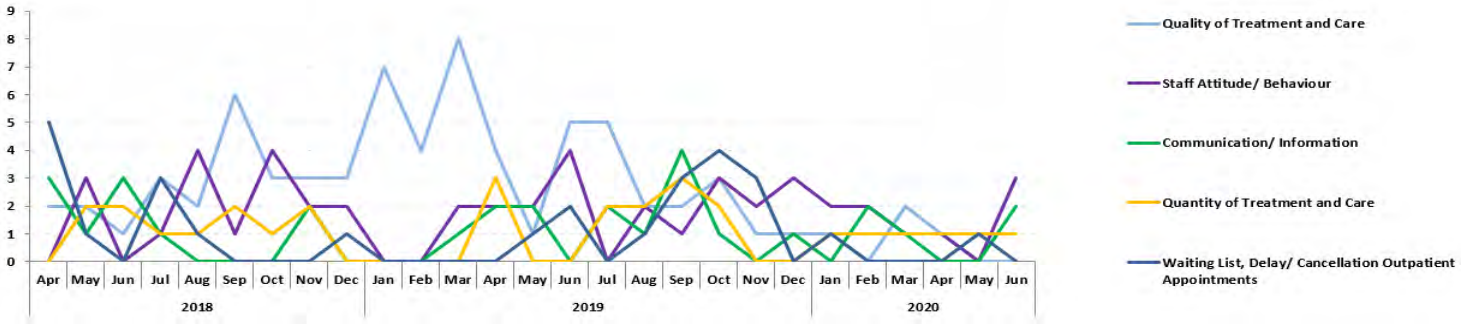
Adult Community and Older People Services



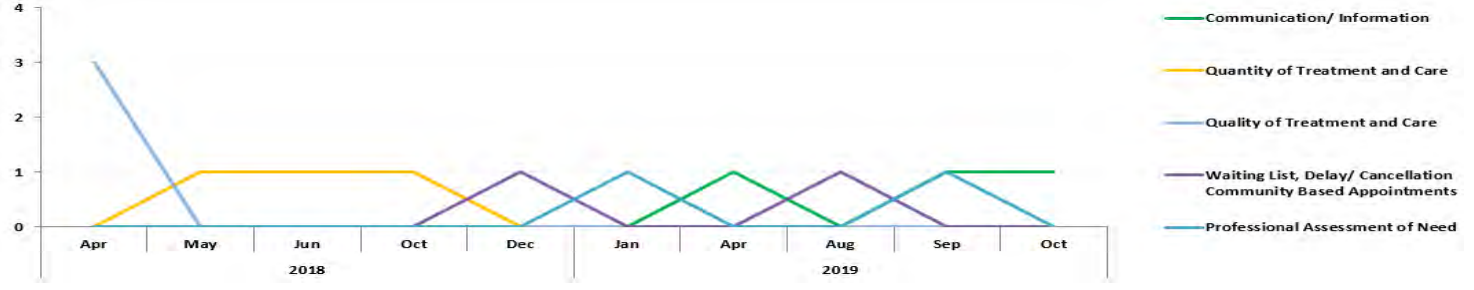
Learning Disability



Mental Health



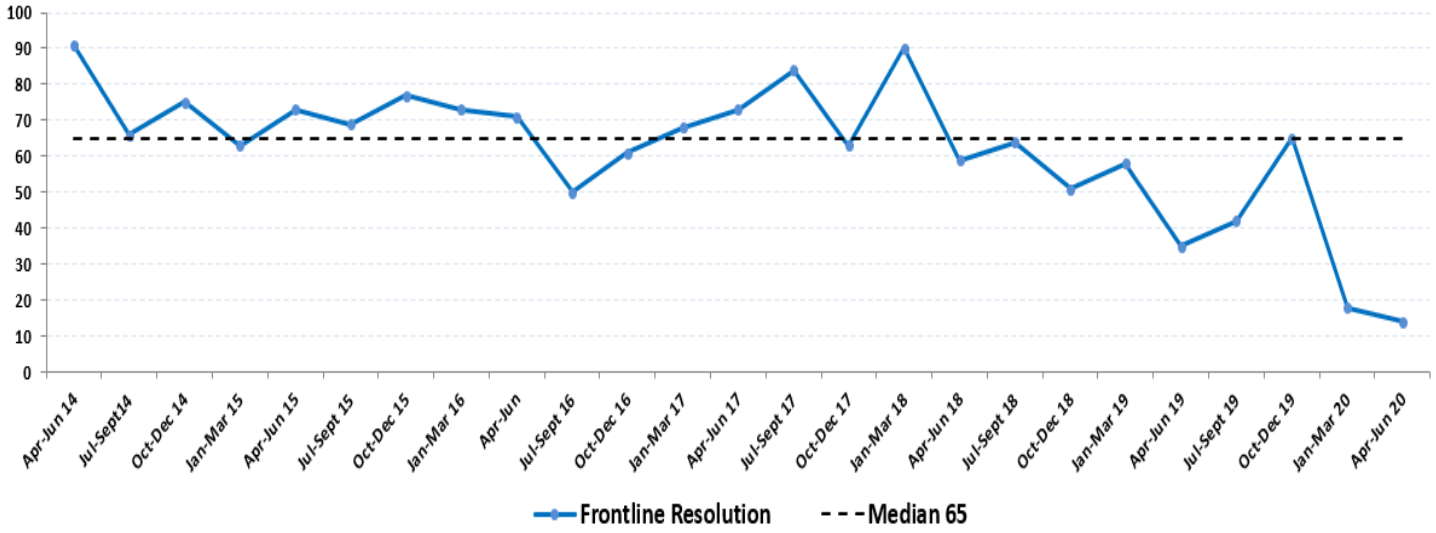
Psychological Services



KPI 6 - Frontline Resolutions

The Trust encourages staff to resolve concerns at “first point of contact”. Service users may subsequently request that their concerns are further investigated formally under the HSC Complaints Procedure.

Frontline Resolutions formally reported to Complaints Team 2014-2020:



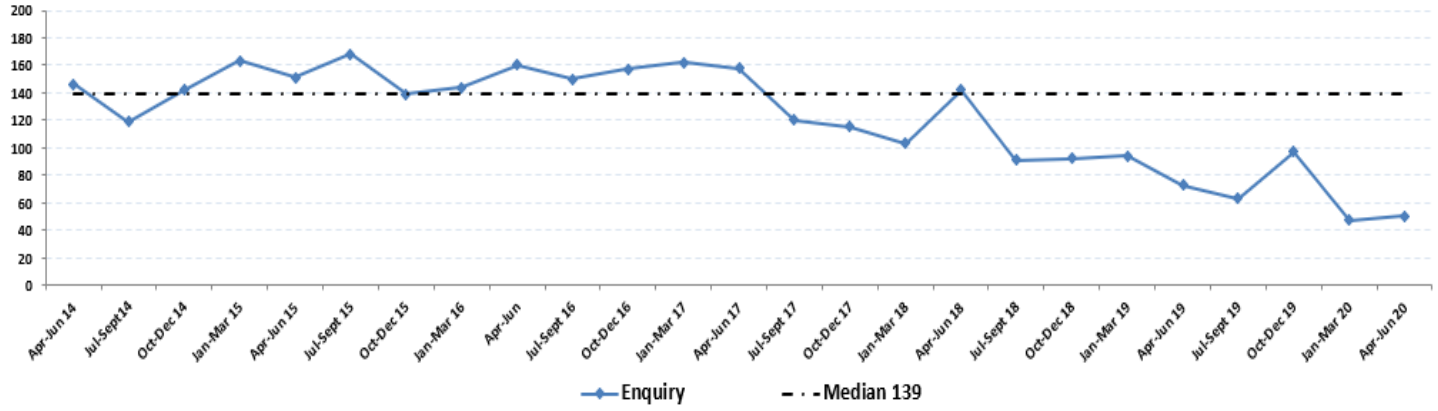
KPI 7 – Revisited Complaints:

Formal complaints may be revisited within the quarter in which they are opened and closed, or beyond the initial quarter. Reasons for revisiting complaints can include: disagreement with the response provided, request for additional information, request for further investigation, request to meet with Trust staff and other stakeholders.

Formal Complaints Revisits during Q1 20-21	High	Medium	Low	TOTAL
Adult Social and Primary Care	**1**	**2**	**4**	**7**
Mental Health	0	1	3	4
Older Peoples Services	1	0	1	2
PHD and Sensory Support	0	1	0	1
Children's Community Services	**0**	**3**	**0**	**3**
Family and Child Care	0	3	0	3
Finance	**0**	**0**	**2**	**2**
Accounting and Financial Services	0	0	2	2
Specialist Hospitals & Women's Health	**3**	**6**	**2**	**11**
Acute and Community Paediatrics	1	2	0	3
ENT Services	0	1	0	1
Trauma and Orthopaedics	1	1	2	4
Women's and Maternity	1	2	0	3
Surgery and Specialist Services	**0**	**1**	**1**	**2**
Surgery	0	1	1	2
Unscheduled and Acute Care	**3**	**1**	**7**	**11**
Emergency Dept, Medical & Cardiology Services	2	0	5	7
Neurosciences	1	1	2	4
TOTAL	**7**	**13**	**16**	**36**

Enquiries

"**Enquiries**" are issues or concerns which are not subject to the HSC Complaints Procedure. Examples include queries about position on a waiting list, clients unable to contact specific wards/departments and clients who specifically request that their concerns are not dealt with as a complaint. A total of **50 enquiries** were received during Quarter 1 2020-21.



Enquiries – By Directorate and Top 5 Subjects – Quarter 1 2020-21:

Q1 20-21 Enquiry Subjects	Specialist Hospitals & Women's Health	Unscheduled and Acute Care	Surgery and Specialist Services	Adult Social and Primary Care	Human Resources	Children's Community Services	Nursing and User Experience	Performance, Planning & Informatics	TOTAL
Staff Attitude/ Behaviour	2	0	1	2	4	1	2	1	13
Communication/ Information	3	6	2	1	0	1	0	0	13
Waiting List, Delay/ Cancellation Outpatient Appointments	4	1	0	0	0	0	0	0	5
Quality of Treatment and Care	0	2	1	2	0	0	0	0	5
Waiting List, Delay/ Cancellation Planned Admission to Hospital	2	0	2	0	0	0	0	0	4
Other	0	0	1	1	0	0	0	0	2
Confidentiality	0	1	0	0	0	1	0	0	2
Infection Control	1	0	0	0	1	0	0	0	2
Quantity of Treatment and Care	0	0	1	1	0	0	0	0	2
Policy/ Commercial Decisions	0	0	1	0	0	0	0	0	1
Waiting List, Delay/ Cancellation Community Based Appointment	0	0	0	1	0	0	0	0	1
Professional Assessment of Need	0	0	0	1	0	0	0	0	1
TOTAL	**12**	**10**	**9**	**9**	**5**	**3**	**2**	**1**	**51**

Independent Sector Complaints

When an Independent Sector Provider (ISP) complaint is received by the Trust, the ISP is given the opportunity in the first instance to respond to the Complainant, although the Complainant can specifically request that the Trust investigates their concerns. Work continues within the Trust and regionally on how best to manage and monitor ISP complaints.

Five ISP formal complaints were noted during quarter 1. This related to four different nursing homes. The complaints department continues to liaise with the team for Commissioned Services in relation to ISP complaints.

Compliments

The DoH requires HSC Trusts to formally report the number and subjects of all written compliments received each quarter. As such, Service Areas are required to report compliments received within the following categories to the Complaints Team:

Quality of Treatment & Care
Staff Attitude & Behaviour
Communication & Information
Environment
Other

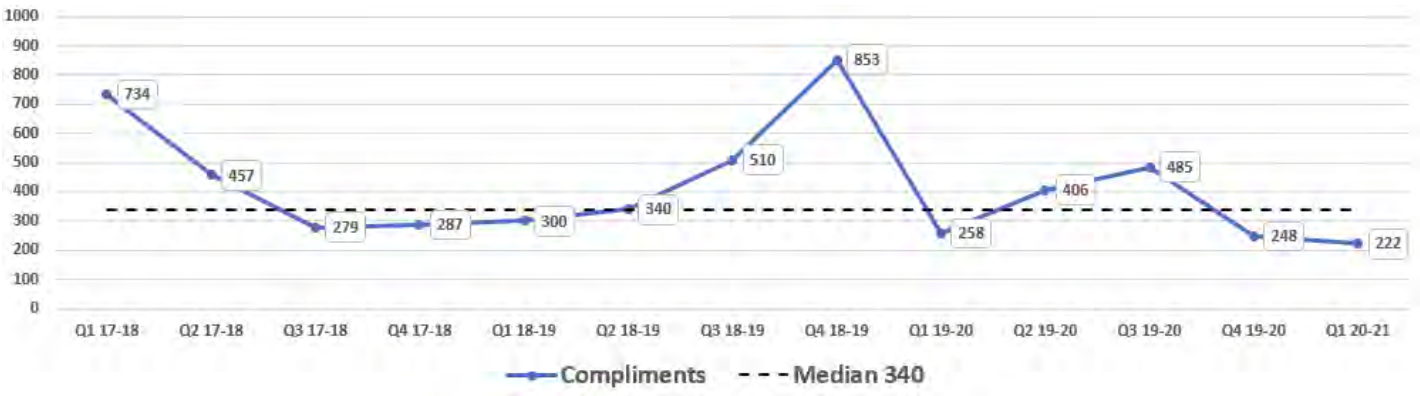
A dedicated e-mail box is in place to facilitate submission of compliments by wards and departments for inclusion in the required reports to DoH (compliments@belfasttrust.hscni.net) and *pro formas* for staff to record compliments are available via the Trust Intranet (the Hub).

The Care Opinion platform launched within the region during August 2020. The Complaints Department is presently liaising with the Trust Care Opinion Facilitator in order to integrate compliments from this platform into the Trust return to evidence additional positive feedback.

Formally reported Compliments by Directorate Q1 2017 – Q12020:

Adult Social & Primary Care Compliments

Specialist Hospitals & Women's Health Compliments



Surgery & Specialist Services Compliments

Children's Community Services Compliments

Unscheduled & Acute Care Compliments

2.046

Belfast Health and Social Care Trust
caring supporting improving together

Minutes of the Confidential Trust Board Meeting Held on 3 September, 2015 at 09.00 am in the Boardroom, Trust Headquarters Belfast City Hospital

PRESENT:

Mr Peter McNaney	Chairman
Professor Martin Bradley	Non-Executive Director
Dr Paddy Loughran	Non-Executive Director
Mr James O'Kane	Non-Executive Director
Dr Val McGarrell	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Michael McBride	Chief Executive
Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Dr Cathy Jack	Medical Director

IN ATTENDANCE:

Mr Brian Barry	Director Specialist Hospitals and Women's Health
Mr Shane Devlin	Director Performance, Planning and Informatics
Mr Damian McAlister	Director Human Resources/ Organisational Development
Ms Catherine McNicholl	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Specialist Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
sensitive & personal data	Service User
Mrs Caroline Parkes	Senior Manager, Complaints Department
Ms Marion Kerr,	Senior Investigating Officer NI Ombudsmen's Office
Mr Tom Flannery	Consultation Neurologist

APOLOGIES:

Mrs Miriam Karp,	Non Executive Director
Dr Val McGarrell	Non Executive Director
Ms Anne O'Reilly	Non Executive Director
Mr Cecil Worthington	Director Social Work/Children's Community Services

Mr McNaney opened the meeting and welcomed everyone with a special welcome to Dr Paddy Loughran attending his first meeting following his recent appointment as Non Executive Director.

Mr McNaney drew member's attention to agenda item 6 advising that the meeting would commence with this item and going forward there would be a regular and formal allocation of time to a service user story.

19/15 Service User Stories

Dr Jack gave an overview of the proposal to formalise 'Service User Stories' at Trust Board, highlighting this was an approach used widely across the NHS as a methodology to drive change and improve the quality of care. Dr Jack drew member's attention to a paper outlining the purpose and process, explaining proposed actions to ensure a representative and balanced programme of stories throughout a year. She advised of sources from which stories would be sought and highlighted methods of sharing these stories could be a Director or member of staff relating the story, a video or audio presentation, or as completed today, the service user may wish to provide their experiences directly to the Board themselves.

Dr Jack emphasised the importance of appropriate support for both services users and staff and described how this would be achieved, together with follow up processes and feedback.

Dr Jack highlighted the 'Service User Checklist for Boards' included in papers, stating it is intended to support both Executive and Non-Executive Board members in preparing for these items and acknowledged this was a document adapted with permission from the Brudett Nursing Trust (Patient Stories – checklist for Boards).

Following an opportunity to comment on the checklist Mrs McKeagney commented that she found it very helpful and welcomed it use.

In response to a comment from Mr O'Kane, Mr McNaney advised that Trust Board members would be provided with sufficient information in their papers to support preparation and provide context for stories.

Further discussion followed and Mr McNaney reiterated the purpose and the important link with assurance and the Board's role in adding to this.

a. Service user Story – sensitive & personal data

Mr McNaney explained that sensitive & personal data a complainant would be sharing the poor experience of her late husband and her family with the Trust Board. Mr McNaney provided a brief background to the case. He continued that sensitive & personal data would be supported by Mrs Caroline Parkes, Senior Manager Complaints and Ms Marion Kerr, Senior Investigating Officer NI ombudsman's office. Mr Flannery, Consultant Neurologist would also be attending to present service improvements established following the Ombudsman's Report.

At this point Mr McNaney left the meeting to personally accompany sensitive & personal data into the room.

Mr McNaney welcomed sensitive & personal data Mrs Parkes, Ms Kerr and Mr Flannery to the meeting. Following a brief overview of proceedings Mr McNaney invited sensitive & personal data to share the experiences of her late husband and her family.

sensitive & personal data provided Trust Board with a detailed and emotional account of the poor experience of services provided to her late husband and family during the last weeks of his live. Mr McNaney acknowledged how distressing this was and how saddened he was by this.

Mr Flannery proceeded to present a summary of improvements within Neuro – oncology to sensitive & personal data and Trust Board, many of which have been directly attributed to learning from the family's experiences.

19/15 (Contd.)

In closing Mr McNaney thanked sensitive & personal data for her openness and willingness to work with the Trust to ensure this didn't happen again, offering his sincere apology for the failings of the Trust. Mr McNaney said he hoped that hearing first hand of improvements may in some small way help reassure her and her family that the Trust had learnt from this and was working hard to prevent reoccurrence.

sensitive & personal data Mrs Parkes, Ms Kerr and Mr Flannery left the meeting.

Following a query from Mr O'Kane, Dr Jack provided further clarity and assurance around management of the complaint.

After further discussion, Mrs Welsh provided an update in relation to the complexity and challenges of successfully running Multi-Disciplinary Team (MDT) meetings. She highlighted findings from a recent MDT peer review, were also a priority to take forward, some of which were within the Trusts gift, some requiring additional funding and needing engagement with other organisations and commissioners.

In bringing the discussion to a close, Mr McNaney highlighted the need for Directors to regularly review complaints and consider appropriateness of responses. He acknowledged that a review was due to commence in relation to complaints management and advised he would want an item regarding management of complaints to return to the Trust Board once this review was complete.

20/15 Minutes of previous meeting

The minutes of the Trust Board meeting held on 4 June 2014 were considered and approved.

21/15 Matters arising

There no items raised

22/15 Chairman's business

a. Conflict s of Interest

There were no conflicts of interest reported.

b. Non Executive Director Appointments – Update

Mr McNaney updated Trust Board on progress in relation to appointment of new Non-Executive Directors and advised that Miriam Karp had now been appointed for a 4 year term commencing 1 September 2015.

Mr McNaney queried progress for the upcoming induction programme planned for newly appointed Non-Executive Directors. Mr McAlister confirmed this was progressing as expected and provided an overview of the agenda for the first session 16 September 2015.

23/15 Chief Executive's Report

a. Emerging Issues

i. ED Transfer to Critical Care Building

Dr McBride informed Trust Board that the ED, RVH had successfully transferred to the new Critical Care building on 19 August 2015. He continued that early indications suggested the new models of care were supporting an improvement in performance against targets and reduced admissions.

ii. Business Case – 100K Genomes Project – to develop a NI Genomic Medicine Centre

Mrs Welsh referred to the 100Kk Genomes Project a regional proposal, partially led by the NI Pathology Network and now with Belfast Trust as the lead and the organisation which will ultimately host the NI Genomic Medicine Centre (GMC). She advised that DHSSPS had requested the Trust to formally submit a business case.

Mrs Welsh explained the NIGMC would co-ordinate the collection of DNA and health records data for consenting patients with cancer and rare diseases. The sequencing of their genomes and analysis of records would mean that these patients will have a more rapid and accurate diagnosis and therefore a shorter pathway to appropriate treatment and care. Ultimately, patients should need fewer clinical appointments and the cost of testing will be reduced. The data will be included in a UK-wide anomyised data bank for analysis by disease specific Clinical Interpretation Partnerships (CIPs) to develop new tests and treatments that can be targeted to individual patient needs.

Mrs Welsh advised that the business case had to be submitted to DHSSPS with part of the funding also sought from Medical Research Council (MRC). MRC deadlines led to some haste in seeking approval for the business case. Due to the timing of Trust Board meetings over the summer the Chairman and Chief Executive had approved the business case for submission to DHSSPS in early July, subject to retrospective approval being given by Trust Board and advised she would be seeking such approval in the public meeting.

iii. Precision Medicine Catapult

Mrs Welsh referred to a recent announcement by the UK Government regarding the creation of a Precision Medicine Catapult and explained that this would be developed on a hub and spoke basis with five Centres of Excellence.

Mrs Welsh was delighted to report that Northern Ireland will be one of the Centres of Excellence, following a successful bid to the sponsoring organisation Innovate UK. She explained that the key component of the NI bid was the Molecular Pathology Laboratory (NIMPL) which is a joint venture between the Trust and QUB.

23/15 (Contd.)

NI will play a significant role in the collection and analysis of clinical data at scale, testing and validation of new precision medicine ready clinical trial models and the development of HSC/NHS adoption routes for precision medicine.

Mrs Welsh advised that the ultimate vision was the development of robust clinically validated new molecular diagnostic tests and the potential for Industry to scale up in Northern Ireland.

Members welcomed the Trust's involvement in the Precision Medicine Catapult and congratulated all staff involved in Northern Irelands successful bid.

Chairman congratulated the team and acknowledged the significance of achieving this level of success. He continued to highlight the importance of ensuring key successes are publicised.

iv. Medical Engagement Scale

Dr Jack briefed Trust Board on the recently completed review of Medical Engagement Scale (MES) , highlighting this had been used as a diagnostic tool. Dr Jack explained the differences between NI and UK which made direct comparison not feasible.

The results indicate there appears to be room for improvement, those in leadership roles report to be better engaged than the other consultants.

In response to a query from Mr McNaney , Dr Jack outlined proposed work regarding design and development of medical engagement and proposed review in relation to structures. She continued to explain importance of Safetember and CLIME in relation to this, explaining CLIME in more detail for the benefit of the New Non Executives.

Dr McBride highlighted that this is also a significant piece of work in the context of wider engagement and advised this would come to Trust Board at an upcoming meeting.

Chairman's Statement – 31st January 2018

I welcome everyone here today for the launch of the report of the Inquiry into hyponatremia related deaths. Thank you for coming this afternoon. I realise that it has already been a long day for those of you who have been reading the report since early this morning. It will have made difficult and emotional reading for many of you. The report is very long, extending to three volumes. Nobody will have had time to read it in full this morning. I encourage you to do so when you have more time and feel able to complete your reading.

It is usual for reports such as this to have an executive summary of some sort. However the range of issues which we covered and the complexity of those issues made it impossible to draw up a summary. We experimented with the idea but in order to be accurate and fair the summary became longer and longer, thereby defeating the point of a summary in the first place. That being the position I want to take this opportunity to draw out some of the main findings of the report:

- The death of Adam Strain was avoidable.
- The death of Claire Roberts was avoidable.
- The death of Raychel Ferguson was avoidable.
- The evidence given in Banbridge showed conclusively that all three of these children received medical care which fell far below acceptable standards.
- The death of each child was the direct result of that negligent care.

If that was the total learning from the Inquiry it would be important in its own right. But what we learned is much greater and unfortunately much worse than the fact of Adam's, Claire's and Raychel's deaths. In the next part of this statement I will deal with each child in turn.

Adam Strain

Adam was four years old when he died in the Royal Belfast Hospital for Sick Children in 1995. In Adam's case we learned that it was recognised almost immediately that he had died from hyponatremia. We also learned that Adam's mother wasn't told that fact. We further learned that there was a failure to confront that issue within the Children's Hospital and with the paediatric anaesthetist whose

mistakes were so obvious. And we learned that there was a failure to assist the Coroner because those involved in Adam's treatment did not fully disclose to him what they knew and what they believed.
A major element of the Coroner's role, in addition to identifying the cause of death is to consider if action might be taken to prevent further deaths. As the report makes clear, the Coroner was led to believe that in future all anaesthetic staff would be made aware of the complications of hyponatremia and advised to act appropriately. That did not happen, even in the Children's Hospital never mind beyond. Instead the lessons which could have been learned and shared from Adam's death were neither learned nor shared.

Let me make one final point about Adam if I may – even after all the written and oral evidence I do not know the full story of what happened in the operating theatre. My belief is that evidence was withheld about what happened there. That is shocking.

Claire Roberts

Claire was nine years old when she died in the Royal Belfast Hospital for Sick Children in 1996. The Inquiry scrutiny of Claire's death came about despite the efforts of some doctors in the Children's Hospital, not because of them.

My conclusions about Claire's death are clear. Mr and Mrs Roberts were deliberately misled when they were told she had received good care. The fact that her death was not referred immediately to the Coroner for an inquest is indefensible. And it is not just indefensible with hindsight – it was indefensible at the time. The reason for not referring Claire's death to the Coroner was to avoid scrutiny of the negligent care which he had received – in effect a cover up by the two consultants who Mr and Mrs Roberts spoke to on 23 October 1996 when she died.

Even after they saw the UTV documentary in 2004 and contacted the Children's Hospital, efforts to avoid the truth continued. Some of the information given to them was inaccurate, evasive and unreliable. At the inquest in May 2006, nearly ten years after her death, efforts to minimise or deny failings in Claire's care continued. And the effort to protect the Trust's interests and reputation rather than learning lessons was apparent again. That was the position even after this Inquiry had been established.

Lucy Crawford

Lucy was 1½ years old when she died in April 2000. While she died in the Children's Hospital the critical treatment which she received was in the Erne Hospital.
As most of you know Lucy's parents withdrew from the Inquiry in 2008. This changed the scope of the investigation which focused on what happened after her

death because that was potentially relevant to the treatment which Raychel Ferguson received in Altnagelvin in June 2001.

What we learned from this part of the Inquiry is depressingly familiar:

- The cause of Lucy's death was discernible with very little effort.
- Her death was avoidable.
- Her parents were not told the truth about her death.
- An investigation was at least initiated by the then Sperrin Lakeland Trust but it failed to report what was and should have been obvious.
- There was a lack of professionalism and more importantly a lack of candour on the part of many of those who should have assisted the investigation and help it reach the only conclusion possible.
- The Crawfords were excluded from playing any role in any of the investigations which considered Lucy's death.
- The cause of Lucy's death was not just identifiable in the Erne Hospital but also in the Children's Hospital.
- There was a failure to be honest with the Crawfords in the Children's Hospital as well as at the Erne.
- There was a failure to report Lucy's death to the Coroner in the way in which it should have been reported. Such report as was made was hopelessly incomplete.
- The death certificate issued in 2000 was wrong, illogical and simply made no sense – it was in effect medical gibberish.
- Lucy's death only went to the Coroner after Raychel's death and inquest because of the alertness of the late Mr Stanley Millar.
- No lessons were learnt from Lucy's death.
- Lessons could have been learned which may have affected Raychel's care.
- The inter-play between Sperrin Lakeland Trust and the Western Health and Social Services Board was inadequate. It might have led to lessons being learned but so far as we know at the moment it was allowed to fade away.

Raychel Ferguson

Raychel was nine years old when she died in June 2001. Although she died in the Children's Hospital in Belfast the critical treatment she received was in Altnagelvin Hospital.

By the time Raychel was admitted to Altnagelvin in June 2001 no lessons had been learned from the deaths of Adam, Claire or Lucy.

What happened after Raychel's death was different from the others and to a degree better. A critical incident review was conducted within Altnagelvin which led to

failings being identified and steps being taken to improve the level of care. In addition Raychel's death was reported to the Coroner. More significantly as it turned out it was reported to the Department of Health. This led to the establishment of a Departmental Working Party and to the introduction of very good guidance on hyponatremia and how to avoid it.

But, and it is a huge but, none of this information was shared with the Fergusons. Even when Mrs Ferguson and her sister met the Chief Executive and others on 3 September 2001 at the hospital the meeting was handled appallingly. No sincere effort was made to answer Mrs Ferguson's questions. The hospital representatives knew much more than they were prepared to share.

Remember – Raychel's death had already been reported to the Coroner and to the Department and failings in her care had been identified. Yet even then at a face to face meeting the truth was denied to the Fergusons.

How much anguish, anger and frustration would the Fergusons and the other families have been saved if they had just been told the truth from the start?

The truth is not very difficult. It involves four points:

- We made mistakes in the care we gave to your child.
- We are very sorry.
- We are determined that will not happen again.
- This is what we are going to do better in future.

Raychel's inquest then featured some of the same features as I have already referred to. There was an unwarranted and factually wrong challenge to the expert evidence of the Coroner's expert Dr Sumner. There was an intention to resist criticism on the basis that standard practices and procedures were followed when they were not. There was the withholding of expert medical evidence obtained by Altnagelvin which confirmed that the care given to her was inadequate. Accordingly an effort was made to mislead the Coroner.

The length of the chapters in the report shows how much more I have to say about the circumstances of each child. Again I urge you to read those chapters – they gave a much fuller picture than I can possibly can in speaking to you today.

Let me move on - I have already referred to the Hyponatremia Guidance issued by the Department in March 2002. That guidance was prompted by the report of Raychel's death. It is an example of the system working well – of a terrible case of a

child's death leading to meaningful central action. I credit everyone involved for making that happen.

But isn't that what should have happened much earlier? The frustration here is that the authorities showed that they can respond, and respond well. That is what we all want and need but we need it to happen earlier and more effectively so as to protect more children.

At this point I turn to Conor Mitchell. Conor Mitchel was 15 when he was treated in Craigavon Area Hospital in May 2003. He did not die from hyponatremia but he died after the guidance was issued by the Department. There were some concerns about the fluid management in Conor's case so the care which he received was added to the work of the Inquiry to test the way in which the guidance was followed just over a year after it had been issued.

This segment of the hearing was shortened because the Trust conceded that the guidance was not followed. Inevitably I criticise the Trust for that. However the Trust's admission to the Inquiry was welcomed by the Mitchell family and led to some better and positive exchanges which are reflected in Chapter 6 of the report. In addition there is evidence that in Craigavon sincere efforts have been made and steps taken to improve procedures and standards.

The Department

What then of the Department itself? The answer emerged quickly and was conceded by the Department at the hearing – the Department simply had no system in place for knowing what was going on in its hospitals.

How did this come about? The answer is that when the Health Service was reorganised in the early 1990s and Trusts were established, no requirement was imposed on those new Trusts to report deaths or other serious incidents to the Department. That was a huge mistake. Senior departmental witnesses said that they would have expected to be told about all of these deaths. They weren't but they should have realised that they were not being kept informed because our Health Service could not possibly have been operating so well.

As Chapter 7 shows I credit the Department for its work on the guidance, the first such guidance in the United Kingdom. However, I go on to criticise the then Chief Medical Officer Dr Campbell for her responses to the media and particularly to Ulster Television when its programmes exposed the hyponatremia issue. She was inaccurate, defensive, evasive and complacent.

Final remarks

Is there any reason to be more optimistic today? In November 2013 I heard evidence about current practices in the Health Service. The point of that evidence was to test the line which I had heard repeatedly that things were by then much better than they had been between 1995 and 2001. That evidence showed some signs of improvement but such improvement as there was was inconsistent and patchy.

Chapter 8 of the report sets out further steps which have been taken since 2013. If those measures are followed and enforced they will bring important positive change but the Department, the Health and Social Care Board and the other statutory bodies must be vigilant. The unfortunate lesson from this Inquiry is that not all doctors and managers can be trusted or relied on to do the right thing at the right time.

I do not believe that all doctors and managers behave so inadequately, evasively, dishonestly and ineptly as some of those who featured in this Inquiry. We all know that is not the case. There will be many people working in the Health Service who will be dismayed and angered by what came out in the course of the Inquiry. They will feel let down and they will be right to feel let down.

The Health Service has to improve so that when mistakes are made they are faced up to and the families are told. That already happens with good doctors and good managers. It must happen in all cases. That is why in Chapter 9 of the report my first recommendation is that as a matter of urgency a statutory duty of candour should be introduced. This would impose an obligation to tell patients or their families about major failings and to give a full and honest explanation of what has happened. There are 96 recommendations but that is the key one.

I want to finish this statement by making four final points:

(1) This Inquiry was established as a health inquiry under health legislation. My remit does not extend to coroners, but I welcomed and was grateful for the input and experience of Mr John Leckey who was the Senior Coroner for Northern Ireland until his retirement. He took the time and trouble to come to Banbridge and gave significant evidence.

I am sending this report to Mrs Justice Keegan who is now the Head of the Coronial Service because there are lessons to be learned by coroners. My fundamental concern is this – the evidence we gathered shows that on some occasions, the ones we looked at, some doctors and managers worked against the principles behind inquests rather than with them. It is time the medical profession and health service managers stopped putting their own reputations and interests first and put the public interest first instead.

(2) The same applies to litigation. No parent benefits significantly from suing a Trust over the death of a child. Financial compensation is limited. The cases brought against the Trusts in the deaths which I have examined were open and shut. But instead of accepting that, the Trust aggravated the parents' grief with denials of liability and efforts to impose confidentiality clauses. In these cases those responses were unwarranted and inappropriate.

(3) I urge doctors, nurses and managers to do three things:

(i) Listen to parents
(ii) Talk to parents
(iii) Tell them the truth

(4) In Banbridge on 30 August 2013 Altnagelvin fully and publicly accepted its responsibility for Raychel's death. In October 2013 the Belfast Trust followed by accepting fully responsibility for the deaths of Adam and Claire. And in a more limited context the Southern Trust apologised for the failings revealed in Conor's case.

I cannot imagine how the families felt in hearing those apologies. I understand they were welcomed but they would have been more valuable and more meaningful if they had not been extracted by a long inquiry after extensive questioning of witnesses who in some cases had to have the truth dragged out of them.

Inquiries do not and cannot happen all the time. Often they take too long and cost too much. And they demand of families the resolution and dignity in pursuit of the truth which the families in this Inquiry have shown. None of that should be necessary. If patients and families are told the truth inquiries will be largely unnecessary. The ordeals which these families endured must be avoided in future. The responsibility for that lies with everyone in the Health Service from the top to the bottom.

2.008

Belfast Health and Social Care Trust
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Minutes of the Confidential Trust Board Meeting
Held on 4 October 2018 at 9.00 am
in the Boardroom, Belfast City Hospital

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Mr Gordon Smyth	Non-Executive Director
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Mrs Maureen Edwards	Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development (Interim)
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Miss Marion Moffett	Executive Assistant – Minute Taker

Apologies

Ms Claire Cairns	Head of Office of Chief Executive

At the outset of the meeting Mr McNaney welcomed Mrs Diffin to her first meeting of Trust Board in her new role as Director and wished her well for the future.

1. Minutes of Previous Meeting

The minutes of the previous confidential Trust Board meeting held on 6 September 2018 were considered and approved.

2. Matters Arising

No items raised.

3. Chairman's Business

3.1 Conflicts of Interest

There were no conflicts of interest reported.

3.2 IHRD Workstreams

Mr McNaney, Mrs McKeagney and Ms O'Reilly reported on the induction training in respect of the IHRD Workstreams they had been assigned to.

Mr Smyth advised that he had been appointed to one of the Workstreams in his role as Non Executive Director, NI Fire and Rescue Service.

3.3 Chairman's Awards Visits

Mr McNaney referred to the Chairman's Awards and wished to record his appreciation to Professor Bradley and Mrs McKeagney for their commitment to undertaking a series of visits in relation to the entries received.

3.4 Board Development

Mr McNaney confirmed the dates of the two Board Development Workshops had been agreed as 25 October and 13 December, in the Mount Centre. It was agreed the workshops would be held from 8.00am to 2.00pm.

4. Report of Chief Executive

4.1 Neurology Review – Update

Mr Dillon provided an update in respect of the Neurology Patient Call Back. There had been 2529 patients involved with 2509 seen and appointments booked for the remaining 20. There were 1451 patients requiring a further review appointment following their diagnostic test and these would be completed by the end of October. A total of 462 patients had been discharged.

Members noted that the HSCB/PHA are finalising a paper outlining options for the review of patients who had been discharged from the care of Dr Watt back to their GP. This would take a risk-based approach to the assessment and treatment of patients seen by Dr Watt, or where he influenced assessment or treatment, in any setting. This work has been informed by neurology colleagues, devising criteria, in the prioritisation of patients.

Mr Dillon advised that given NICE guidance and associated risks the DoH Assurance Group asked that prioritisation be given to female patients born on or after 1 January 1963, of childbearing age when treated) prescribed valproate between 1 January and 30 June 2018.

Mr Dillon referred to the RQIA Review of Outpatients and advised the Trust had completed and submitted a detailed response to the questionnaire required as

part of the review. The RQIA Review Team had visited outpatients on each of the sites, RVH, BCH, MIH and MPH. They had also met various groups and teams of staff week commencing 10 September, including members of Trust Board. RQIA have indicated they will be undertaking unannounced inspections of outpatients on each of the sites between September and December 2018. In relation to the RQIA Review of Deaths, Ms Owens advised that the Review Team had been established.

Members noted the Trust had submitted relevant documentation to the Independent Inquiry, with 11 submissions completed by 31 August, and further submissions to be provided by 30 September

Members noted that Dr Jack, Mrs Owens, and relevant staff had met with the Solicitor and Secretary to the Inquiry. They gave an outline of the Inquiry's draft project plan. A further meeting is scheduled to take place on 9 October. Staff are scheduled to be interviewed by the Inquiry team commencing October. Mrs Owens pointed out that the Inquiry Team had advised that it would be the last review to report, indicating a 24 month timeframe.

Mrs Owens advised a regional Neurology Service Improvement workshop had taken place on 11 September, involving the commissioners, neurologists and wider multi professional teams.

Member noted the Trust is progressing an investigation within the MHPS framework. External investigators have been appointed and have commenced their investigation. The GMC are scheduled to visit the Trust 8 to 10 October 2018 as part of their investigation.

Mr Dillon advised that the DoH were due to meet with MLAs on 3 October to provide a briefing in respect of the Call Back exercise to date, Dr Craig had been invited to attend this meeting.

In response to a question from Mr McNaney, Mrs Owens advised that the outcome report would not be available for some time as it was important that all data was reviewed and accurate.

Mr McNaney sought clarification regarding the additional costs associated with the review.

Mrs Edwards advised the Trust was drafting a costed plan and liaising with the HSCB and PHA regarding the additional funding required in respect of the on-going review.

Members emphasised the importance of adequate funding being made available for the review.

Mr Dillon wished to acknowledge the huge contribution of staff involved in facilitating the call back within the 12 week period. He advised that a Learning event was scheduled for 24 October to review learning from the exercise.

Mr Dillon referenced the significant number of complaints being received in respect of negligence claims and the increased workload in respect of these.

4.2 Audiology Report – Update

Mr Dawson provided an update in relation to the Audiology Service audit in respect of concerns raised by the HSE Report. The audit reported that all patients in the risk groups identified in the HSE report had been managed appropriately and the report had been submitted to PHA for consideration and approval. A meeting was scheduled with PHA for 7 October.

Members noted the Audiologist in question had not been involved in the operational provision of hearing aid services to children in the Trust.

Mr Dawson advised the audit had raised some concerns regarding governance of Audiology Services regionally, not linked to the HSE Report, and these were being followed up with the PHA.

Members noted the Permanent Secretary and Chief Executive were scheduled to meet with Sinn Fein to discuss the HSE Audiology report.

4.3 Live Governance Weekly Reports

Mr Dillon referred to Live Governance Weekly Reports considered by Executive Team. He explained the report provides update information in relation to Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases, Complaints (including NIPSO), Corporate Risks and RIDDOR.

Members noted the report is drawn from corporate information systems and is identified by Directorate. This is discussed via a weekly conference call by a group of Governance staff and includes representation from the Corporate Risk and Governance Team and Deputy Medical Director alongside Directorate Governance staff and Corporate Nursing and User Experience. The weekly call provides an early opportunity to consider emerging governance issues with sharing of learning ahead of established governance processes and is subsequently considered by Executive Team.

Mr Dillon sought views to extending the circulation to Trust Broad to provide ongoing and regular live governance information. He pointed out this would also assist the Trust in meeting IRHD recommendation 81, "Trusts should ensure that all internal reports, reviews and related commentaries trouncing upon SAI related deaths within the Trust are brought to immediate attention of the Board".

Members welcomed the proposal as this would provide real time information in keeping with the IHRD recommendation.

4.4 Muckamore Abbey Hospital – Update

Mrs Heaney tabled a confidential copy of the Review of Safeguarding at Muckamore Abbey Hospital report for information.

Members noted receipt of the report.

4.5 New Regional Children's Hospital

Mr Dillon was pleased to report that the DoH had approved the Addendum to the Outline Business Case for the New Regional Children's Hospital.

Members welcomed the approval of the additional capital costs.

Mr McNaney wished to record members' appreciation to Mrs Edwards and the Capital Development Team.

4.6 Theatre Nurse Workforce

Mrs Owens highlighted significant challenges in relation to theatre nursing workforce resulting in a reduction of approximately 12 elective surgery sessions per week on the RVH site. She outlined action being taken to identify appropriate agency staff to address the issue.

In response to a comment from Professor Bradley regarding UK wide difficulty in attracting theatre nurses, Mrs Owens advised that two part time Nurse Educators had been appointed to support theatre staff.

Mr McNaney reflected on the overall workforce position and the impact vacancies were having across services.

Mrs Kennedy advised the DoH were chairing a regional sub-group of Directors of HR, Finance and Nursing currently looking at agency spend and options to incentivise staff to increase usage of Bank.

Miss Creaney outlined a number of initiatives being considered to create a nursing workforce fit for the future.

Professor Jones referenced the need to train more nurses and undertook to follow up with Miss Creaney.

In noting the position Mr McNaney asked that workforce issues be considered in more detail at a future workshop.

4.7 IHRD Update

Mr Dawson advised that NCAS had completed the review of doctors named in the IHRD report and a meeting had been scheduled to discuss. The QC is currently considering the decisions made by the Trust and would report in early November. The GMC review was ongoing.
Members noted the position.

4.8 Infected Blood Inquiry

Mrs Leonard provided an update in respect of the Infected Blood Inquiry.

Members noted the Trust had registered as a core participant to the Inquiry. An exercise has been undertaken to identify the number of individuals concerned who are likely to request their medical records and relevant action was being taken to collate any relevant legacy corporate information for the Inquiry.

Members noted the position.

5. Any Other Business

No further items raised.

Belfast Health and Social Care Trust
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FOR DISCUSSION AT TRUST BOARD WORKSHOP – 3rd SEPT 2020

Right Care, Right Place, Right Time

BHSCT Quality Management System – Draft Proposed Framework

We are committed to bringing together the different approaches we have had in the past to performance management, quality improvement, accountability and assurance processes. We plan to achieve this through the **development of a single integrated Quality Management System (QMS) to support the delivery of our vision to deliver Safe, Effective and Compassionate Care through *Right Care, in the Right Place, at the Right Time.***

Our Quality Management System (QMS) will:

- Enable Directors and Divisional Teams to develop the management information they want to make sense of their business in a consistent, integrated framework across all Directorates;

- Keep building and amplifying sensitivity to operations, using the Charles Vincent Model as our methodology for measuring and monitoring safety (see **Appendix 1**), both in our daily safety huddles and in regular but less frequent sense making forums;

- Integrate our assessments of safety, outcomes, efficiency, access, patient and staff experience under the banner of quality;

- Instil confidence in ourselves as a team of Directors as the basis of our providing reliable and transparent assurance to Trust Board, Commissioners, Department of Health (DOH), our partners and public on the effectiveness of our decision-making and progress to meeting regional and local priorities & targets; and

- Continue to satisfy the reporting requirements of the Health & Social Care Board and Department of Health.

This new model, which is set out in **Diagram 1** below, will provide consistency of approach across the Trust, reducing variability and better streamlining how we do our business. It will replace and integrate a number of existing fragmented assurance and accountability reports and meetings:

- Performance & Accountability Framework
- Safety & Quality Steering Group
- MORE Group
- Agency Spend Meetings

The Trust's Safety & Quality Steering Group will continue to run for at least the next 12 months (this timescale will be dependent on the resource being available to fully move to the new QMS approach) and will then be stood down. Divisions will no longer attend Safety & Quality Steering Group but instead move into the Divisional quality management review system where Executive Team will review their overall QMS.

Workstreams which have been established to deliver on the Trust's agreed key priorities will now replace previous 'IMPACT' groups.

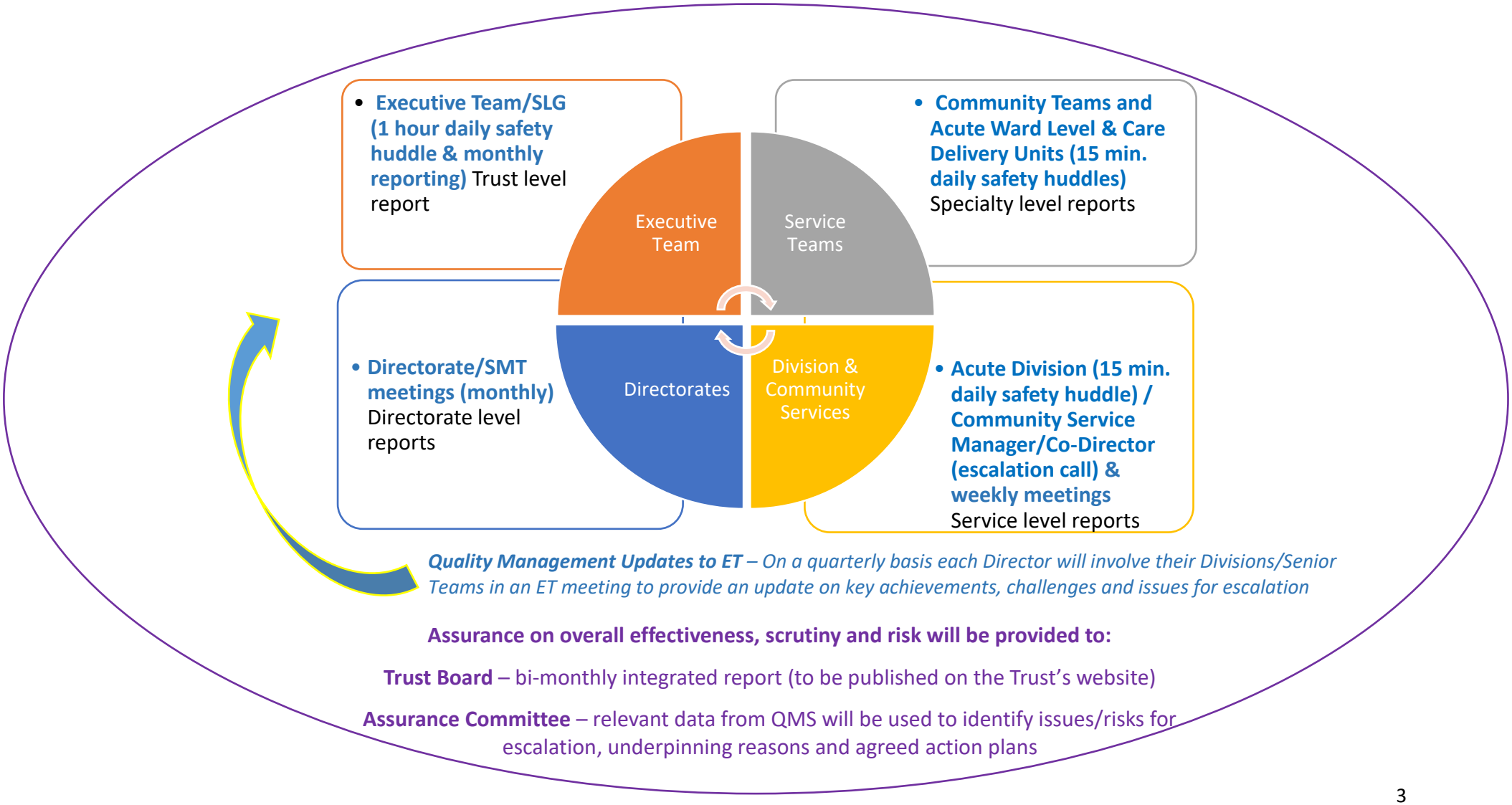
This work will refresh the Trust Board Assurance Framework to reflect our new QMS approach as the basis of our accountability and assurance processes (**Appendix 2** provides an overview of the existing Board Assurance Framework, Performance & Accountability Framework and Quality Improvement Strategy).

This new approach will inform the refresh of our next 3 year Quality Plan.

Diagram 2 summarises the new QMS system.

Diagram 1: Reporting process

The formal QMS structure and processes, through which we will ensure robust and efficient internal accountability arrangements and provide necessary assurances, are described in the diagram below:



Likely internal safety meetings within this QMS framework:

- **Sensitivity to Operations - Daily Charles Vincent Safety Huddles/Calls will take place at every Level, the process adapted by hospital and community teams will differ to reflect how services work:**

  For Hospital Teams:

  - **Care Delivery Unit Leadership Teams** – will meet daily for a Charles Vincent Safety Huddle:
    - **Ward Level Safety Huddle (Clinical Lead/ASM/Band 7) at 8.00-8.15am** with any escalation of concerns to Care Delivery Unit
    - **Care Delivery Unit Safety Huddle (Clinical Director/Service Manager/Senior Nurse) at 8.30-8.45am** with any escalation of concerns to Divisional Team
  - **Divisional Team Safety Huddle (Chair/Co-Director/Divisional Nurse) at 9.00am-9.15am** with any escalation of concerns to Director for discussion at Executive Team Safety Huddle.
  - **Executive Team Safety Huddle at 11.00-12.00pm**

  For Community Teams:

  - **Community Team** – will have a daily 'check-in' telecall between 9.00 and 9.15am led by the Team Leader to agree any concern to be discussed or escalated through relevant line management structure.
  - **Service Manager to Co-Director call** to agree any escalation of concerns to Director for discussion at Executive Team Safety Huddle.
  - **Executive Team Safety Huddle at 11.00-12.00pm**

Whether delivering hospital or community services, the essential element of the model is that daily escalation processes are followed at every level to highlight or flag issues of concern so that there that the appropriate manager can respond to any situations. It should be noted that usual escalation processes apply outside of this arrangement.

- **Wider QMS assessment forums, including assessment of safety:**

    - **Monthly Directorate SMT Meetings** – will meet monthly to review all Division level information for the Directorate.

    - **Monthly Executive Team Meetings** – A QMS report will be presented to Executive Team/Senior Leadership Group on a monthly basis and to Trust Board on a bi-monthly basis, each Director will summarise their analysis of their business. In addition, each Director will involve their divisions in presenting a quarterly Quality Management Update to Executive Team. This will include an update on key achievements, challenges and issues for escalation. Directorate sessions will be scheduled for 1 hour to provide 30 minutes for presentation followed by 30 minute discussion.

- **Quarterly Senior Leadership Group** – Executive Team will lead on current analysis of the business with the sharing of learning through Senior Leadership Group (one all Directorates have had an opportunity to present to Executive Team).

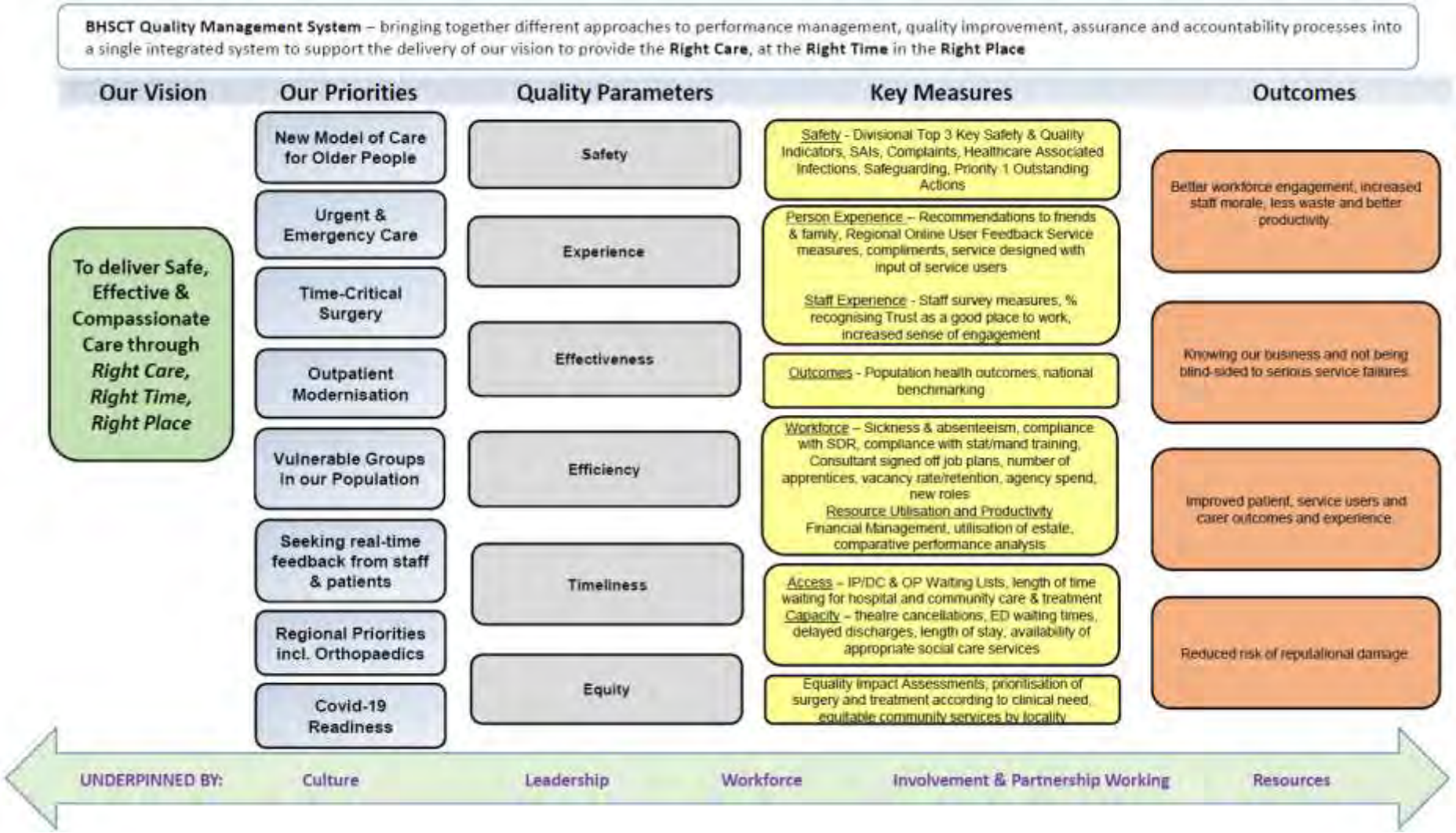
Reporting in these forums will cover the following 6 quality parameters as defined by the Institute of Medicine (IOM):

- Safety
- Experience
- Effectiveness
- Efficiency
- Timeliness
- Equity

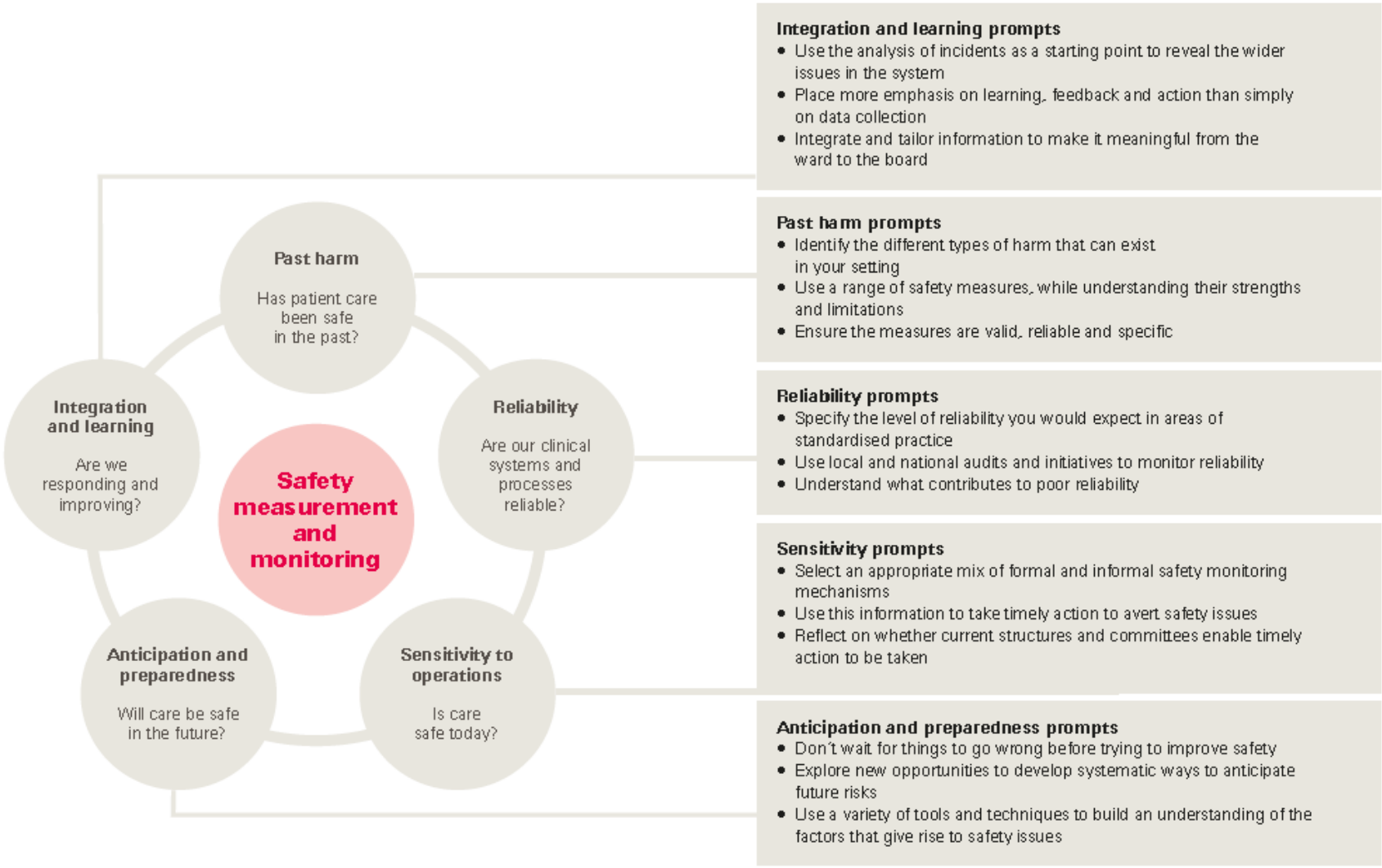
We expect robust escalation processes at each level in the Trust.

- **At an individual level**, Staff Development Reviews (SDRs) will be developed on the basis of individual staff contribution to our Quality Management System to deliver our vision of ***Right Care, Right Place, Right Time*** with a focus on effectiveness, efficiency and access; and experience.

Diagram 2: Summary of BHSCT Quality Management System



Appendix 1 Overview of Charles Vincent Model: The Framework for measuring and monitoring safety



Appendix 2 Overview of current BHSCT Frameworks

Assurance Framework 2019-20

The Assurance Framework is described as an integral part of the Trust's governance arrangements which should be read in conjunction with the Trust Corporate Management Plan 2018-2021. It 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. Its purpose is to outline the source 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.

It explains that the 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.

This paper also discusses the basis of accountability and what is covered in the Trust Performance & Accountability Framework, this paper provides an overview of both the Corporate Plan and Trust Delivery Plan and the process of cascading corporate objectives and associated annual targets (regional and local).

In defining what assurance means, the framework recognises the need to take stock of the full range of activities and their relationship to key risks as a substantial but necessary task. It also sets out the Trust's risk management strategy and the Trust's commitment to quality improvement.

The Board Assurance Framework summarises the roles of Committees and Key Staff in providing Board Assurance.

Performance & Accountability Framework (June 2017)

The DOH has set out the role of Trusts in embedding effective performance management and ensuring clear and robust accountability arrangements to deliver better outcomes for patients and clients.

This framework discusses how our corporate objectives are articulated throughout various levels in the organisation through the Trust Corporate Plan, Trust Annual Delivery Plan, Directorate/Divisional/Care Delivery Service/Team Plans and individual staff PDPs. It describes the Trust's accountability arrangements, setting out reporting and meeting arrangements and key roles and responsibilities, and refers to the Board Assurance Framework.

It attempts to differentiate between the frameworks:

Board Assurance Framework: Key committees which provide the Trust Board with assurance about overall effectiveness, scrutiny and risk.

Performance & Accountability Framework: Processes and meetings providing Trust Board, Chief Executive and Executive Team with assurance about strategic direction and corporate performance.

Quality Improvement Strategy 2017-2020

This strategy sets out the Trust's commitment to develop a culture of excellence in safety and quality by engaging, inspiring and supporting our workforce to deliver improved outcomes and experience for those in our care. Its five key principles are:

1. Placing the **person** clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation.
2. Ensuring a **relentless focus on safety and quality improvement** through the implementation of our Quality Improvement Plan, aligned to our corporate objectives and assurance framework.
3. Ensuring that we are **open, transparent and supportive organisation** that is continually learning and sharing both within and beyond the organisation.
4. Using **measurement and real time data, linked to goals, to learn and improve at every level;**
5. Enhancing our **will, capability and structures** to undertake quality improvement consistently, everywhere and every day.

Right Care, Right Time, Right Place

Quality Management System (QMS) Report
July 2021

Trust Board
Thursday – 2nd September 2021

Charlene Stoops
Director of Performance, Planning & Informatics

Overview of Report

- QMS Framework
- Overview of Current Position & Covid-19 Update
- Delivery Plan Update
- 6 Quality Parameters:
  - *Safety*
  - *Experience*
  - *Effectiveness*
  - *Timeliness*
  - *Efficiency*
  - *Equity*

Appendix 1: Phase 6 Delivery Plan – 31st July 2021

Appendix 2: CPD Performance Overview - June/July 2021

QMS Framework

1. Care Delivery Unit/Specialty Level – daily safety huddles/sitreps and weekly wider QMS assessment through Team meetings

2. SMTs – Monthly review of QMS Division/Team-level data packs

3. Executive Team – Weekly review of QMS assessment & Directorate-led QMS presentations (quarterly for Service Directorates and bi-annually for Corporate Directorates)

4. Assurance Committee – QMS data pack/slide deck and summary presentation as shared with ET is shared quarterly with Assurance Committee. In addition, further detail is provided to drill down key risks and actions being taken.

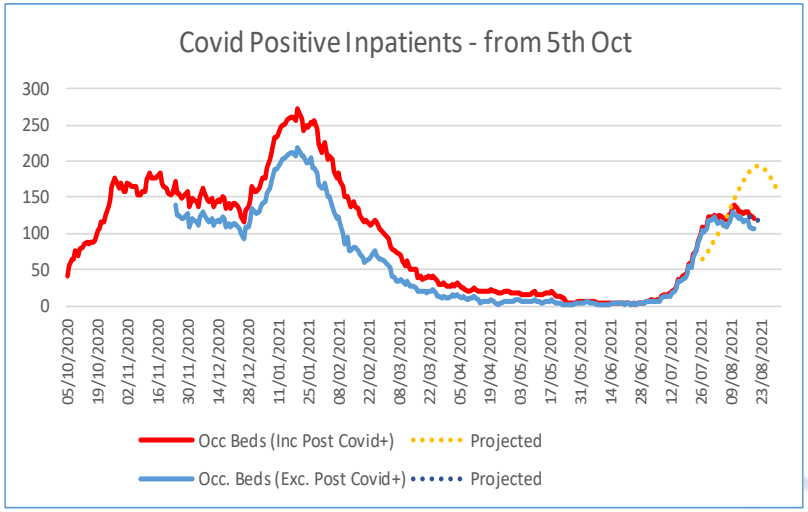
5. Trust Board – A bi-monthly QMS Report will summarise a range of Trust-level data on our current position, including an update on Covid-19 and rebuild plans; and an overview of progress against the 6 quality parameters.

Covid-19 Update – 20th August 2021

1. **Covid19 positive (+) and Post-Covid19 Hospital Inpatients**

Today, 106 Covid19+ patients (3 in last Trust Board report) are in our hospital wards and there are 14 patients post-14 days (3 in last Trust Board report), in hospital. In total, 120* Covid19 related patients remain in hospital. The current Covid19 related inpatient levels are at a similar level to mid-October. Today's number in hospital equates to 44% of the total at the peak of Surge 3 on 20th January (272). A downward projection is now forecast, based on recent numbers. The graph displays both current and post-Covid19 patients

16/07/2021	36	01/08/2021	124	17/08/2021	130
17/07/2021	37	02/08/2021	125	18/08/2021	125
18/07/2021	41	03/08/2021	119	19/08/2021	124
19/07/2021	43	04/08/2021	125	20/08/2021	120
20/07/2021	46	05/08/2021	123	21/08/2021	0
21/07/2021	57	06/08/2021		22/08/2021	0
22/07/2021	59	07/08/2021	118	23/08/2021	0
23/07/2021	71	08/08/2021	125	24/08/2021	0
24/07/2021		09/08/2021	124	25/08/2021	0
25/07/2021		10/08/2021	136	26/08/2021	0
26/07/2021	100	11/08/2021	139	27/08/2021	0
27/07/2021	110	12/08/2021	135	28/08/2021	0
28/07/2021	105	13/08/2021	130	29/08/2021	0
29/07/2021	111	14/08/2021	130	30/08/2021	0
30/07/2021	123	15/08/2021	127	31/08/2021	0
31/07/2021	124	16/08/2021	129	01/09/2021	0



Covid-19 Update – 20th August 2021

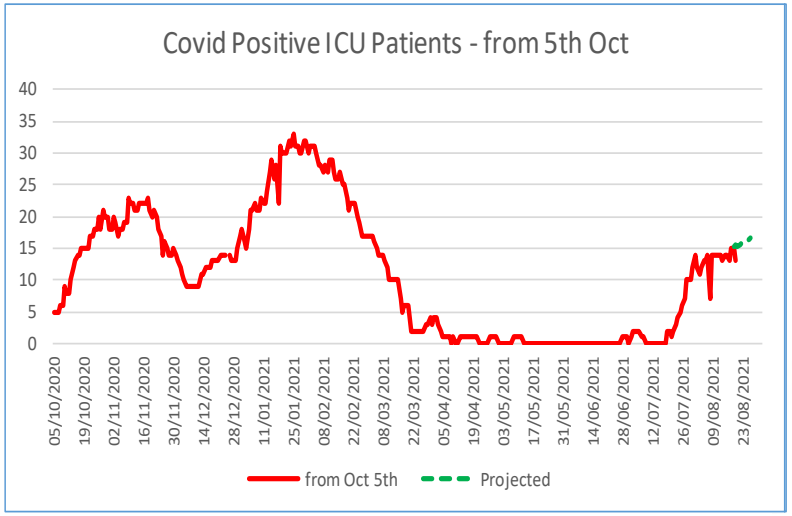
2. Numbers of Patients in Intensive Care

- **Today in ICU, we have 13 Covid19+ patients, and 0 suspect Covid19 patients (No Covid19+ patients in last Trust Board report). On the wards* there are 16 patients on CPAP, 3 on AIRVO and 1 on NIV. There are currently less than 5 patients identified as possibly needing escalation within the next 24 hours. An upward projection is forecast, based on recent activity..**

** Due to the potential for individual patients to be identified where there are less than 5 patients likely to be escalated the exact number will not be provided.*

ICU Occupancy – Covid+ Inpatients

16/07/2021	0	01/08/2021	14	17/08/2021	13
17/07/2021	0	02/08/2021	12	18/08/2021	15
18/07/2021	0	03/08/2021	11	19/08/2021	15
19/07/2021	2	04/08/2021	12	20/08/2021	13
20/07/2021	2	05/08/2021	13	21/08/2021	0
21/07/2021	1	06/08/2021	13	22/08/2021	0
22/07/2021	2	07/08/2021	14	23/08/2021	0
23/07/2021	3	08/08/2021	7	24/08/2021	0
24/07/2021		09/08/2021	14	25/08/2021	0
25/07/2021		10/08/2021	14	26/08/2021	0
26/07/2021	6	11/08/2021	14	27/08/2021	0
27/07/2021	7	12/08/2021	14	28/08/2021	0
28/07/2021	10	13/08/2021	14	29/08/2021	0
29/07/2021	10	14/08/2021	13	30/08/2021	0
30/07/2021	10	15/08/2021	14	31/08/2021	0
31/07/2021	12	16/08/2021	14	01/09/2021	0

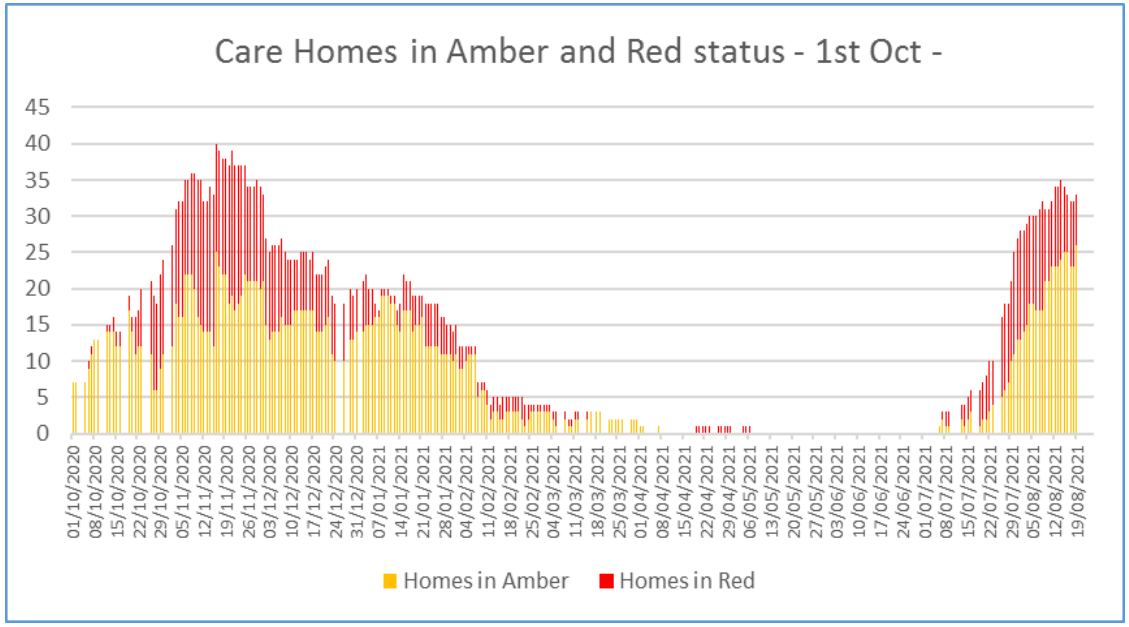


Covid-19 Update – 20th August 2021

3. Community

We have 89 care homes in the Belfast Trust area, caring for over 2,200 residents.

- **As at Thursday 19th August, we have 33 care homes with a confirmed outbreak –** 26 in amber status and 7 in red status. (There were no homes in outbreak at 1st June 2021 in the last Trust Board report)



Covid-19 Update – 20th August 2021

4. Covid19 Vaccinations

- **The Trust vaccination programme began before Christmas, continuing throughout the Christmas period and into 2021. Over 209,000 vaccines have been delivered. (153,000 in last Trust Board report). Over 6,000 of that total have been delivered through the mobile walk in clinics**

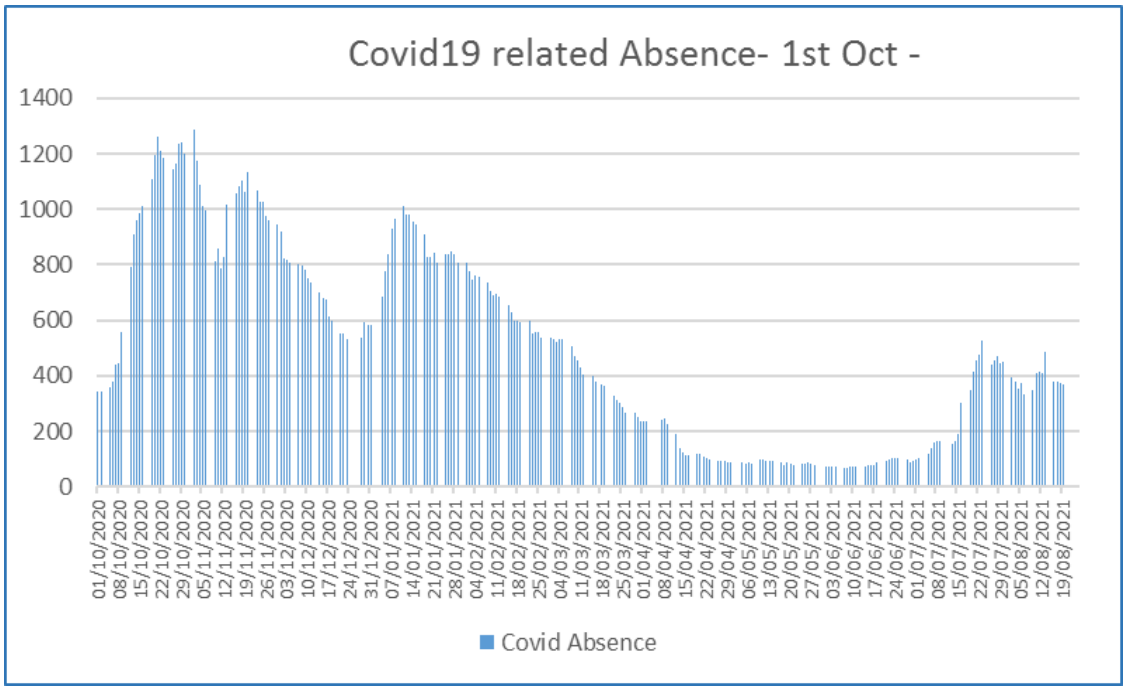
- The table below shows the vaccination activity for the last 7 days, and the cumulative total so far. Nursing and Care home residents, wards and day care facilities and staff, Covid19 Vaccination centre numbers and wasted dose numbers are provided.

Day	Date	No of Care homes	No. of inpatient wards/day care facilities	Residents	AZ patients	Care Home Staff	Total Care Homes	Mobile Clinic Walk in	Vaccination Centre	Daily Total	Running Total	Wasted Doses	Cum Wasted Doses	% Cum Wasted Doses
Fri	13-Aug-21	0	0	0	0	0	0	0	516	516	**205540**	0	227	0.11%
Sat	14-Aug-21	0	0	0	0	0	0	537	306	843	**206383**	4	231	0.11%
Sun	15-Aug-21	0	0	0	0	0	0	70	410	480	**206863**	0	231	0.11%
Mon	16-Aug-21	0	0	0	0	0	0	0	432	432	**207295**	0	231	0.11%
Tue	17-Aug-21	0	0	0	0	0	0	0	456	456	**207751**	0	231	0.11%
Wed	18-Aug-21	0	0	0	0	0	0	399	457	856	**208607**	2	233	0.11%
Thu	19-Aug-21	0	0	0	0	0	0	276	468	744	**209351**	0	233	0.11%
Totals				**5954**	**308**	**5951**	**12010**	**6242**	**191020**	**209351**				

Covid-19 Update – 20th August 2021

5. Workforce

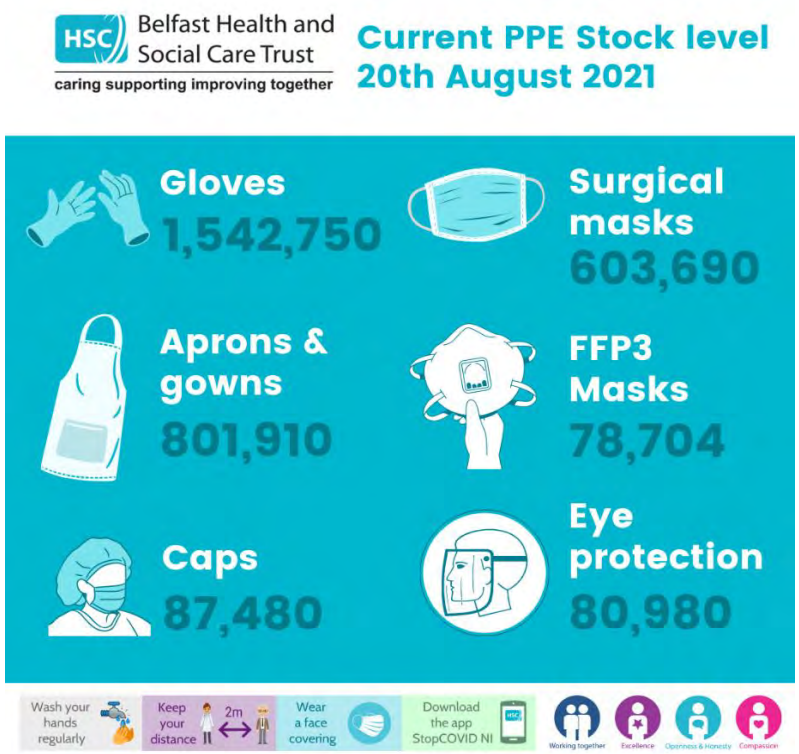
- This day last week, we had 409 staff off work with Covid19 related issues, in addition to ongoing workforce challenges as a result of high vacancy levels within the Trust. **Today, 367 staff are off work with Covid19 related issues, a decrease of 10% over a 7-day period.** (**compared to 74 in last Trust Board report)**



Covid-19 Update – 20th August 2021

6. PPE Stock levels

PPE stock levels are monitored daily and the infographic below gives a breakdown of levels of stock for each type of PPE equipment. This stock level does not include stock received and available at ICU/Ward/Department/ Community level for immediate use.



What do we deliver in a typical week?

Blue = weekly average in 2019 (pre-Covid)

Green = weekly average in 2021 (Jan-May)

BHSCT Weekly Activity

Scope Procedures
267 (160)

ED Attendances
3,707 (2,979)
530 daily (426)

Emergency Surgery
177 (239)

Red Flag Referrals
407 (409)

Day Cases
1,232 (968)

Elective Admissions
398 (236)

Non Elective Admissions
1,097 (787)

Outpatient Attendances
Virtual
234 (4,061)

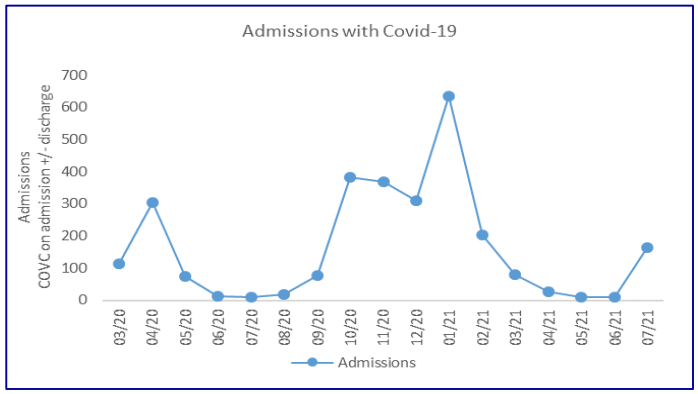
Outpatient Attendances
Face-to-face
10,582 (5,568)

Belfast Health and Social Care Trust
caring supporting improving together

Working together Excellence Openness & Honesty Compassion

Meeting Covid-19 Demands

Inpatients



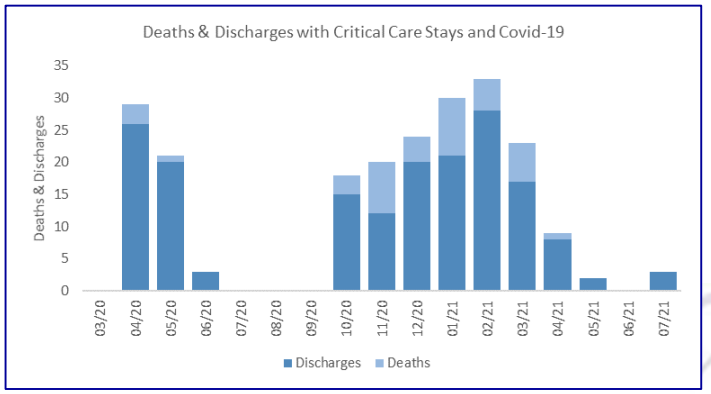
Inpatients (to 31st July 21)

- **2,789 inpatients** due to Covid-19
  - **2,387** were discharged (86%)
  - **391** patients died (14%)
  - **11** patients remain in hospital (0.4%)

Demand on Beds

- Covid-19 patients used **26,177** bed days in general wards

Critical Care



Critical Care (to 31st July 21)

- **226** admissions to Critical Care (8% of Covid inpatients)
  - **175** were discharged (77%)
  - **40** patients died (18%)
  - **11** remain in hospital (5%)

Demand on Beds

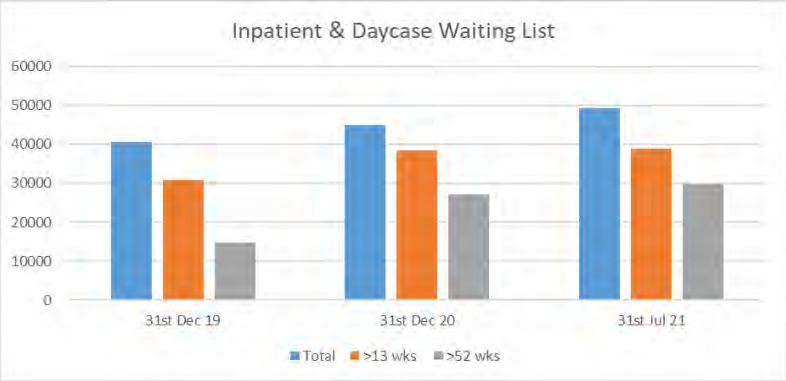
- Covid-19 patients used **3,783** bed days in critical care

Belfast Health and Social Care Trust
caring supporting improving together

Working together · Excellence · Openness & Honesty · Compassion

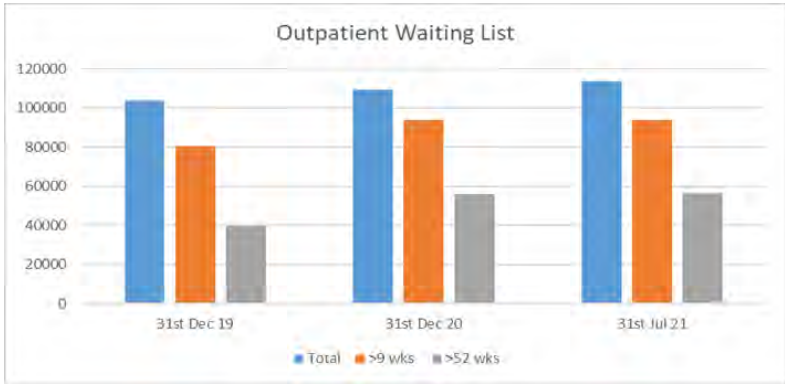
Impact on Waiting lists

Inpatient & Daycase Waiting Lists



Inpatient & Daycase Waiting List	31st Dec 19	31st Dec 20	31st Jul 21
Total	40579	44867	49397
>13 wks	30826	38371	38962
>52 wks	14892	27205	29697
% waiting< 13 wks	24%	14%	21%
% waiting> 52 wks	37%	61%	60%

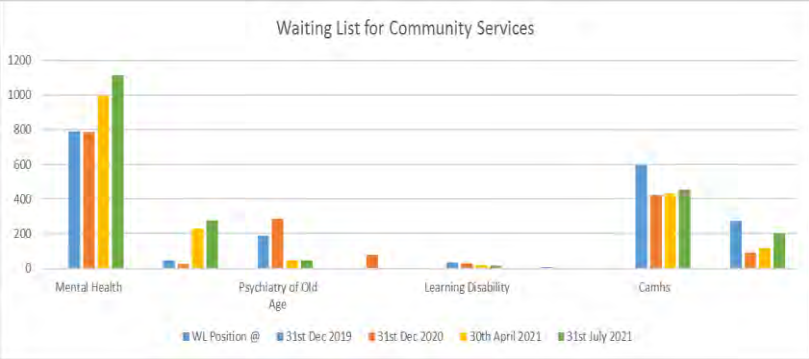
Outpatient Waiting List



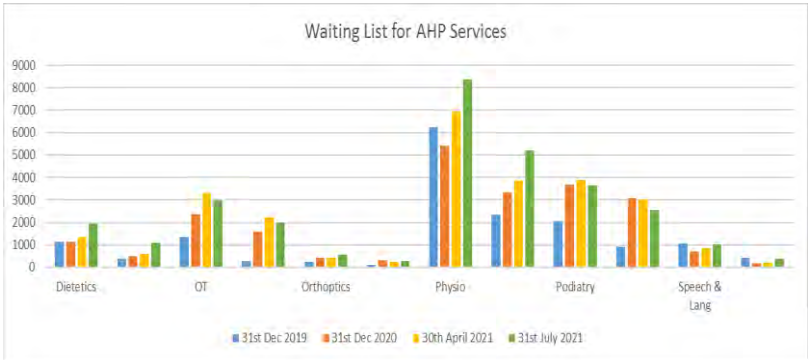
Outpatient Waiting List	31st Dec 19	31st Dec 20	31st Jul 21
Total	103700	109209	113549
>9 wks	80410	93600	93707
>52 wks	39450	55790	56334
% waiting< 9 wks	22%	14%	17%
% waiting> 52 wks	38%	51%	50%

Impact on Waiting lists

Community Waiting Lists



AHP Waiting Lists



	Mental Health		Psychiatry of Old Age		Learning Disability		Camhs	
WL Position @	Total Waits	> 9 wks	Total Waits	> 9 wks	Total Waits	> 9 wks	Total Waits	> 9 wks
31st Dec 2019	790	45	190	4	34	6	597	273
31st Dec 2020	785	26	287	80	29	4	422	91
30th April 2021	993	227	46	2	22	1	431	117
31st July 2021	1116	276	49	1	15	2	453	201

	Dietetics		OT		Orthoptics		Physio		Podiatry		Speech & Lang	
WL Position @	Total Waits	> 9 wks	Total Waits	> 9 wks	Total Waits	> 9 wks	Total Waits	> 9 wks	Total Waits	> 9 wks	Total Waits	> 9 wks
31st Dec 2019	1127	386	1334	283	255	119	6224	2350	2055	919	1057	438
31st Dec 2020	1147	497	2383	1596	422	306	5433	3334	3698	3072	692	171
30th April 2021	1338	583	3284	2240	422	260	6960	3846	3894	3003	850	206
31st July 2021	1957	1089	2988	1992	581	291	8360	5208	3641	2551	1021	372

Phase 6 Delivery Plan Position at 31st July 2021

- **Outpatients- overall under-performance - 82% of plan in Opat - New and 82% in Opat review**
- **Cancer Services – continued 100% performance in 14-day Breast –** 31 day performance is at 98% of plan - 62-day performance is 11% over plan
- **Diagnostics** – Overall overachievement against plans
- **Inpatients/Daycases** – Elective Theatre cases at 80%,Daycases at 85% and Endoscopy at 67% of plan.
- **AHPs** – Over achievement in most areas – Dietetics (all) and Podiatry reviews are less than 10% under plan. Orthoptics has a net over-performance with 58% of new and 181% of reviews achieved.
- **Mental Health** –Under-achievement against July projections for Adult Mental Health and CAMHS
- **Dementia** – 136% in 'new' & 86% in 'review' appointments
- **Psychological therapies** – final activity not available as yet.
- **Autism Services** – overachievement in Children's Autism – new interventions.

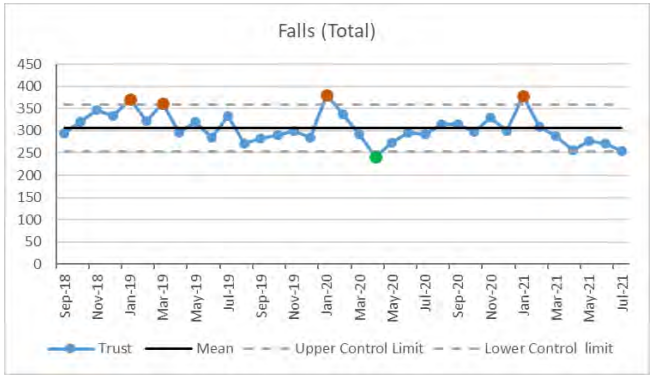
Phase 6 Delivery Plan - Position at 31st July 2021 (cont'd)

- **Day Care & Day Opportunities attendances** – Marginally below plan
- **Domiciliary Care –** achieving against plans – (Statutory 99% / Independent 102%)
- **District Nursing/Health Visiting -** District Nursing 75%
- **Community Paediatrics** – achieving against plans (New 148% / Review 99%)
- **Community Dental** – 'new' is 96% against plan (small volumes), with 103% achievement in 'review' numbers – overall 102%
- **Mental Health admissions** – ahead of plan at 145% (small numbers)
- **Children's Social Care** –
  - Child Protection Referrals ahead of projection (153%),
  - CPR Visits on target (102%)

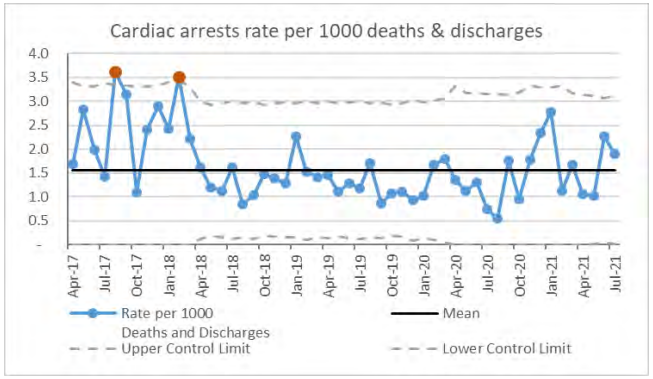
Safety

Classic Safety Thermometer indicators

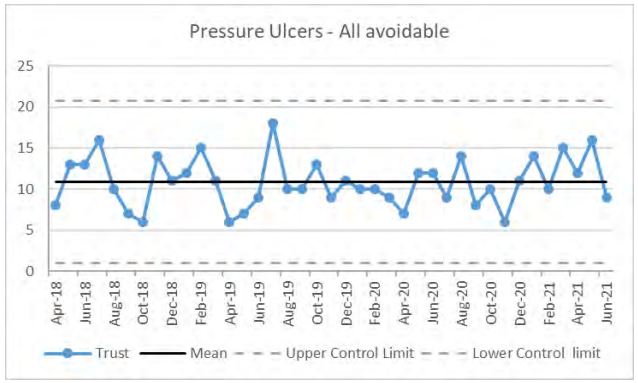
- **Falls**



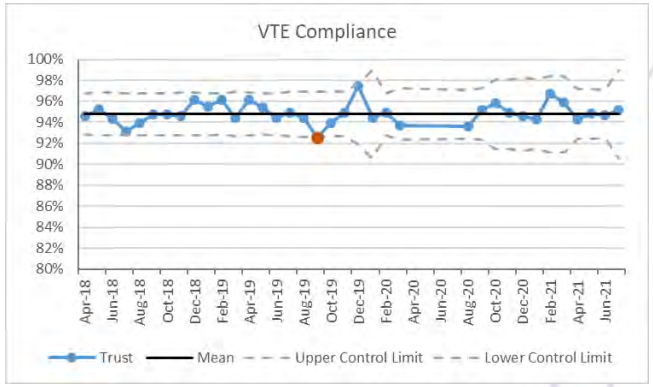
- **Cardiac Arrest Rate**



- **Pressure Ulcers**



- **VTE**



- Indicators are chosen as they provide an effective measure on the progress towards improvement in harm free care.

- All indicators are within control limits in 2020/21.

Safety Thermometer - Maternity

- Maternity – 18 surveys (July 2021)

Maternity Safety Thermometer - July 2021	July 2021 %	*Average Trust %
Harm Free Care - Physical	77.78%	79.68%
Harm free care - Perception of safety	100.00%	99.47%
Harm free care - Combined	77.78%	79.68%
PPH > 1000 mls	5.56%	13.37%
Mothers with perineal trauma or abdominal wound	72.22%	77.54%
Mothers with Infections since onset of labour	0.00%	0.53%
Apgar score of 6 or less at 5 minutes of birth	5.56%	3.21%
Babies unexpectedly transferred to SCBU/NNU/NICU	11.11%	4.81%
Mothers seperated from their baby	55.56%	26.74%
Mothers left alone at a time that worried them	0.00%	0.00%
Mothers whose concerns were not taken seriously	0.00%	0.66%
*Trust Score is the average score of all areas and months to date		

- The data collection commenced in October 2020. Targets/objectives will be introduced during 2021/22 after review of the indicator data captured.

Safety Thermometer – Medications

- Medications - 723 surveys (July 2021)

Medication Safety Thermometer - July 2021	July 2021 %	*Average Trust %	Target
Patients with medicines allergy status documented in their medicine kardex	83.40%	83.58%	97.35%
Patients with an omitted dose (Excl valid Clinical Reason & Refusal)	13.69%	16.86%	12.02%
Patients with an omitted dose relating to a critical med (Excl. valid reason & refusal)	1.38%	2.09%	6.86%
Patients receiving high risk medicine that had a trigger of harm.	0.70%	1.55%	2.08%
Patients with medicine reconciliation started within 24hrs of admission to Trust	47.28%	55.90%	68.43%
*Trust Score is the average score of all areas and months to date			

- Data are produced monthly and fed back at ward/department level.
- Medications Safety Thermometer is discussed at the quarterly Medicines Optimisation Committee.
- The data collection commenced in October 2020.
- Trust level goals have been introduced from April 2021.

Safety Thermometer – Mental Health

- 16 surveys (July 2021)

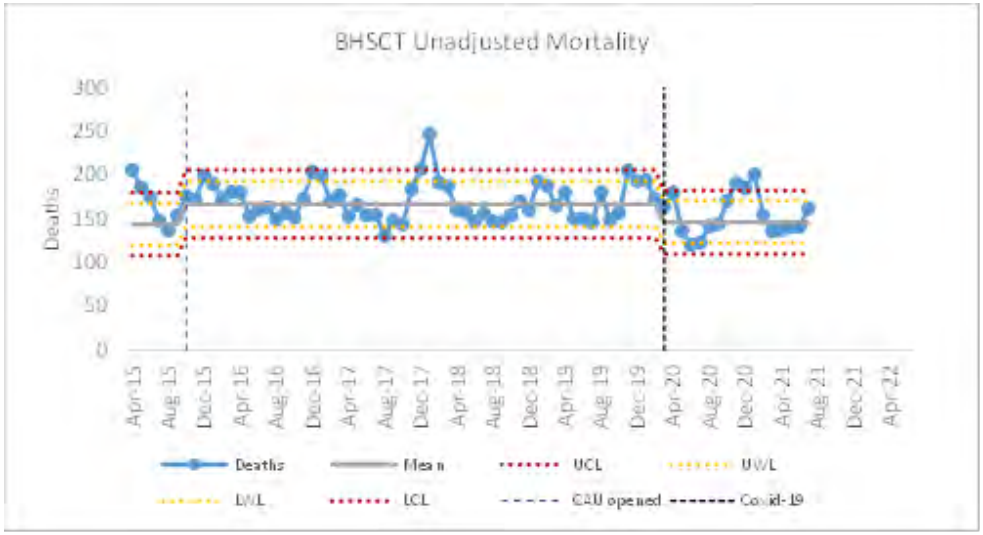
Mental Health Safety Thermometer - July 2021	July 2021 %	Average Trust* %
Harm free Care	93.75%	87.58%
Self harmed in past 72 hours	6.25%	7.27%
Victim of violence or aggression in past 72 hrs	0.00%	1.21%
Percentage of patients with an omitted medicine (Excl valid clinical reason & refusal)	18.75%	14.24%
Felt safe at time of survey	100.00%	95.15%
Required Restrictive Intervention in past 72 hrs	0.00%	0.91%
*Trust Score is the average score of all areas and months to date		

- Monthly reports are provided to wards/division.
- The data collection commenced in October 2020. Targets/objectives will be introduced during 2021/22.

Mortality

BHSCT Mortality Indicators

- **BHSCT Crude Mortality to July 2021.**



Note : Crude Mortality = deaths / total deaths & discharges in hospital (takes no account of case-mix) – as a %

- BHSCT mortality rates remains within normal limits of variation in the current period. Due to the impact of Covid19 on the measurement of mortality rates these limits are re-calculated to adjust for the changes in disease presentation of admitted patients

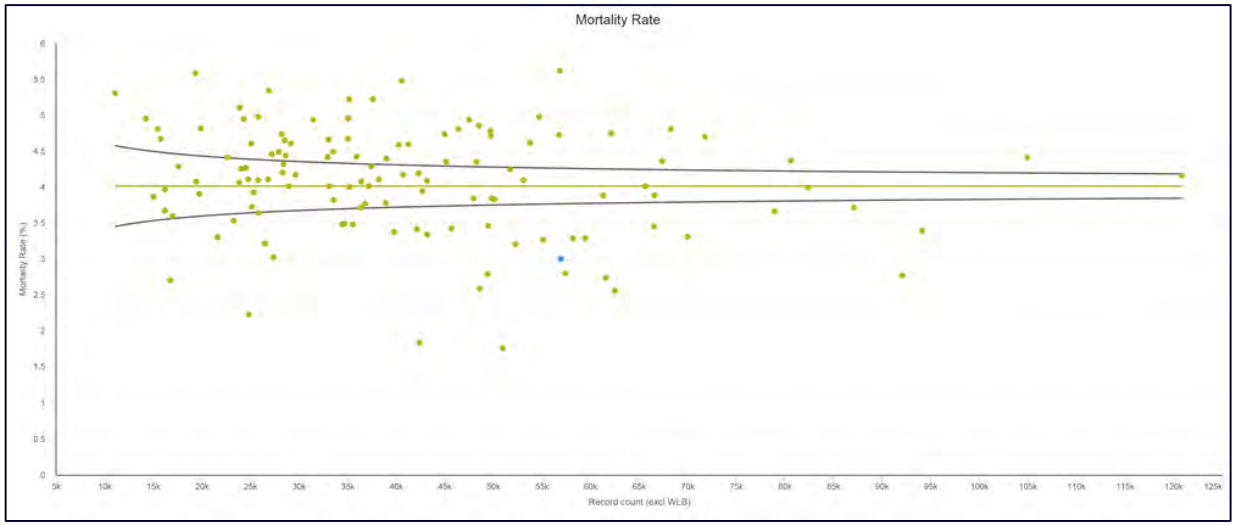
Mortality rates can be further sub-divided into those with surgical procedures

- Belfast Trust mortality rate after elective surgery is 0.18% against a peer figure of 0.18% .
- Belfast Trust mortality rate after emergency surgery is 1.29% against a peer figure of 1.68%

Mortality

BHSCT Mortality Indicators

- **BHSCT Crude Mortality Rate with Peer Comparison- May 2020 to April 2021**

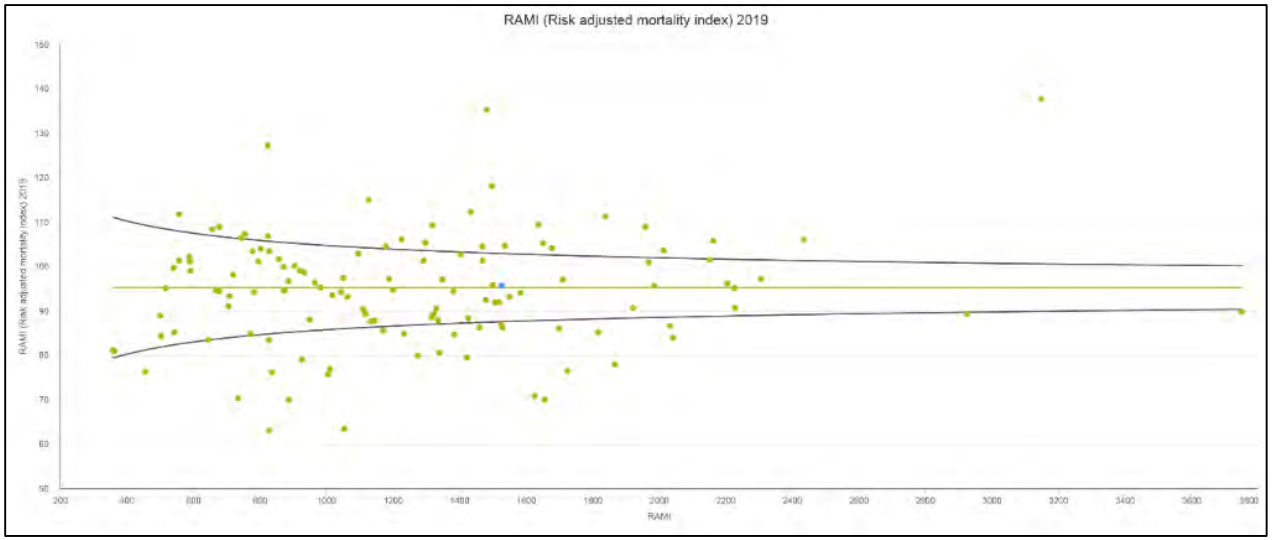


- The Trusts crude mortality rates compare favourably against peer hospitals with a Trust mortality rate of 3% against a peer figure of 4% for the period May 2020 to April 2021 (latest 12 month period)
- Funnel chart: lines are 3 standard deviations either side of the mean (mean crude mortality of all acute hospitals in England in our Peer group e.g. teaching – roughly 150 – each hospital is a dot). BHSCT is represented by the light blue dot and is below the mean which is a positive position.

Mortality

BHSCT Mortality Indicators

- **BHSCT Risk Adjusted Mortality Rate- April 2020 to March 2021**



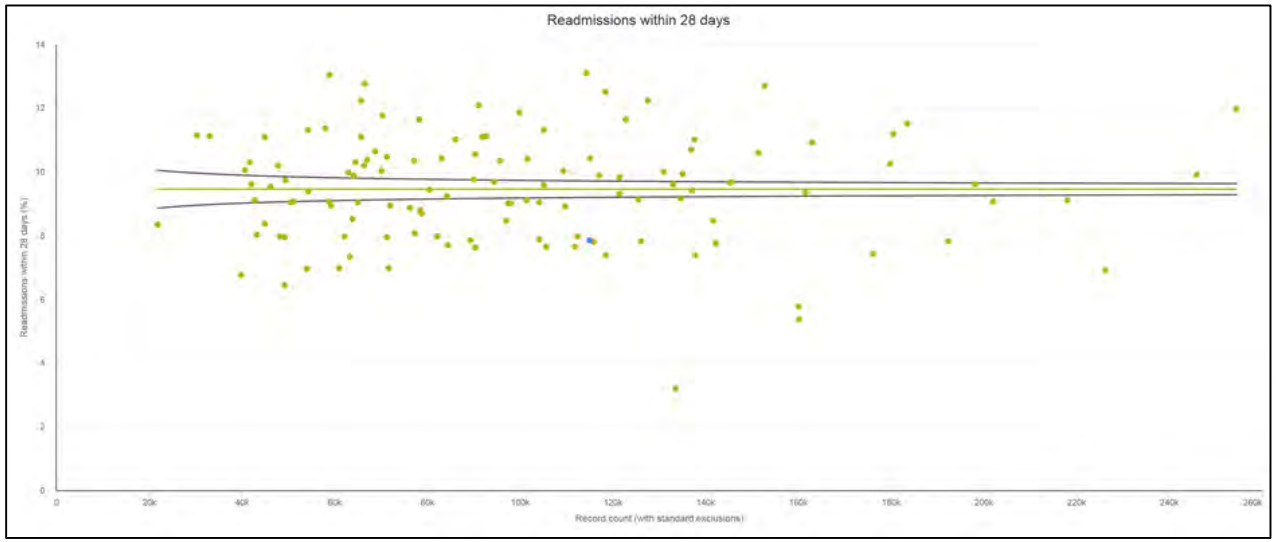
NB. Due to the requirement to wait for submission of peer data from other hospitals and the need for adequate levels of clinical coding completion mortality rates for peer analysis will be less recent than Trusts own figures

- Risk adjusted mortality calculates an expected rate of death (taking account of casemix) and presents this as an index of 100.
- The Trust is measured against this index, therefore a Trust index of 95 means deaths are 5% less than expected in the statistical model. BHSCT (blue dot) is within acceptable standard deviations.

- The Trusts index value is 95 with a peer value of 95 for the period April 2020 to March 2021

Readmissions within 28 days

Belfast Trust Readmissions within 28 days – May 2020 to April 2021

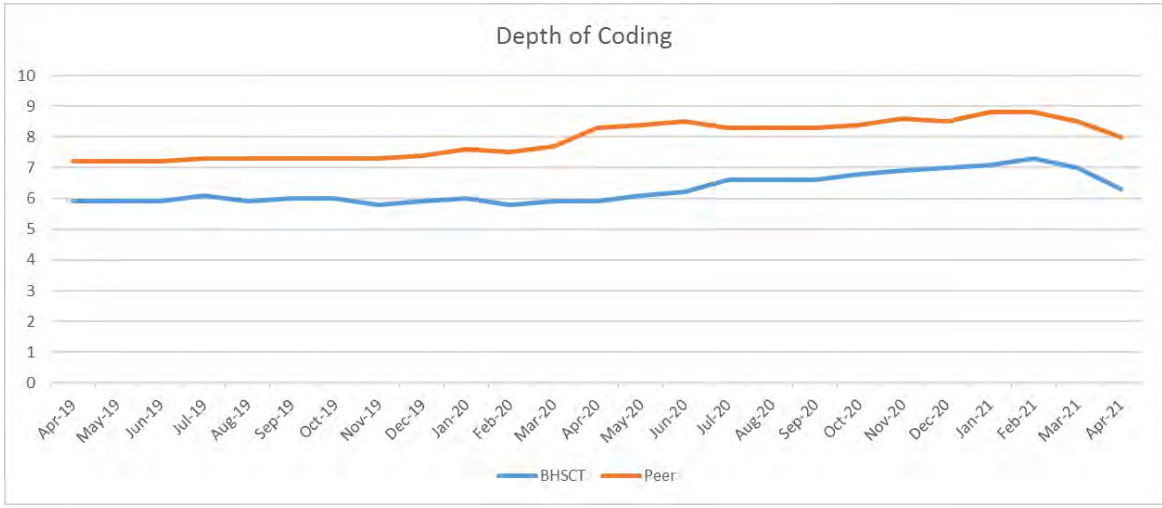


The Trusts readmission rate for the period May 2020 to April 2021 is 8.0% against a peer figure of 9.4% (latest 12 month period).

Readmission rates are a useful indicator of healthcare quality. Some readmissions to hospital will be unavoidable and may be multi-factorial therefore this indicator is often used in comparison with peer hospitals for context. It is also a useful balancing indicator to be observed whenever service improvement or changes are made within the Trust.

Clinical Coding – Depth of coding

Depth of coding illustrates how comprehensively we have described a patients acuity through the recording of the appropriate number and type of diagnoses. This allows us to accurately analyse information for safety, quality, efficiency & effectiveness and is especially important when we use comparative analysis with peer hospitals for examining mortality rates & LoS

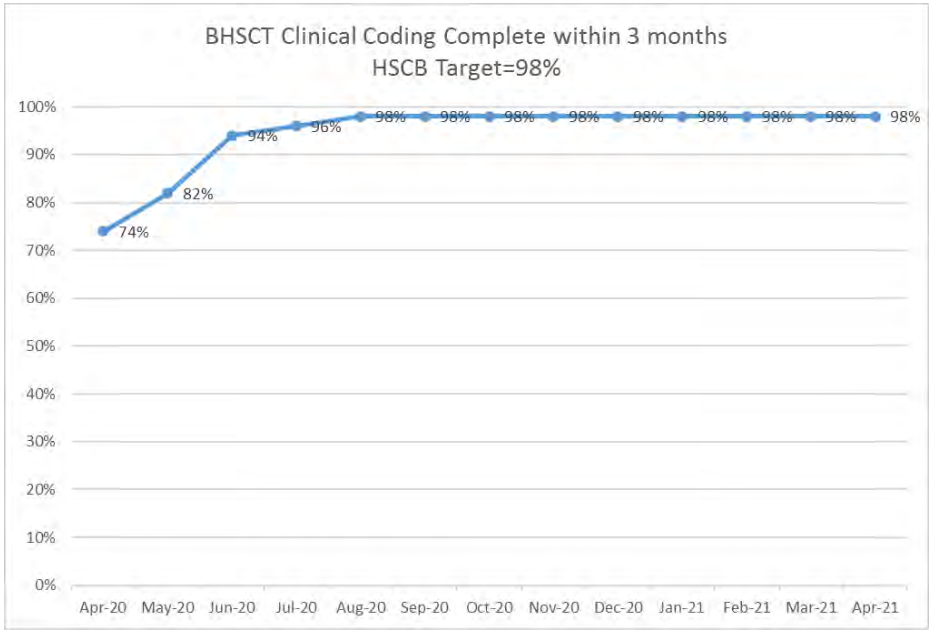


- **Pre-Covid BHSCT Depth of coding was 6 diagnoses per episode against a figure of 7 in the peer**. Lately this figure has inflated due to the Covid crisis and additional codes required to code these and also some change in types of patients admitted. This inflated figure will reduce when the impact of the crisis reduces.
- Coding KPI's are monitored at Specialty level also.

Clinical Coding - Timeliness

STANDARD – 98% within 3 months of discharge

- **Clinical coding Timeliness has reached the HSCB target of 98% for the last 6 months and is on trajectory to maintain this**.



- Some outsourcing of clinical coding has assisted with dealing with backlog whilst newly recruited staff are trained and qualified.

Clinical Coding - Accuracy

- Full casenote audits are completed on an ad-hoc basis, these are resource intensive however a new audit resource has been identified and an audit schedule is under construction to progress this.
- To complement audit a range of data analytical quality indicators are used routinely to target improvement & audit. These have been chosen as having significant impact on coding accuracy.
- It is not always possible to use the most specific code as documentation/evidence may not be available to coders or the patients condition is still under investigation however peer analysis informs us as to how similar we are to the average of peer coded information.

Clinical Coding Accuracy -Indicator Description	BHSCT May 20 - Apr 21	Peer Value	Performance
Data Quality Index-Shows overall data quality for clinical coding based on aggregation of scores from indicators	93	95	
% Uncoded Episodes-This should be as close to zero as possible to ensure all diagnostic information is captured	1.3%	1.0%	
Sign or symptom as a primary diagnosis-Should be minimal or match peer.Potential lack of detail in coding which affects analysis of patient acuity	9.5%	13.0%	
Sign and Symptoms as Primary Diagnosis (Episode 2)-Should be minimal or match peer.Potential lack of detail in coding which affects analysis of patient acuity	9.8%	11.2%	
Admitting Diagnosis Emergency for Elective Admission-Should be minimal or match peer.Potential error in coding which affects analysis of patient acuity	2.4%	1.7%	
Diagnosis Non-Specific-Should be minimal or match peer.Potential lack of detail in coding which affects analysis of patient acuity especially in risk adjustment for mortality.	11.1%	11.4%	
Deaths with palliative care code Z515-Rate should be similar to peer if all relevant cases are coded accurately. This can underestimate acuity of patients in mortality analysis	38.0%	35.7%	
Deaths with palliative care code Z515-Rate should be similar to peer if all relevant cases are coded accurately.This can underestimate acuity of patients in mortality analysis.	2.2%	2.3%	

Poor performance in any of the indicators above may provide misleading information related to patient acuity. This may distort comparisons against peers in a range of quality, safety and efficiency indicators.

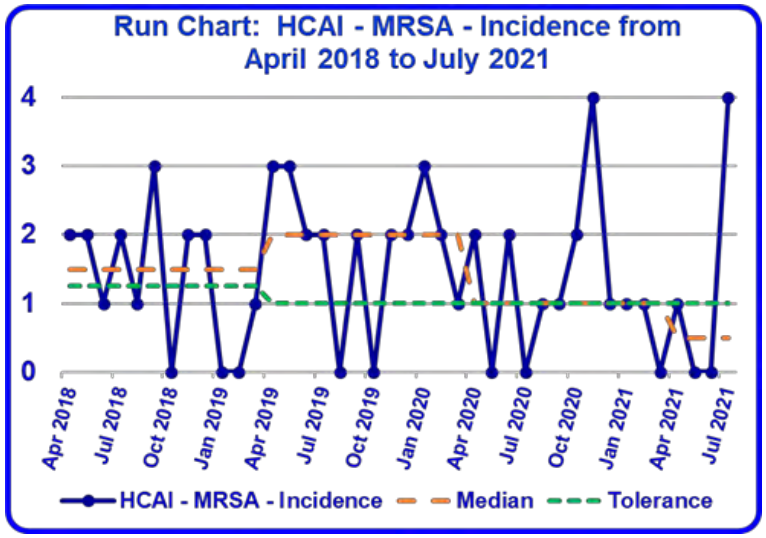
Healthcare Associated Infections

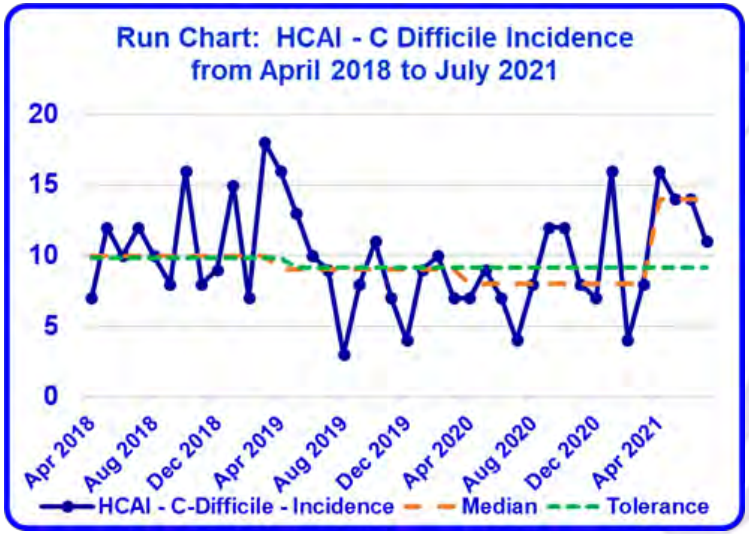
CPD: To secure a regional aggregate reduction of 19% in the total number of in-patient episodes of Clostridium Difficile infection in patients aged 2 years and over compared to 2018/19.

Last year the incidence of C-Difficile was 102 against a target tolerance of 110. The Incidence of C-Difficile to the end of July 2021 is 55, compared to 27 for the same period in 2020.

CPD: To secure a regional aggregate reduction of 19% in the total number of in-patient episodes of MRSA infection compared to 2018/19.

Last year the total incidence of MRSA was 15 against a target of 12. The incidence to the end of July 2021/22 is 5, compared to 4 for the same period in 2020/21.

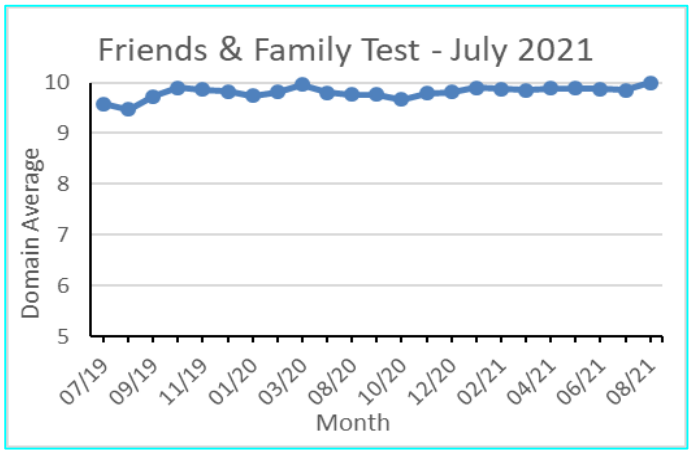


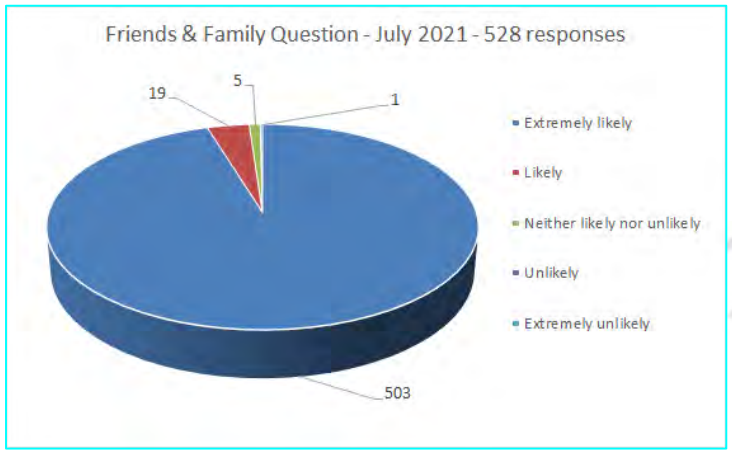


Experience

Real-Time Feedback – Friends and Family Test

- The collection of fortnightly Patient Experience feedback recommenced mid-July 2020 in 48 phase 1 acute areas, with the exception of 3 due to reasons related to Covid-19.
- The patient experience team has expanded with new staff members trained up to roll out to phase 2 wards. Work is planned for further roll out to a wider range of settings to include outpatients & community services.





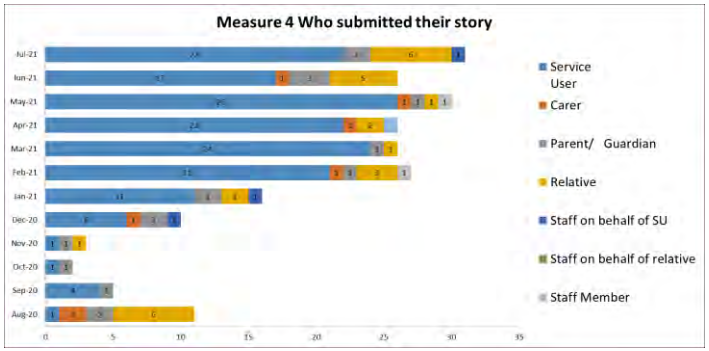
- We have seen consistently high scores in both overall satisfaction and the Friends & Family Test.
- In July 2021, 99% of 528 patients were extremely likely or likely to recommend the ward they were in to their friends or family.

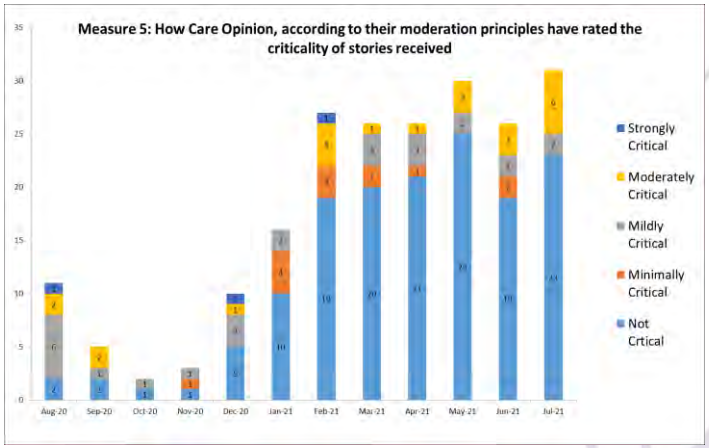
Care Opinion – to July 2021

Care Opinion
What's your story?

TOTAL NUMBER OF STORIES TO DATE (since August 2020)	213
TOTAL NUMBER OF CHANGES	7
TOTAL NUMBER OF CHANGES PLANNED	2
TOTAL NUMBER OF CHANGES MADE	5

- Social Media promotion on a weekly basis.
- Awareness sessions being delivered to teams who are rolling out Care Opinion
- Care Opinion now being embedded as a standing item on Divisional Safety and Quality Governance meetings throughout the Trust.
- Number of staff responding has increased from 146 in Dec 2020 to 317 in July 2021





Belfast Health and Social Care Trust
caring supporting improving together

Working together Excellence Openness & Honesty Compassion

Care Opinion – at July 2021

Top 5 themes reported in relation to good experiences and experiences which require improvement as identified by the authors of the stories

WHAT'S GOOD	Number
Staff	84
Friendly	40
Care	35
Reassuring	27
Support	22

WHAT COULD BE IMPROVED	Number
Communication	13
Staff Attitude	9
Dismissive	6
Access to Specialist	3
Advice	3
Conflicting Information	3
Continuity of Care	3
Referral	3
Not listened	3

FEELINGS & EMOTIONS	Number
Thank You	60
At ease	24
Good	24
Grateful	23
Reassured	23

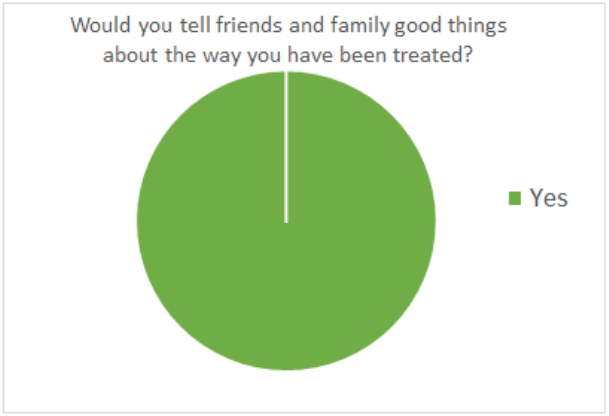
The word cloud is generated from the care opinion database, from stories submitted by individuals, under the tags heading of what was good, what could be improved and how did you feel - for example 'communication',' food' and 'reassured' could be the tags entered which would then be populated into a Trust word cloud. This is based on all the responses with frequent terms such as communication featuring more often hence the emphasis on the word cloud.

Safety Thermometer – Muckamore Site

- 4 surveys (July 2021)

Real Time Patient Feedback Report - Muckamore - July 2021

Domain	Domain Score
Consistency & Coordination	8.75
Respect	10.00
Involvement	10.00
Staff	7.92
Cleanliness	10.00
Pain Control	10.00
Medicines	9.17
Noise at night	6.25
Kindness & Compassion	10.00
Friends & Family	10.00
Overall domain score	9.12



Overall Satisfaction 91%

- The data collection commenced in June 2021.

Safety Thermometer – Domiciliary Care

- 14 surveys (July 2021)

Service User Experience Report - Domiciliary Care

Total Responses - July 2021	14

Domains	Score
Consistency & Co-ordination	10.00
Overall Involvement	9.61
Involvement - Domiciliary Care Worker	9.46
Involvement - Trust Key worker	9.64
Cleanliness	9.73
Carers	9.57
Timeliness	9.38
Kindness & Compassion	9.82
Respect & Dignity	9.82
Privacy & Confidentiality	9.64
Lifestyle, Beliefs and Culture	10.00
Recommendation (F&FT)	9.46
Overall domain score	**9.73**

Breakdown of responses received by:		
Service User	Relative	Other
93%	**7%**	**0%**

Overall Satisfaction	97%

- The data collection commenced in May 2021.

Effectiveness & Timeliness

- Elective Care Action plan
- Elective Inpatient/Day-cases
- Cancer Access
- Diagnostics
- AHPs
- Endoscopy
- Unscheduled Care
- Outpatients
- Fractures
- Mental Health
- Muckamore Abbey Hospital Indicators
- Older People's Services
- Direct Payments
- Children's Community Services

Belfast Trust Response 27/7/2021

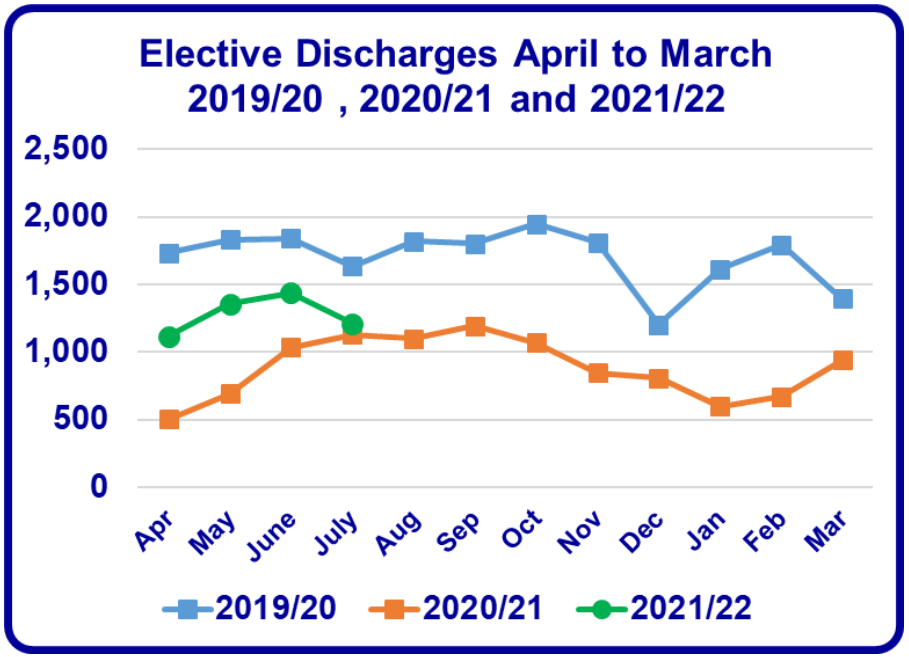
Elective Care Framework Action Plan

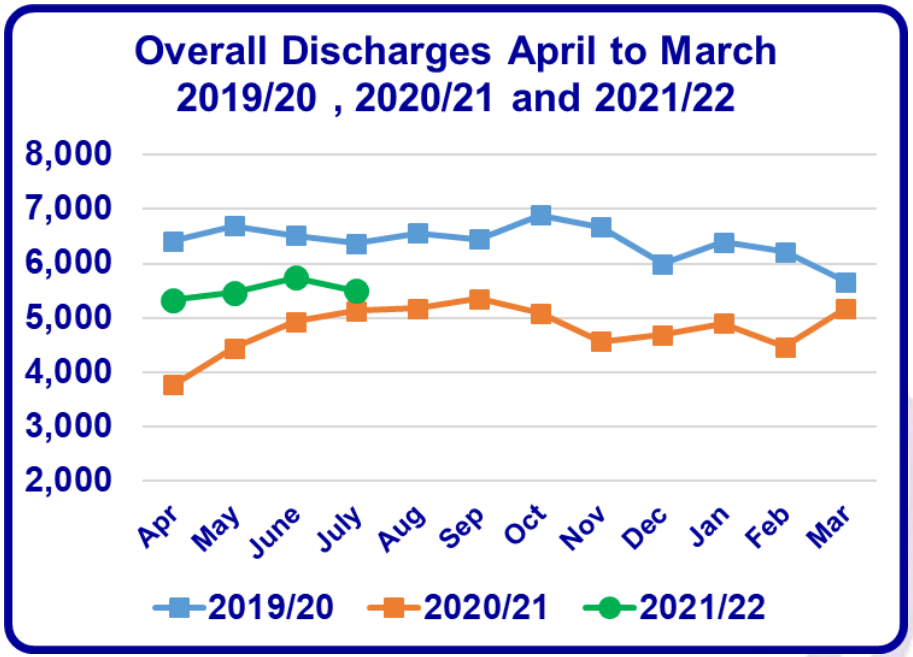
Elective Care Framework Action Plan			
	Action	**Target Date**	**Actions**
2	Make recommendations on medium term contracts to lease theatres to independent providers to address current backlogs. This will include theatre capacity that is not in active use, including use of HSC theatres in evenings and weekends where HSC activity cannot be delivered	IN PLACE - SCOPES	BHSCT has inreach arrangements in place with an IS provider for delivery of weekend Endoscopy sessions. These are expected to continue during 21/22.
		GA DC THEATRE Q3 2021	The Trust is discussing proposals with an IS Provider for use of Trust premises (BCH/RVH sites) for inreach weekend daycase work (provider must meet the necessary governance arrangements inclusive of the supply of relevant pharmacy licence).
			Current bed capacity constraints in the BHSCT will not permit the use of theatres for inpatient surgeries for IS providers.
8	All HSC Trusts will move to provide a minimum of 25% of outpatient attendances virtually, either by telephone or by video conference	Oct-21	BHSCT delivered 34% of SBA OP attendances virtually for Q1 21/22.
			Video technology has been developed and made available in the Trust for a number of specialties and services to facilitate virtual appointments along with telephone appointments.
9	The NI Orthopaedic Network will oversee the development of megaclinics for orthopaedic outpatients	Sep-21	The Trust is part of the NI Orthopaedic Network and is planning for delivery of a small number of orthopaedic mega clinics (3) from September 2021.
			Ophthalmology are also planning mega-clinics (dependent on staffing confirmation and COVID pressures)
11	The HSCB will oversee the introduction of pre-operative assessment megaclinics	Sep-21	BHSCT will on participate and contribute to this initiative overseen by HSCB.
49	All HSC Trusts will ensure the introduction of text or voice messaging services to reduce DNA rates for all elective services	IN PLACE	BHSCT has in place text and voice reminder messaging services for OP services. The reminder messages are being extended to some elective procedure patients and the further use for elective IPDC patients will be further explored.
50	HSC Trusts will invest to increase capacity in patient booking teams to ensure that patients are contacted prior to surgery.	IN PLACE	BHSCT IPDC Bookings Teams contact the majority of IPDC patients by phone prior to admission to confirm admission dates and also to arrange COVID testing dates.
54	In line with increasing HSC capacity, HSC Trusts will move to a 7-day working week for existing theatre infrastructure. There are, however, significant challenges to this. In addition to the necessary investment in the workforce, this will require significant engagement with staff. This is therefore a longer term aspiration and is subject to the delivery of additional recurrent investment.	From January 2023 onwards	The Trust is supportive of utilisation of theatre capacity over 7 days. Staff availability (in particular nursing) and resources to support a 7 day model will be required.
			The BHSCT will work with others in the region to move towards this objective.

Elective Inpatients / Daycase

MAHI - STM - 302 - 326

The Covid pandemic has had a significant impact on elective surgery. The Trust has continued to treat prioritised patients within available capacity.



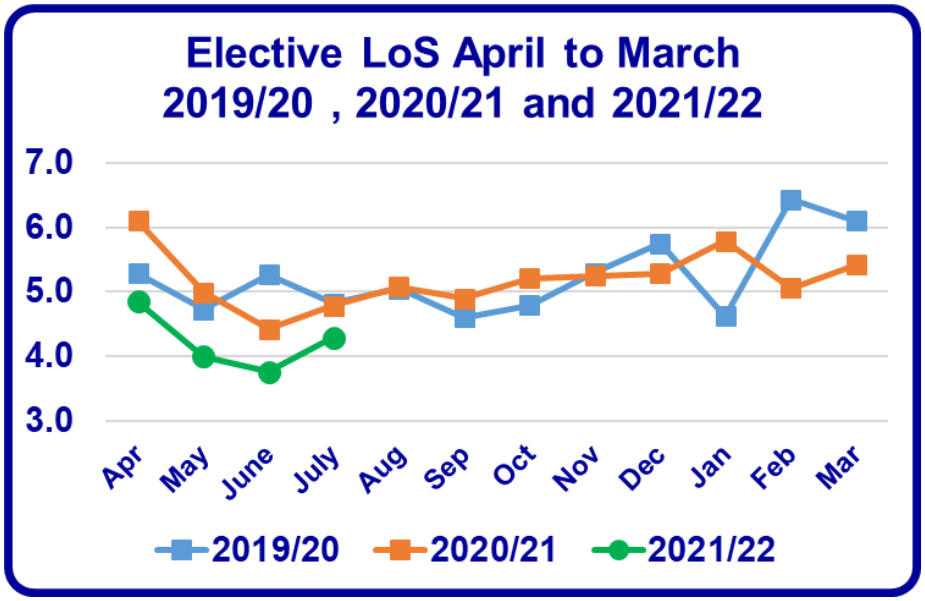


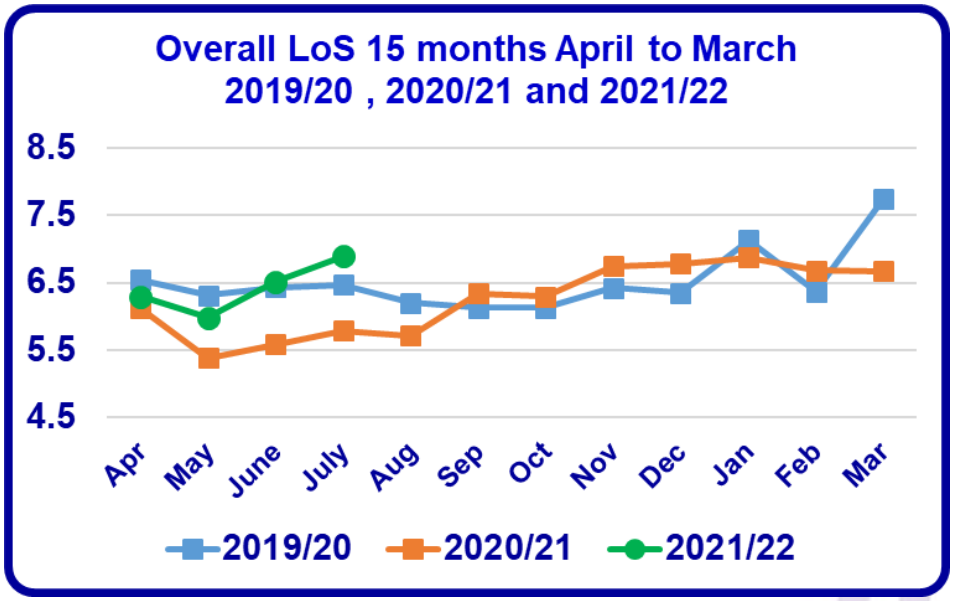
Elective Discharges

There were 1,211 elective discharges in July 2021, 82 (5%) more than in July 2020, however, still 422 (26%) below the Elective Discharges in July 2019 of 1,633.

Elective Inpatients / Daycase

Average Length of Stay (ALoS) at July 2021



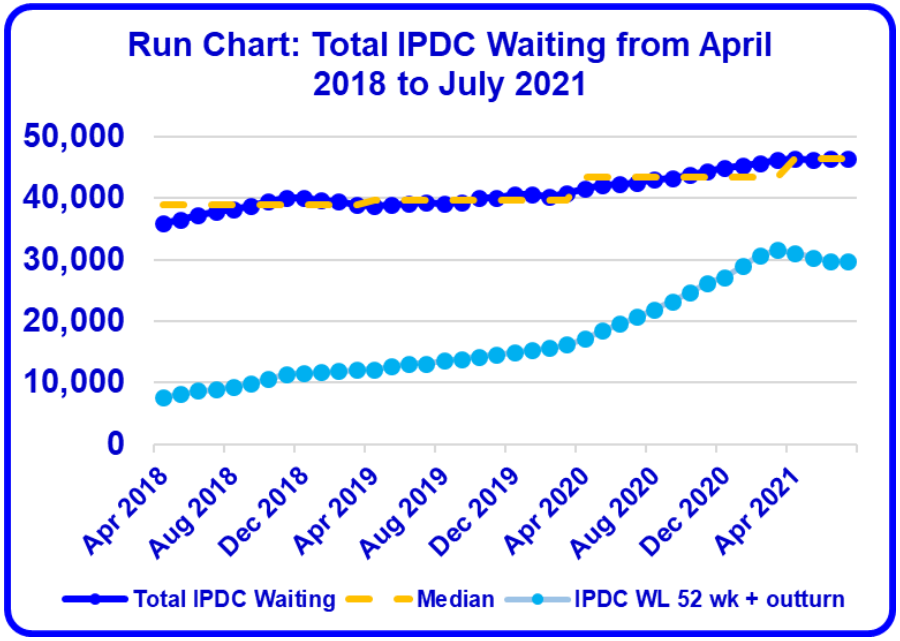


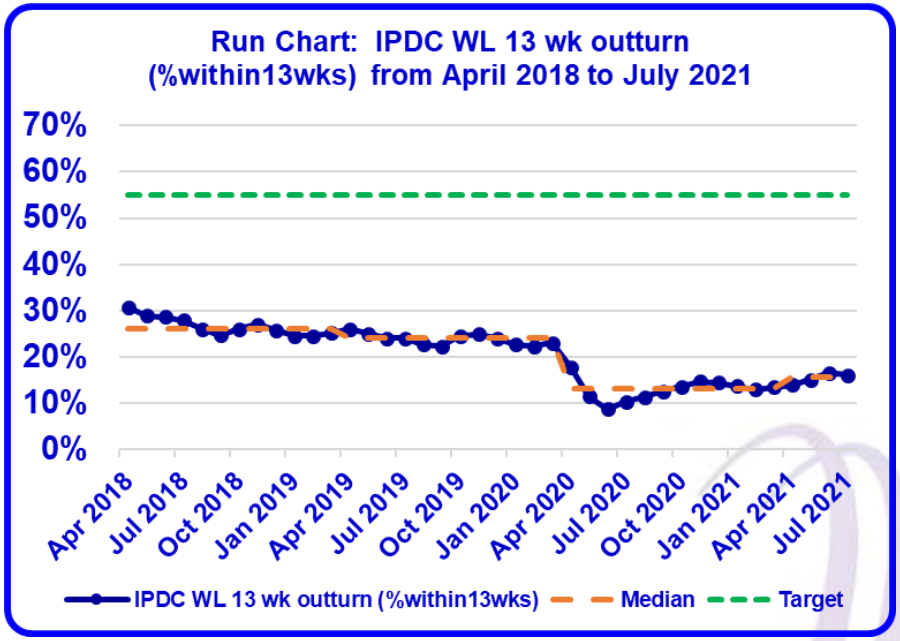
- All sites experienced an increase in LoS at the end of 2019/20 compared to 2018/19, Overall LOS in April – July 2021 is broadly similar to 2019.
- Overall LoS is 6.9 days in July 2021, compared to 5.8 in July 2020 and 6.2 in July 2019.
- Elective LoS is 4.3 days in July 2021, compared to 4.8 days in July 2020 and 4.8 in July 2019.

Elective Inpatients / Daycase

MAHI - STM - 302 - 328

CPD: Inpatient / Day-case (IPDC) Waiting lists (WL) - 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

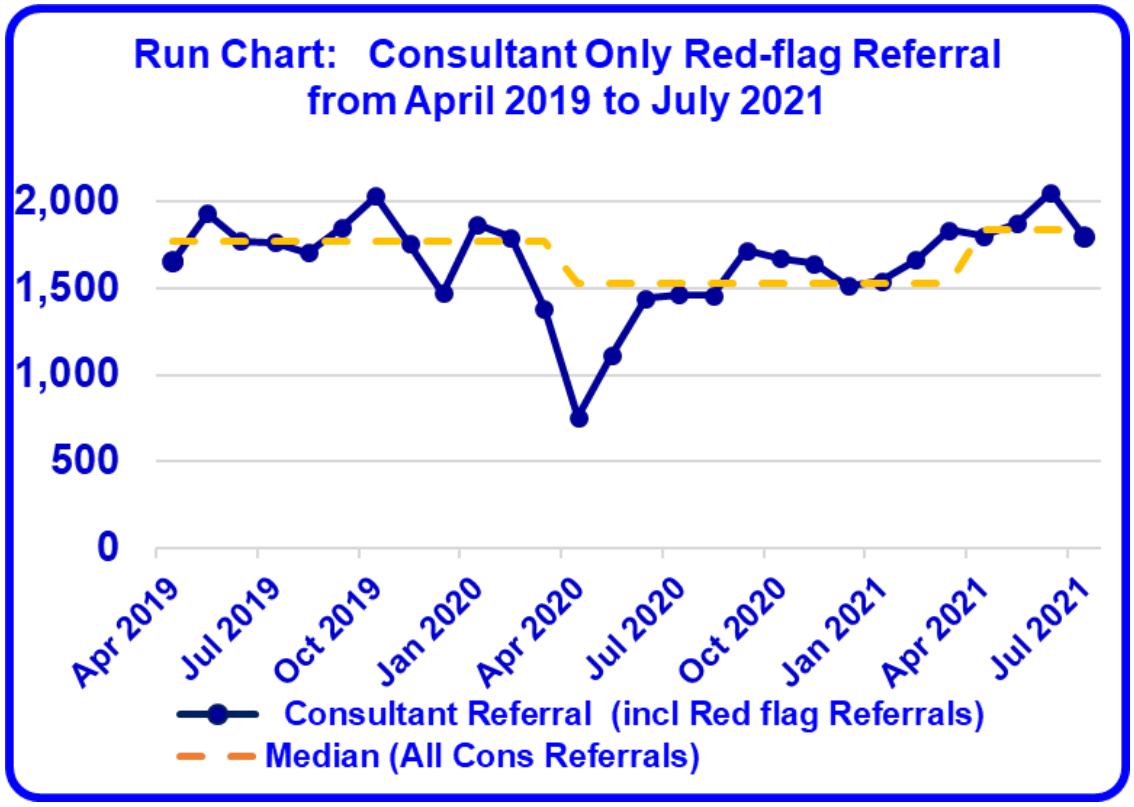




- A total of 46,397 patients were on the waiting list at the end of July 2021, compared to 42,558 at the end of July 2020.
- Numbers of patients waiting > 52 weeks has increased from 20,696 at 31st July 2020 to 29,697 at the end of July 2021.
- The percentage of patients waiting < 13 weeks has increased slightly to 16% at the end of July 2021 from 10.4% at the same time last year. The month with lowest numbers waiting less than13 weeks was June 2020 (9%).

Cancer Access

Red Flag referrals



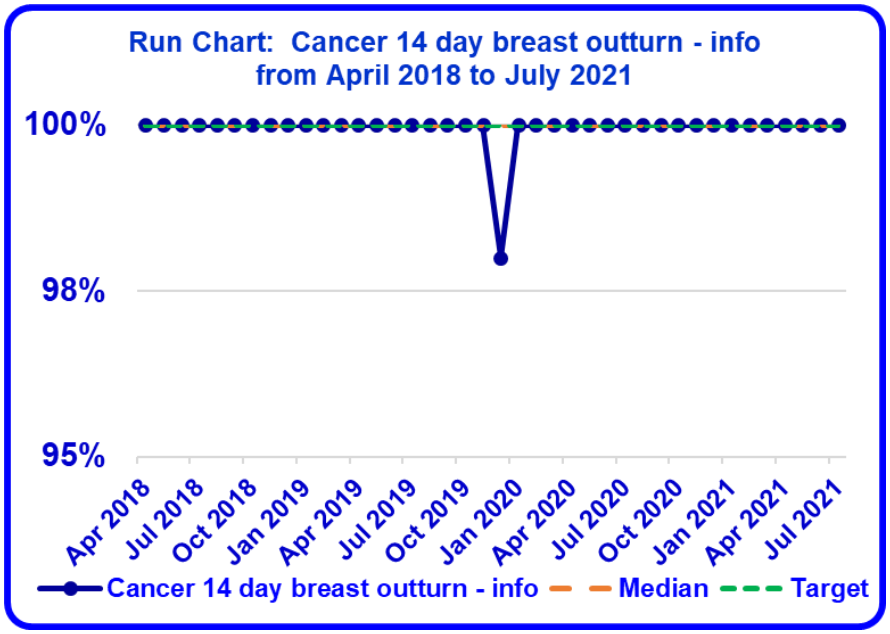
- After an initial drop in red flag referrals in April 2020 to 756 numbers have increased steadily
- At July 2021 there were 1,795 red flag referrals, compared to 1,464 in July 2020.

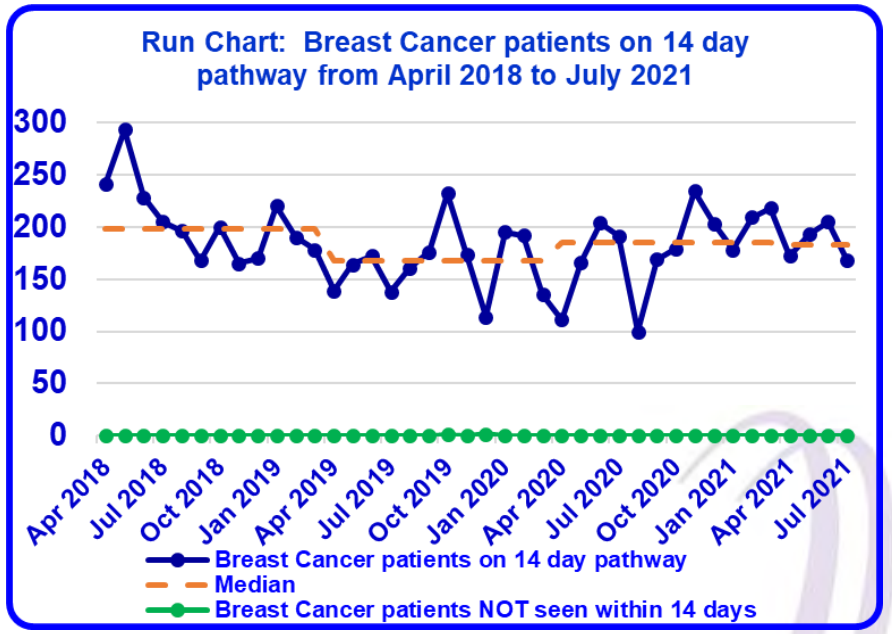
Cancer Access

MAHI - STM - 302 - 330

14-day Breast target

CPD: All urgent suspected breast cancer referrals should be seen within 14 days





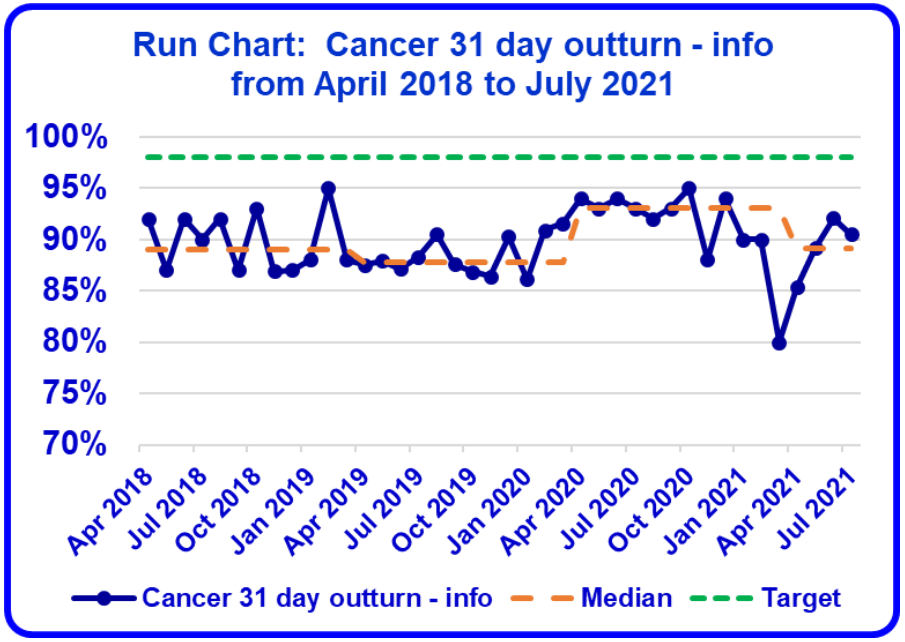
- The 100% target continued to be met between up to July 2021, apart from a drop of 2% in December 2019. Average activity was 166 for 2019/20 and 180 for 2020/21.
- In April 2021 There were 172 patients seen on the 14 Day Breast Cancer pathway. The average monthly number of patients on the 14 day pathway is 180.

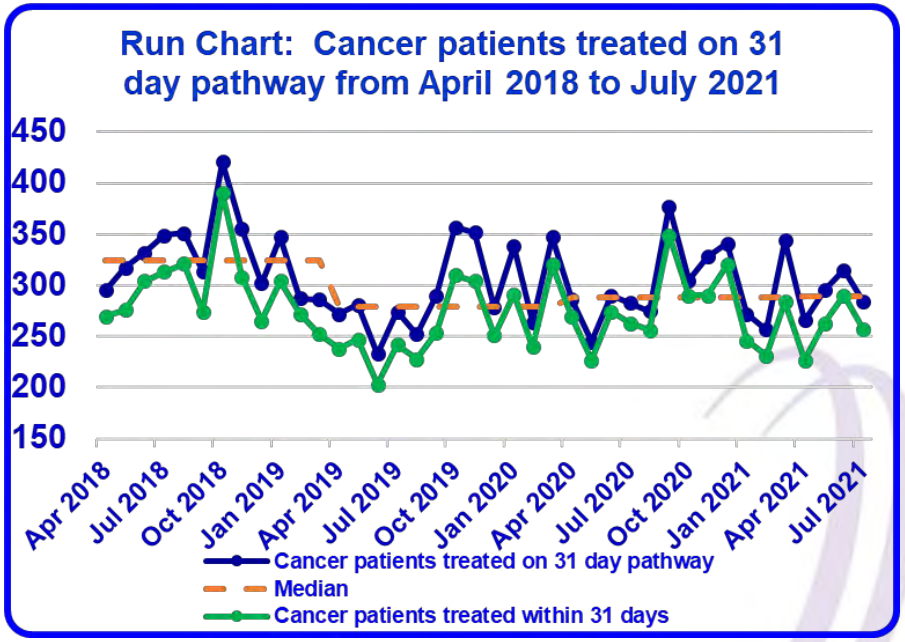
Cancer Access

MAHI - STM - 302 - 331

31-day pathway

CPD: At least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.





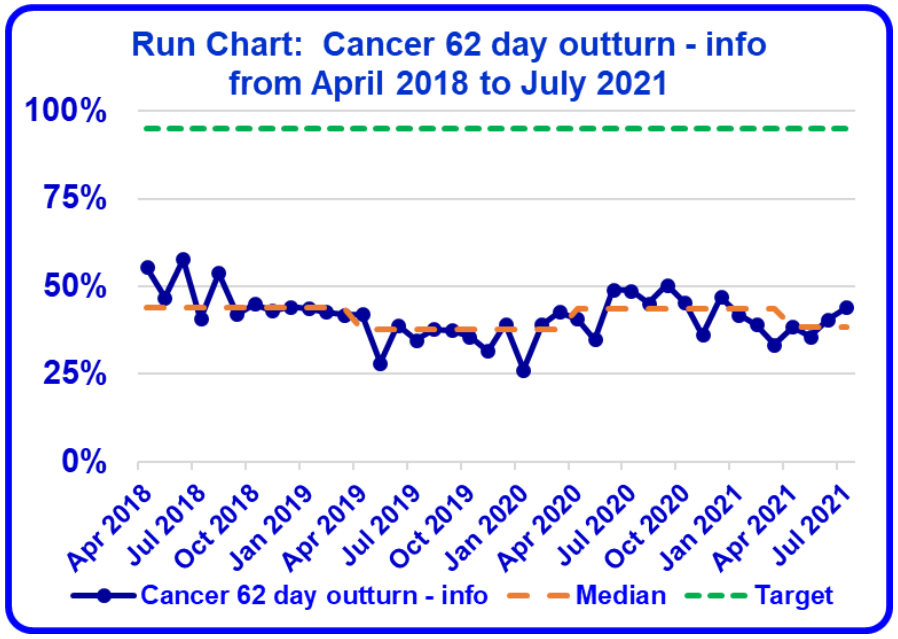
- In July 2021 there were 257 patients (90%) treated within target on 31 day pathway and 27 people exceeding the target of a total of 284 patients commencing treatment..

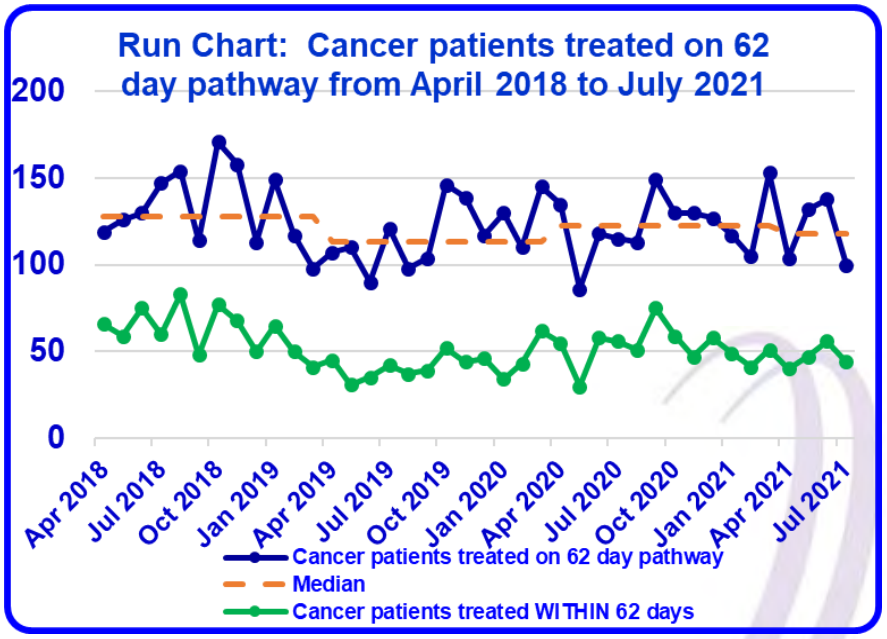
Cancer Access

MAHI - STM - 302 - 332

62-day pathway

CPD: At least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

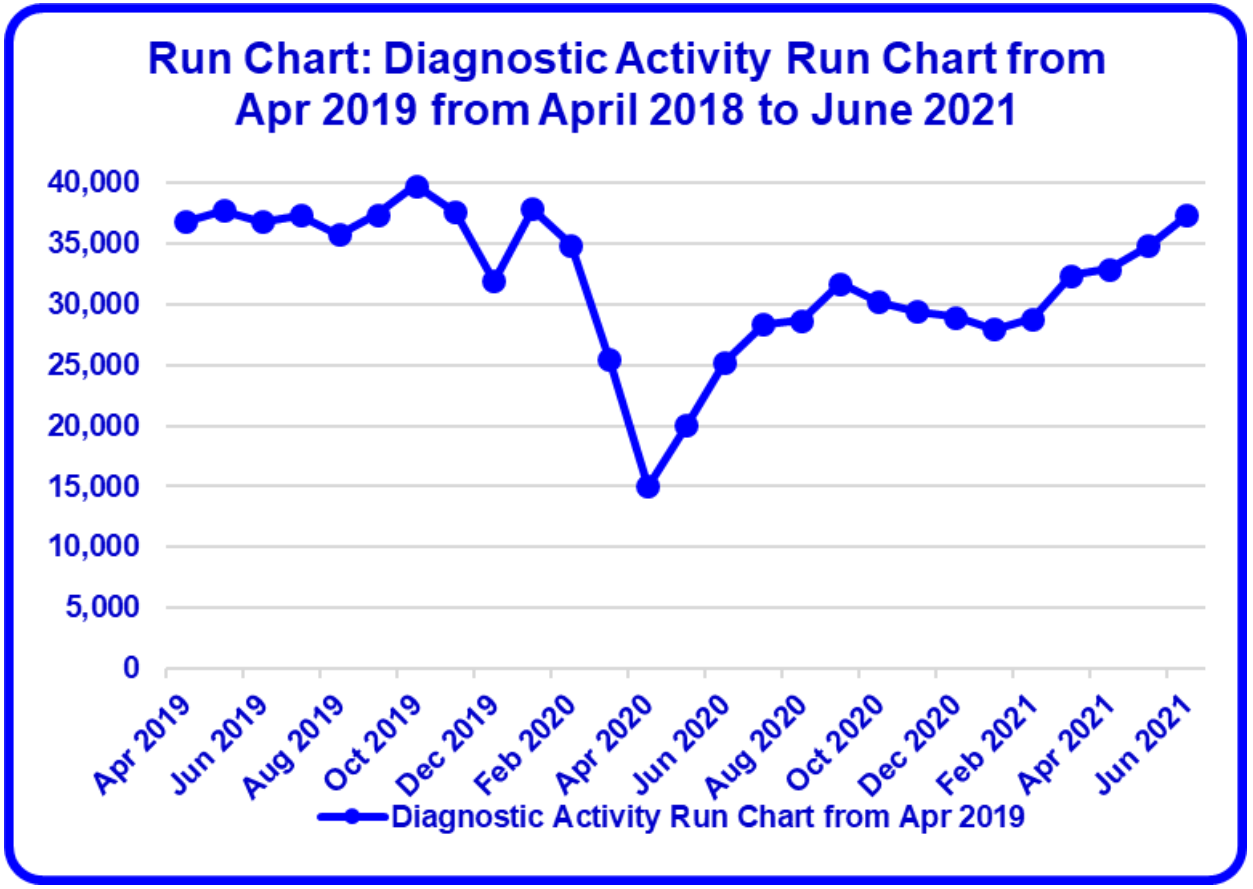




- In July 2021 there were 44 patients (44%) treated within target on 62 days pathway and 56 people exceeding the target.

Diagnostics

Diagnostics – (CT, NOUS, MRI and Ultrasound)

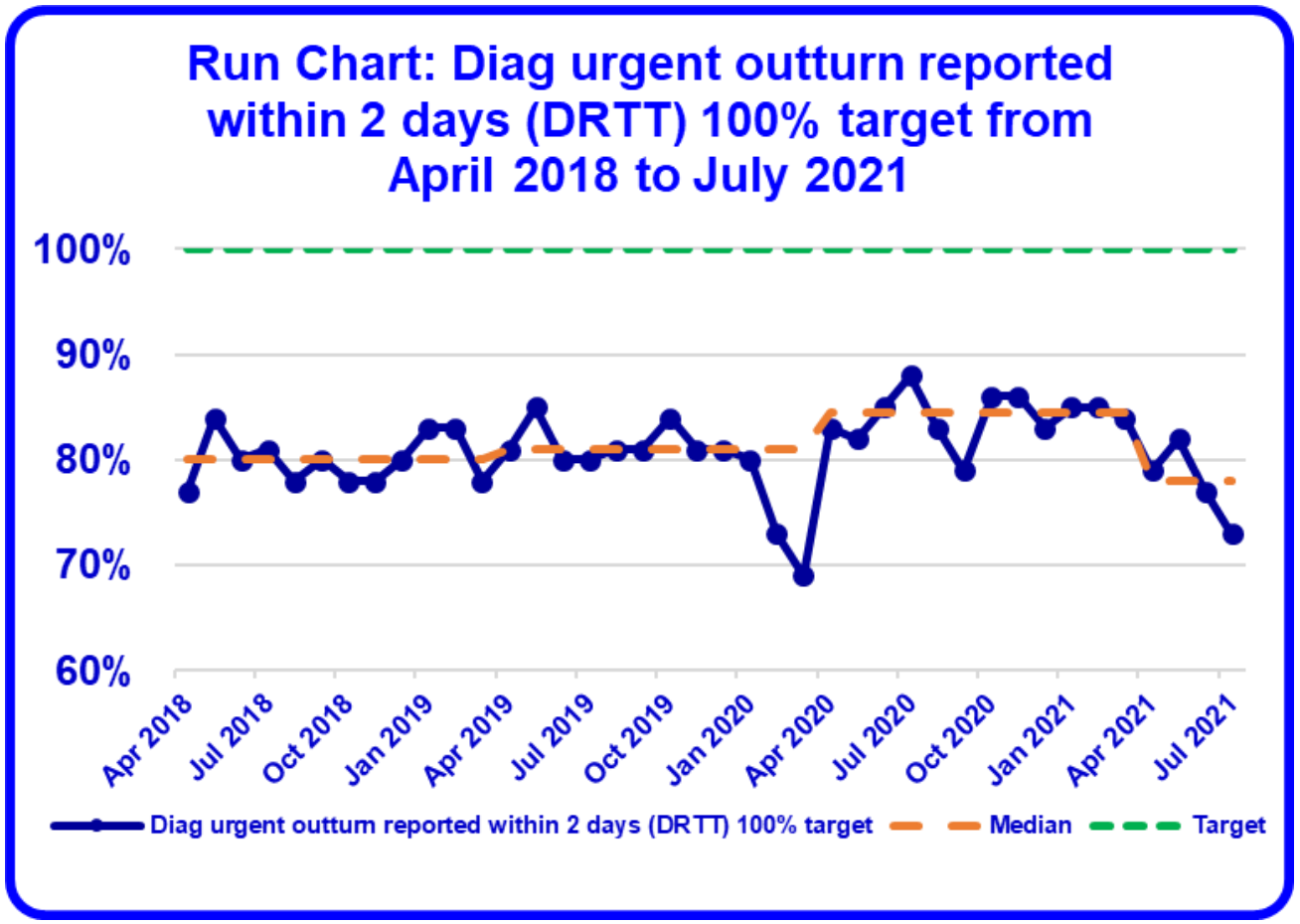


- Activity reduced significantly in early 2020 to 15,027 in April 2020.
- Activity has increased steadily since then to 37,334 in June 2021.

Diagnostics

MAHI - STM - 302 - 334

CPD: All urgent diagnostic tests should be reported on within two days

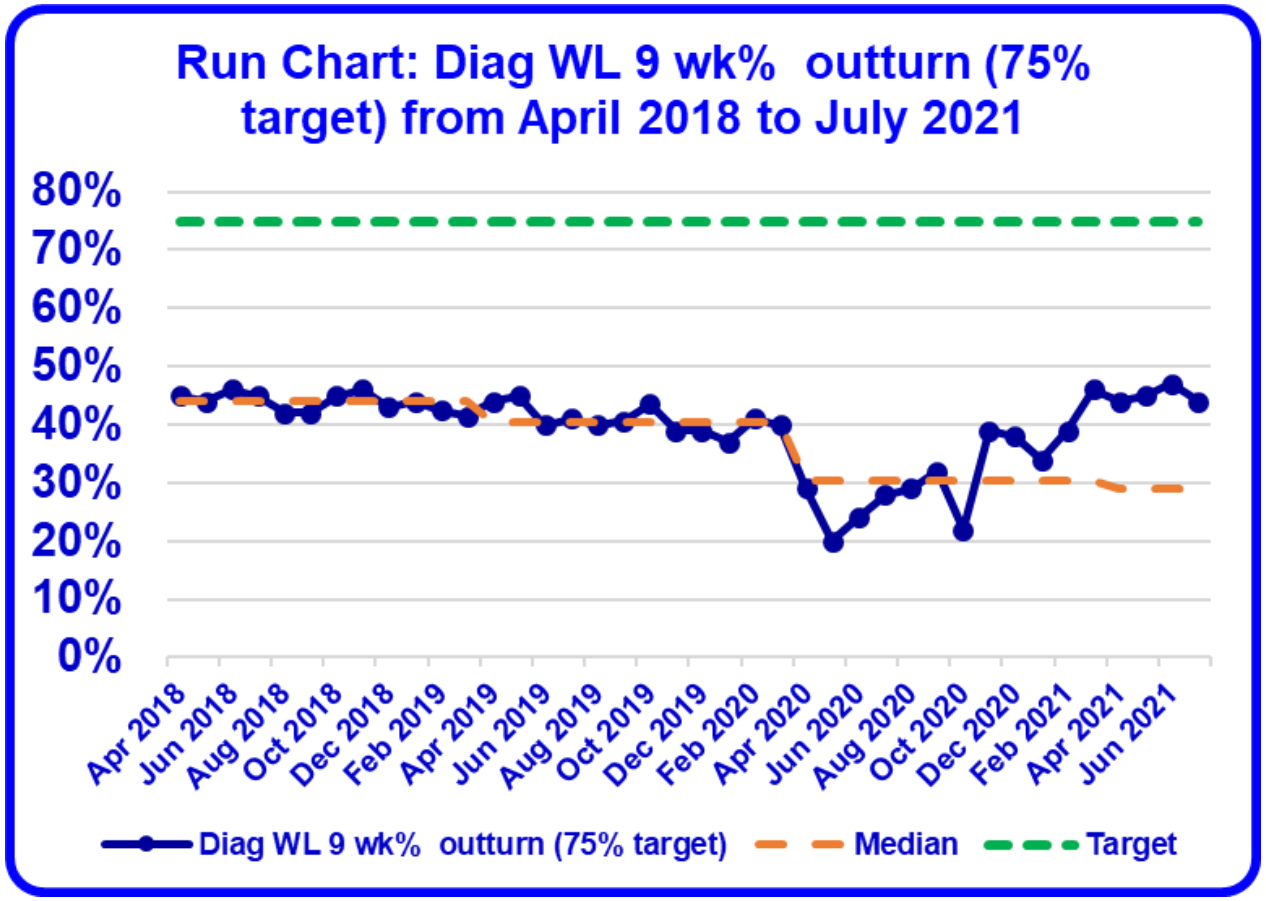


- In July 2021, 73% of urgent diagnostic tests were reported within 48 hours.

Diagnostics

Diagnostics (CT, NOUS, MRI & US)

CPD: 75% of patients should wait no longer than 9 weeks for a diagnostic test

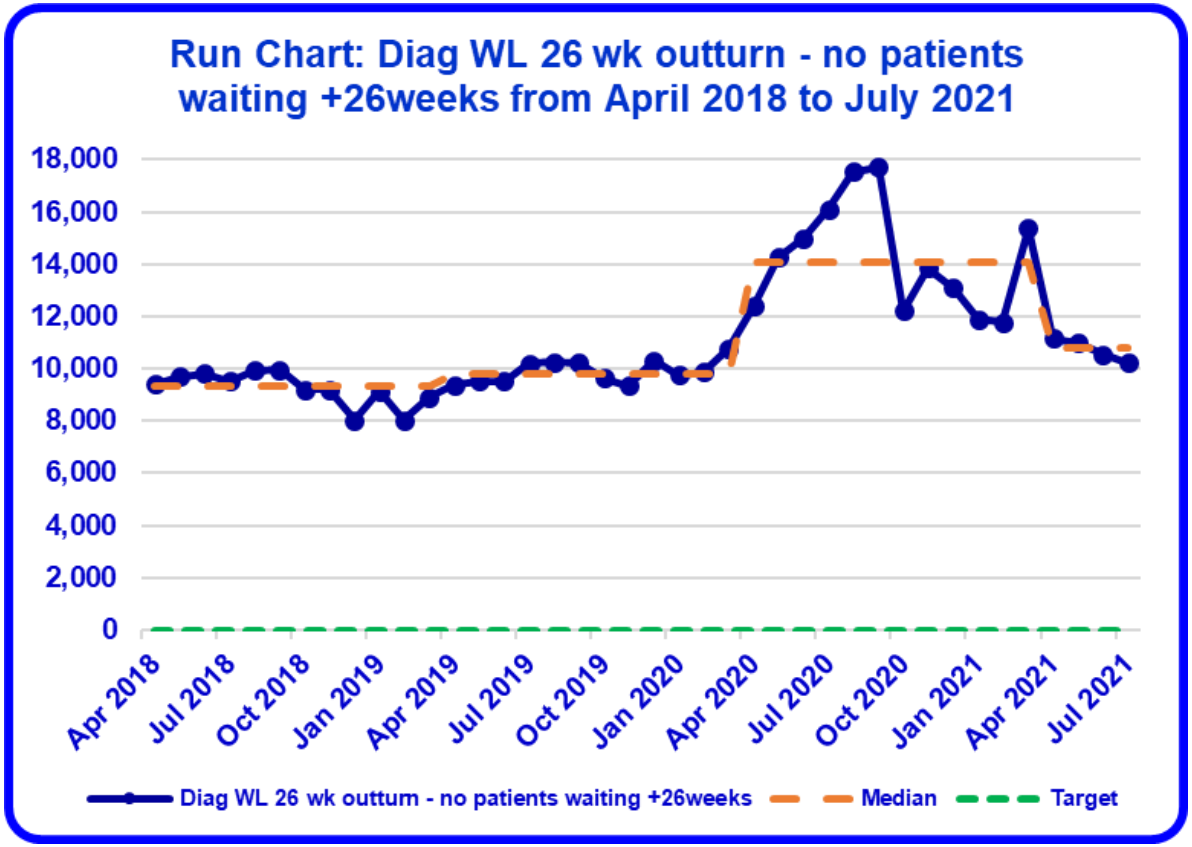


- In July 2021, 44% are waiting less than 9 weeks - this has been a gradual improvement, excluding April to August and October 2020.

Diagnostics

Diagnostics (CT, NOUS, MRI & US)

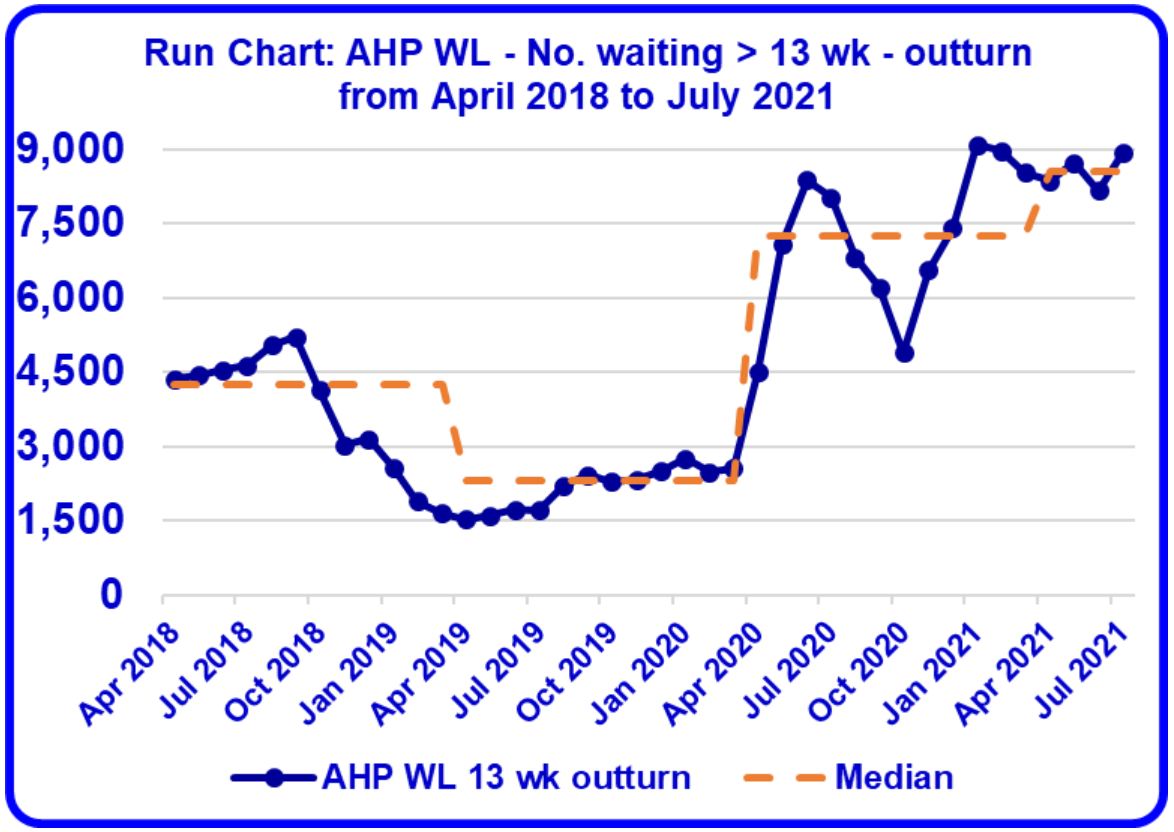
CPD: No patient waits longer than 26 weeks for a diagnostic test



At July 2021 there were 10,237 patients waiting in excess of the 26 week target, compared to 16,110 in April 2020, a decrease of 36%.

Allied Health Professionals (AHP's)

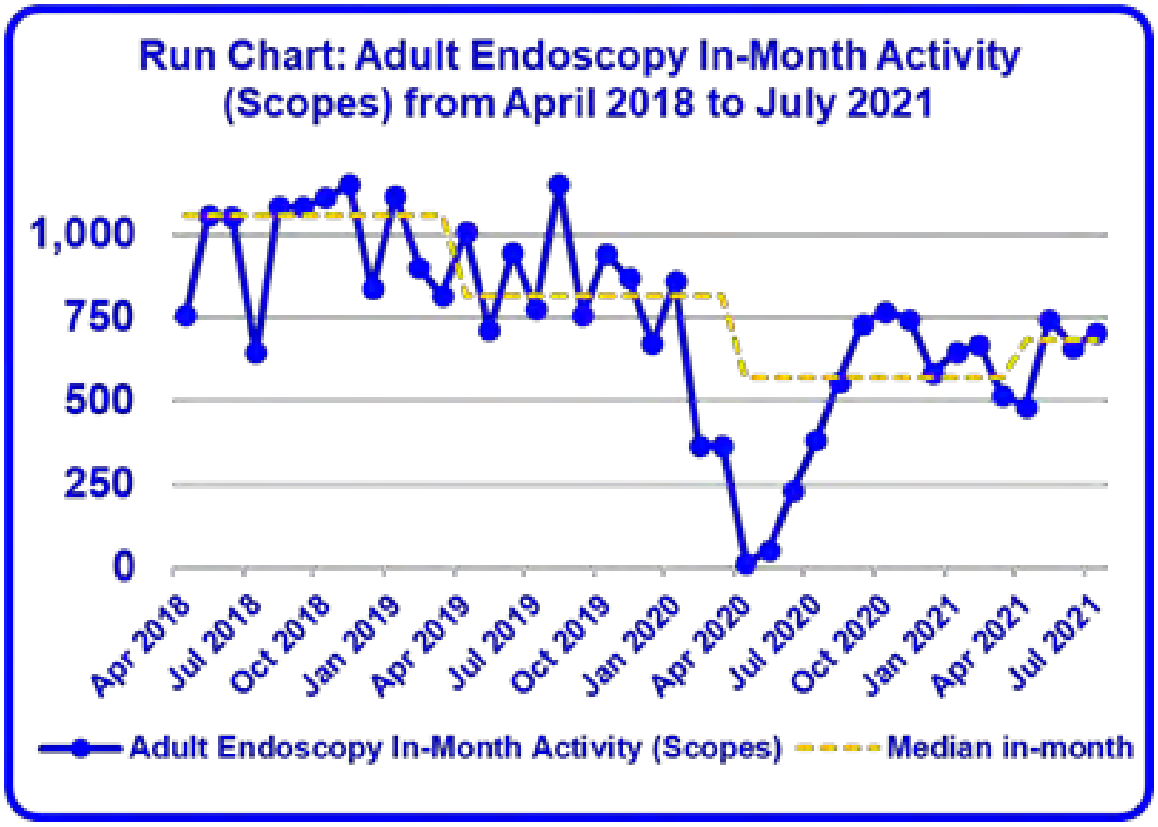
CPD: No patient should wait longer than 13 weeks from referral to commencement of treatment by an Allied Health Professional (AHP).



- At July 2021 there were 8,917 patients waiting in excess of 13 weeks compared to 4,495 in April 2020 and 8,030 in July 2020.
- The greatest number of people waiting in excess of 13 weeks since April 2018 was in January 2021 when there were 9,092 people waiting in excess of the 13 week target.

Endoscopy

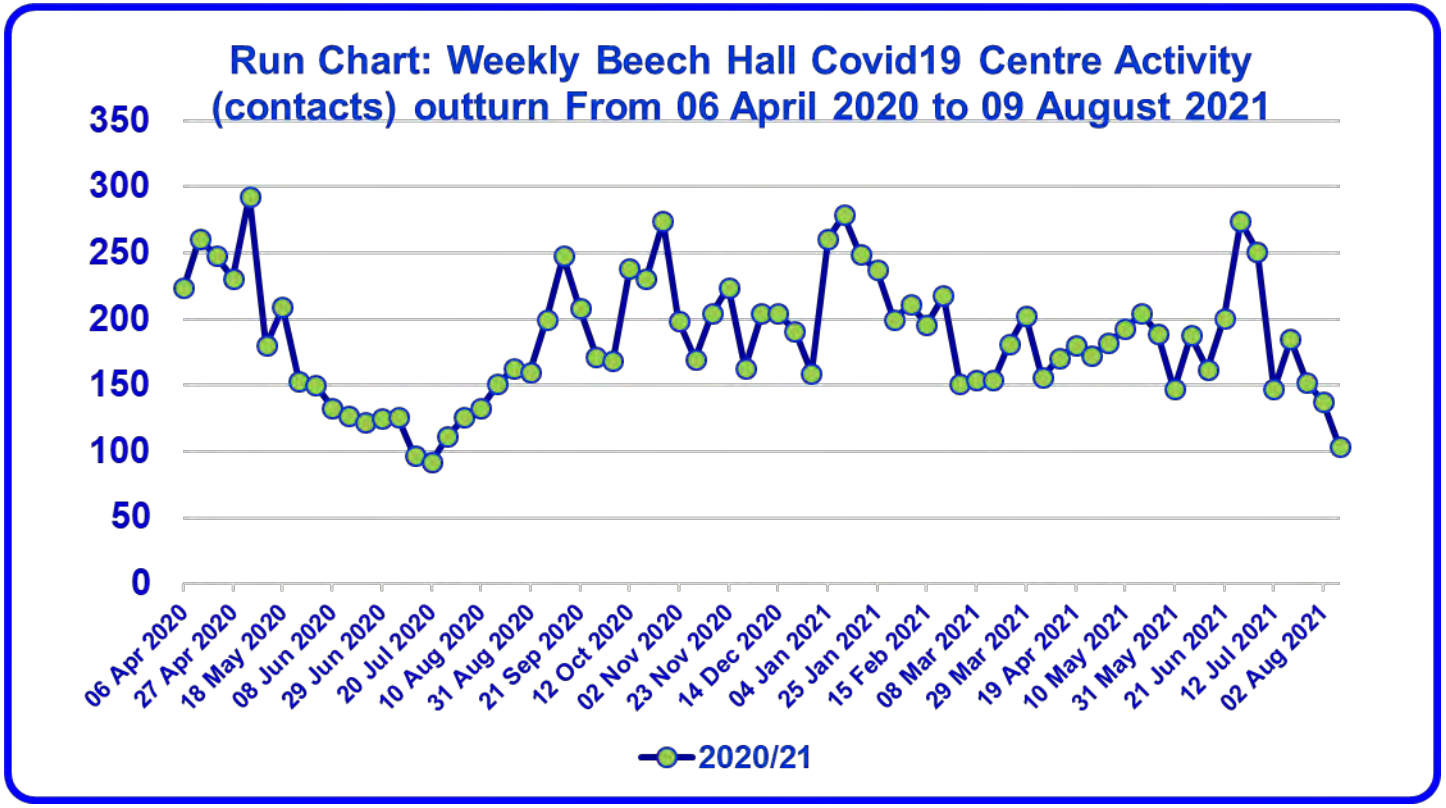
Endoscopy (scopes) activity



Endoscopy (scopes) activity

- In month activity improved from a low of 15 in April 2020 to over 700 in July 2021.
- From April - July 2021 there were 2,604 endoscopies carried out, with a monthly average of 651. In April – July 2020 there were 683 endoscopies with an average of 171 per month.

Unscheduled Care: Primary Care Covid19 Assessment Centre to week beginning 9th August 2021

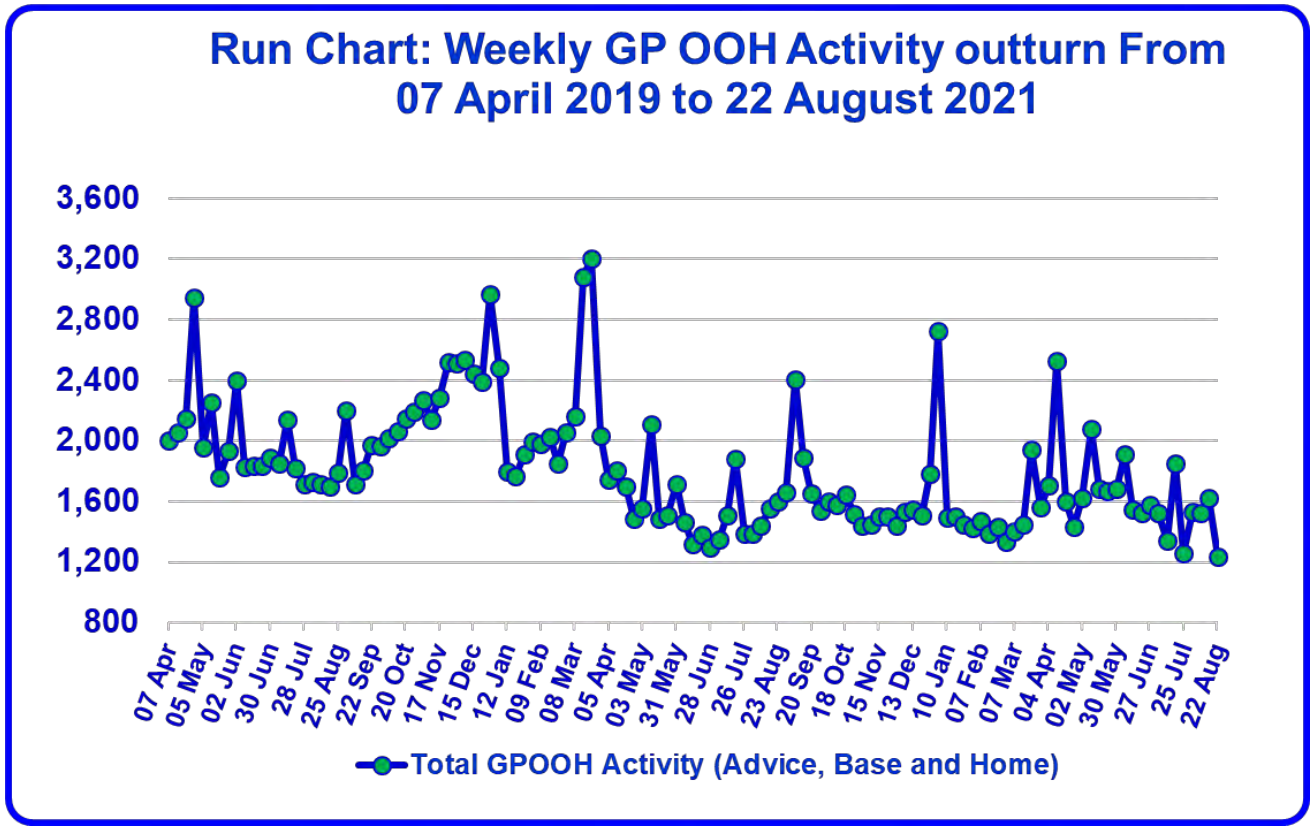


- Weekly numbers peaked at just under 300 in Surge 1 (late April 2020) before dropping within the range 100-150 between May and September 2020.
- Numbers peaked again at over 250 in Surge 2 (late October 2020) and in Surge 3 (early January 2021).
- There was a further surge in June 2021 with average weekly contacts of 207, peaking at 274 in last week of June.
- July weekly average was 184 and the average for the first two weeks in August is 121.

Unscheduled Care: GP Out of Hours Service

MAHI - STM - 302 - 340

Weekly to 22nd August 2021

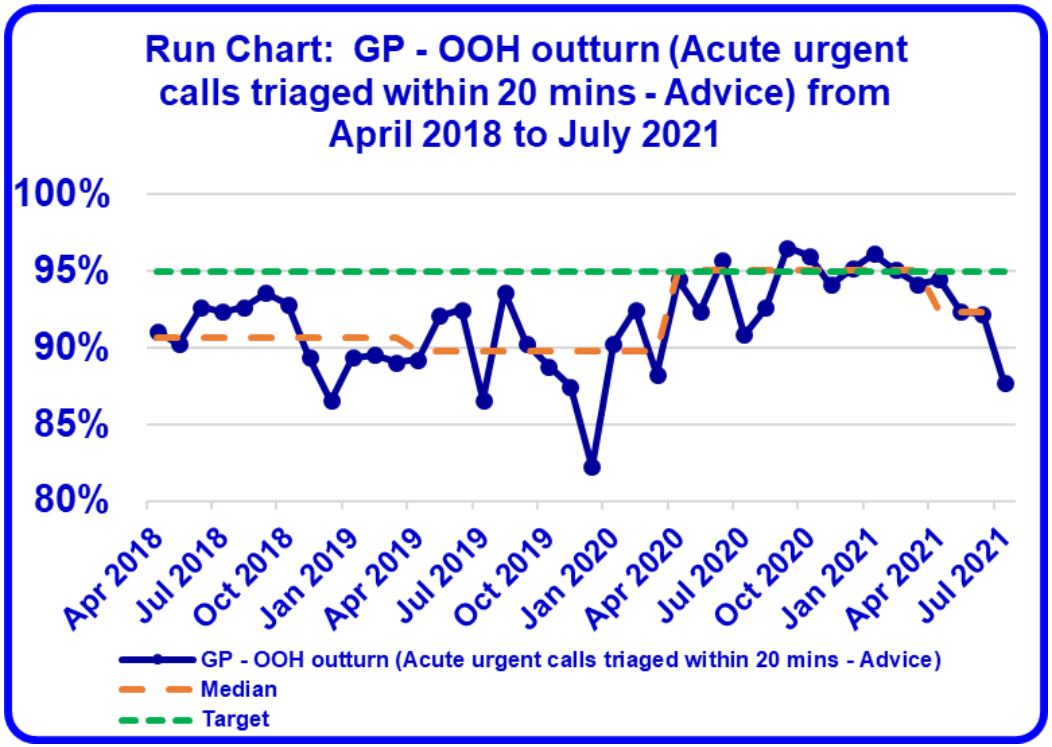


- GP Out of Hours volumes saw a significant rise in March 2020 at the outset of the pandemic. Since then numbers dropped and have generally remained below 2019 levels.
- At week ending 22nd August 2020, there were 1,236 contacts.
- The average each week since January 2020 is 1,693, whilst the average January 2021 to 22nd August 2021 is much the same at 1,630.
- There were peaks in March 2020 of over 3,000, however since then the weekly attendances have stayed below 2,000, and generally around 1,500 with the exception of 2,725 week of 3rd January 2021, 2,524 week of 11th April 2021 and 2,082 week of 9th May 2021

Unscheduled Care

GP Out of Hours Service – monthly

CPD: 95% of acute / urgent calls to GP OOH triaged within 20 minutes



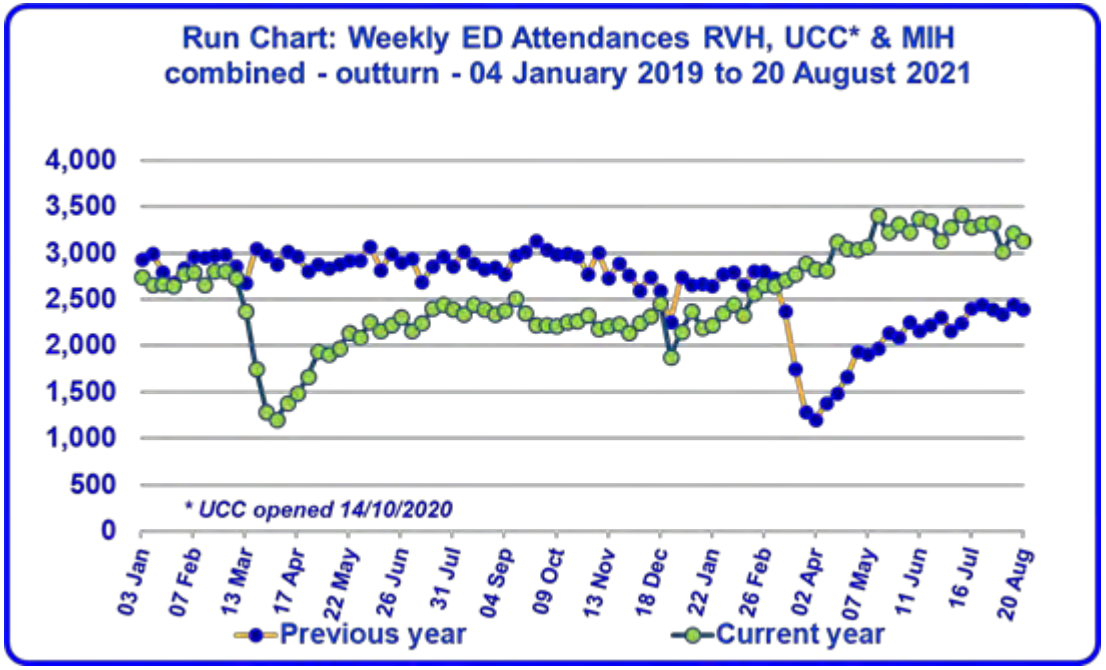
- Whilst performance in July 2021 is 88%, performance generally improved during 2020/21 and this year so far, remaining over 90% and close to the 95% target since January 2020.
- The average total monthly calls was 6,878 for 2020/21.
- There were 6,455 total calls received in July 2021 and an average of 7,512 from April to July.
- Total urgent calls to be seen within 20 minutes in July 2021 is 292. The average monthly total urgent calls between April and July 2021 is 335. The average for 2020/21 was 279 monthly; and 445 monthly for 2019/20.

Unscheduled Care: Emergency Departments

MAHI - STM - 302 - 342

Overall Adult ED activity at RVH & MIH

Weekly comparison previous and current year.

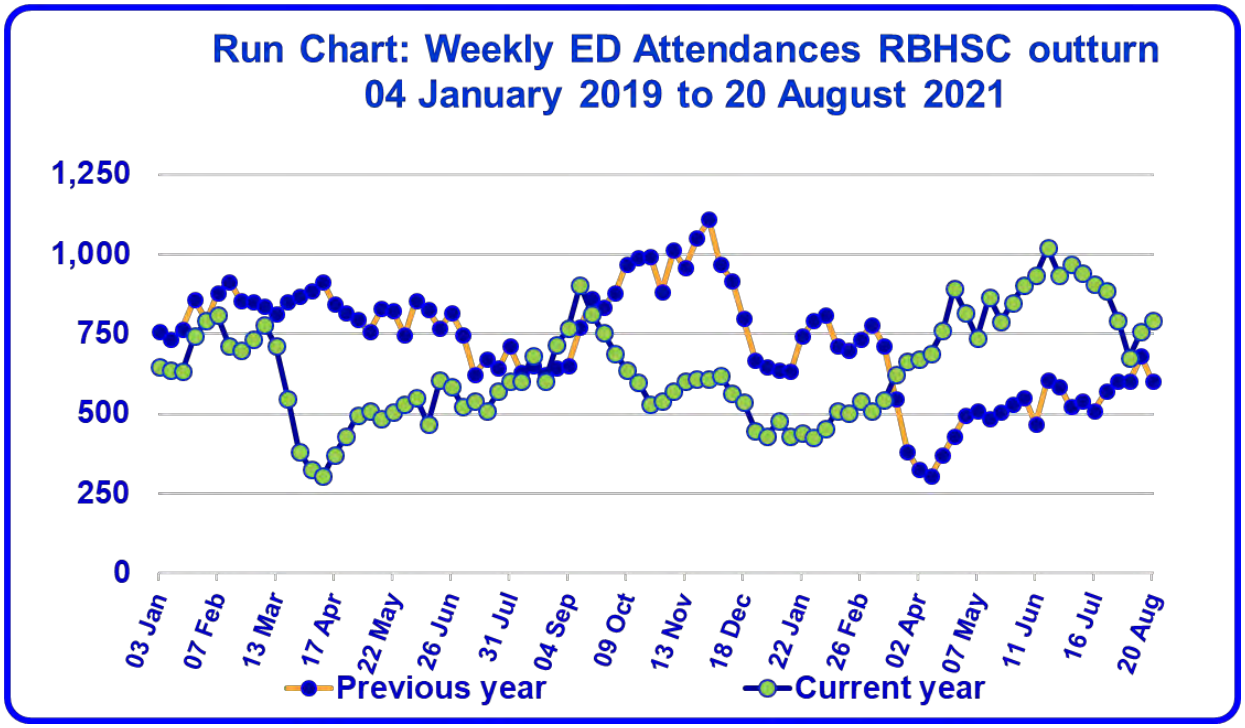


- Weekly attendances dropped significantly in the first wave to a low of 1,208 in early April 2020, 42% of the weekly attendances at 3 April 2019.
- Attendances increased gradually to a peak in week of 11th September 2020 of 2,516, 85% against the same week in 2019.
- Attendances peaked again in May with 3,403 attendances week of 14th May 2021 and increase of 1,427 (172%) on the same week in 2020.
- With the exception of Christmas, attendances have continued to increase again since, exceeding 2,500 attendances by mid February and have been over 3,000 since April. There were 3,137 attendances for week ending 20th August 2021.

Unscheduled Care: Emergency Departments

Overall Children's ED activity at RBHSC

Weekly comparison previous and current year.



- Weekly attendances dropped significantly in the first wave to a low of 303 in early April 2020, 33% of the number to 3 April 2019.
- Attendances increased gradually to a peak of 904 week ending 11th September 2020, 17% more than the same week in 2019.
- Week of 18th June saw an increase to 1,020. June and July had average weekly attendances of 943,
- Attendances at week ending 20th August are 793, an increase of 32% compared to the same week last year.

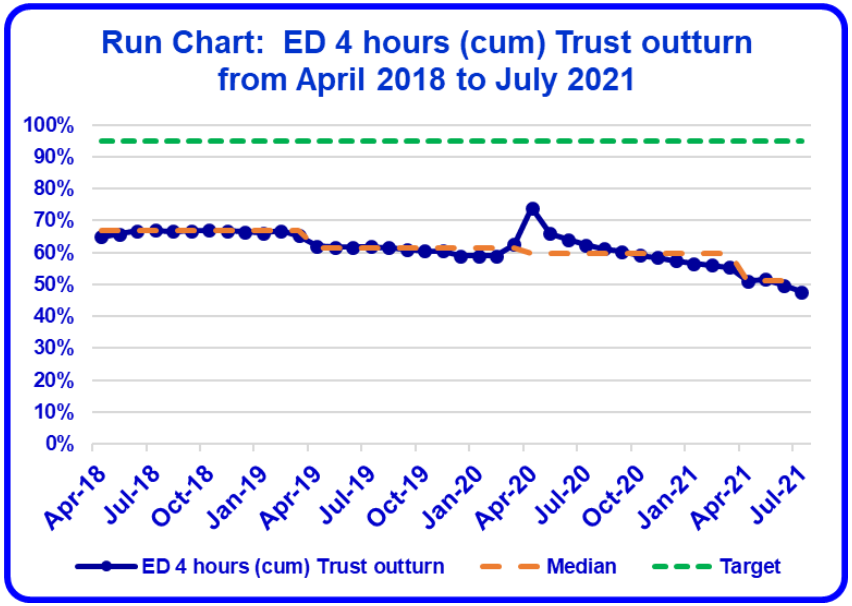
Unscheduled Care: Emergency Departments

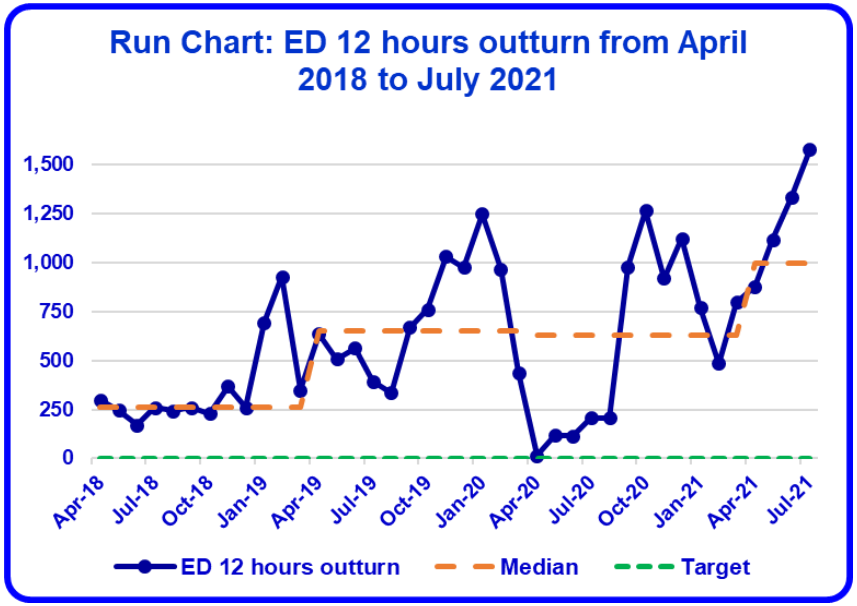
CPD: 95% of patients attending ED either treated and discharged home, or admitted, within four hours of their arrival in the department

Performance is 50% in July 2021, and is the lowest percentage in the period Apr 2018-July 2021.

CPD: No patient should wait over 12 hours

There were 1,577 patients waiting in excess of 12 hours in July 2021 and 1,333 in June 2021. The last 2 months represents the highest monthly figures in the period April 2018 – July 2021



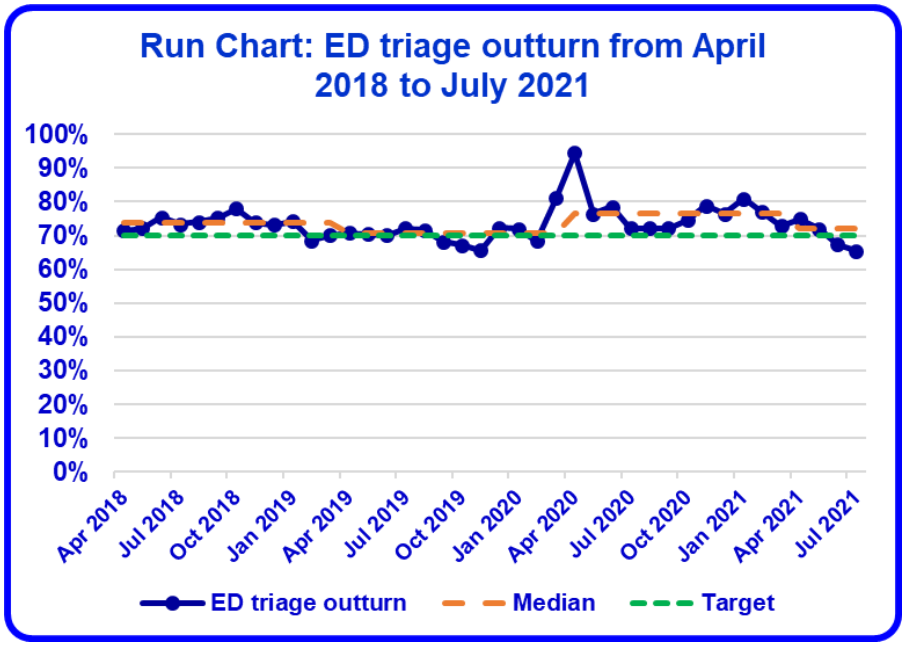


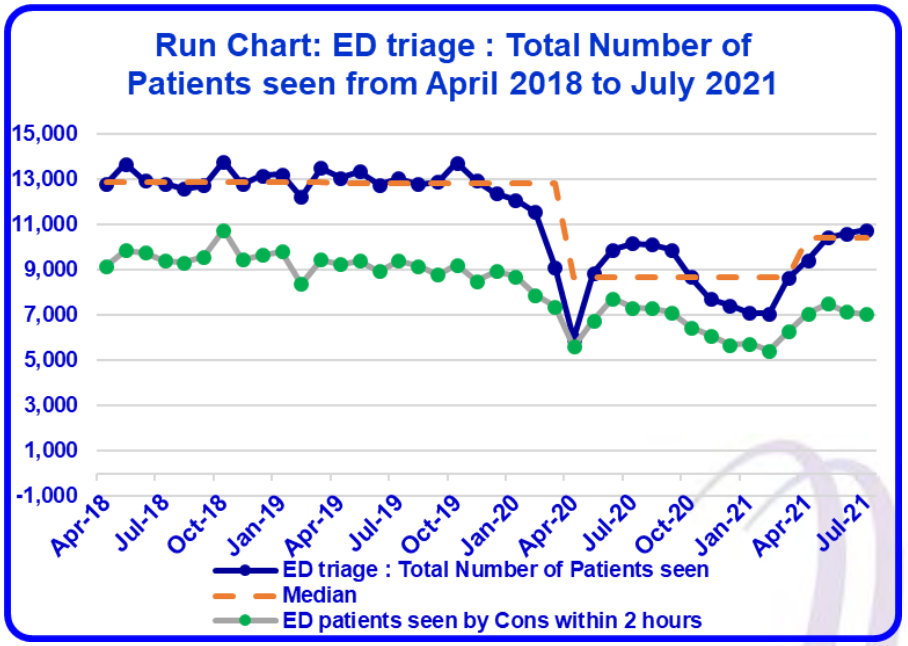
- Total attendances of 13,945 in July 2021 at ED, a 9% increase compared to 12,824 in July 2020.
- Cumulative attendances April to July 2021 are 51,637 compared to 44,449 for the same period last year – an increase of 16%
- Urgent Care Centre (UCC) opened on the 14th October 2020.

Unscheduled Care: Emergency Departments

CPD: at least 80% of patients to have commenced treatment, following triage, within 2 hours.

- Performance is 69.8% April to July 2021 and 65.4% at the end of July 2021



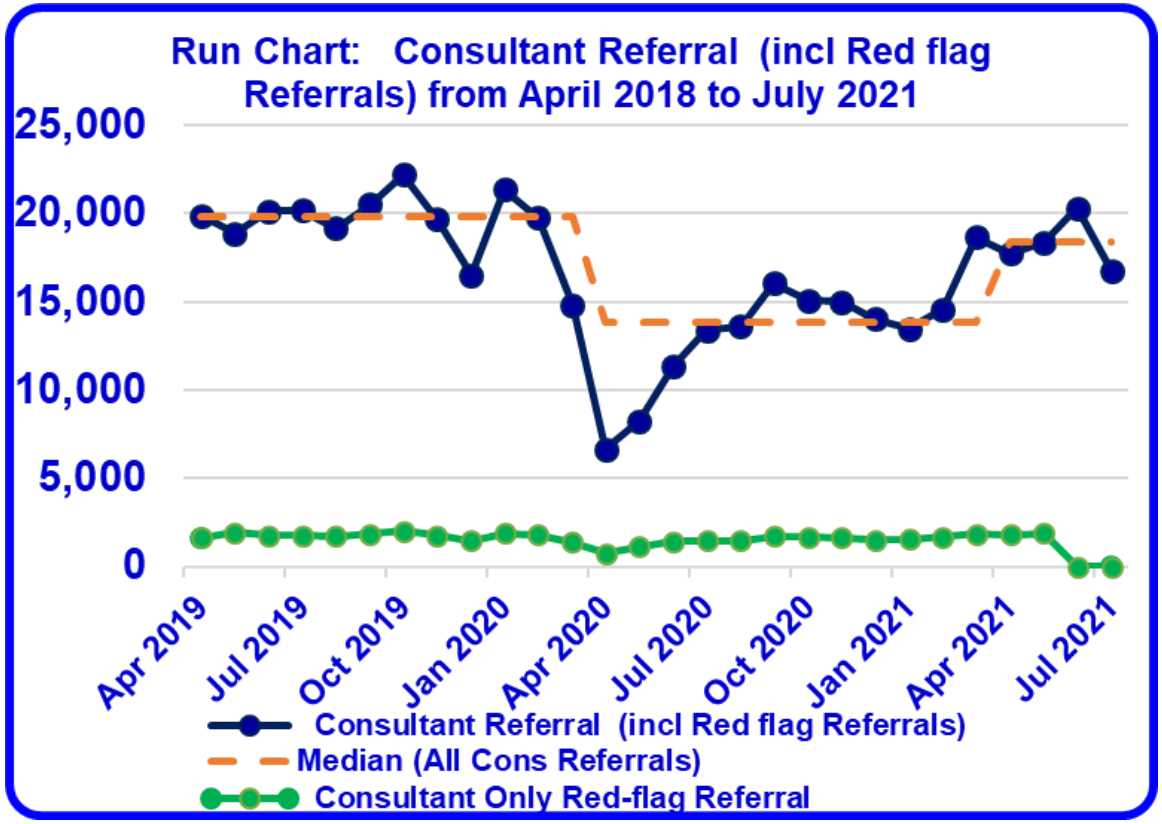


- Total number triaged and seen by a Clinician at the end of July was 10,755, compared to 13,023 at the end of July 2020.
- Of the 41,187 patients triaged April to July 2021, 28,738 (70%) were seen within 2 hours. This compares to 34,824 in the same period last year with 27,455 (79%) seen within 2 hours.

Outpatients

MAHI - STM - 302 - 346

Outpatient Referrals



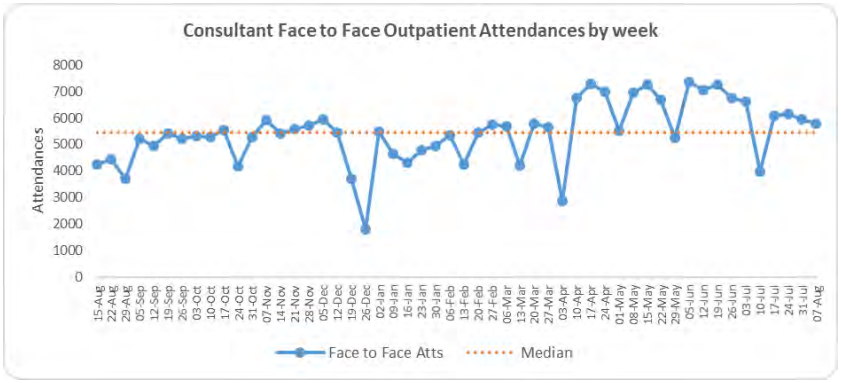
Referral Numbers - By Referral Month (Consultant only)

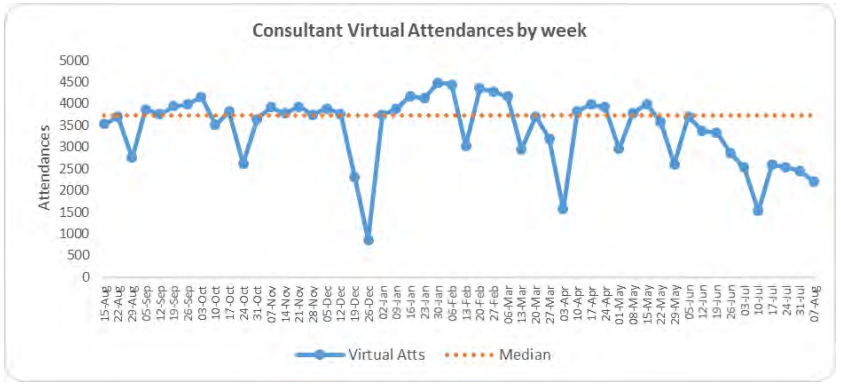
- OP Referrals have increased consistently since the low of April 2020 at the outset of the pandemic, with the exception of the autumn period with 16,750 referrals in July 2021.

Outpatients

MAHI - STM - 302 - 347

Consultant Outpatient Attendances – 14th August 2021





Analysis since week ending 15th August 2020 to 14th August 2021

Face to face contacts:

- Dropped significantly to 1,026 week ending 11th April 2020.
- Weekly average between Aug 2020 -March 2021 was just under 5,000. Between April and August activity has averaged 6,250, with 6 weeks registering greater than 7,000 contacts.

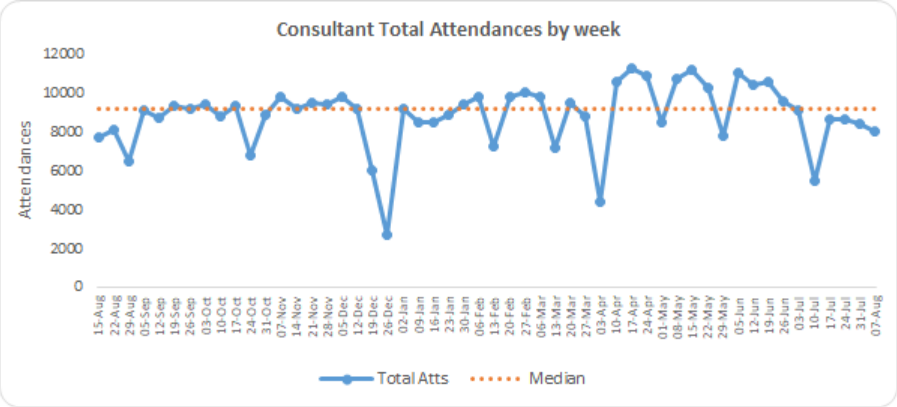
Virtual Contacts (telephone and video contacts):

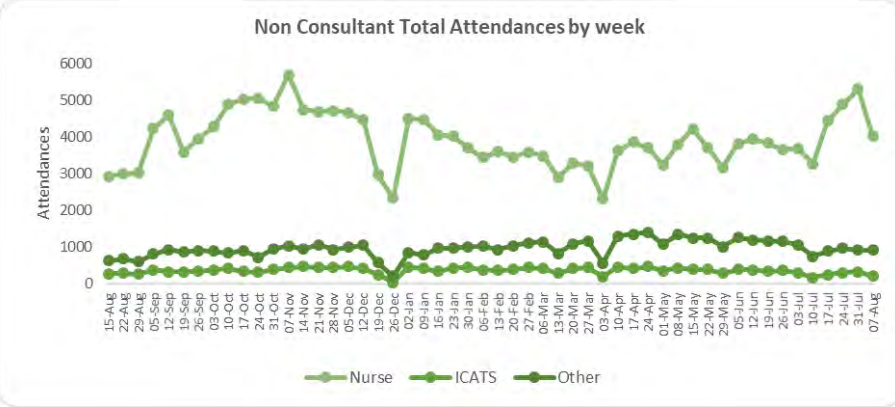
- Dropped significantly to 1,445 week ending 11th April 2020.
- Weekly average between Aug 2020 and March 2021 was 3,600. Between April and August 2021 this has dropped to just over 3,000.

Outpatients:

MAHI - STM - 302 - 348

Outpatient Attendances – 14th August 2021





Analysis since week ending 15th August 2020 to 14th August 2021

Consultant Total Attendances

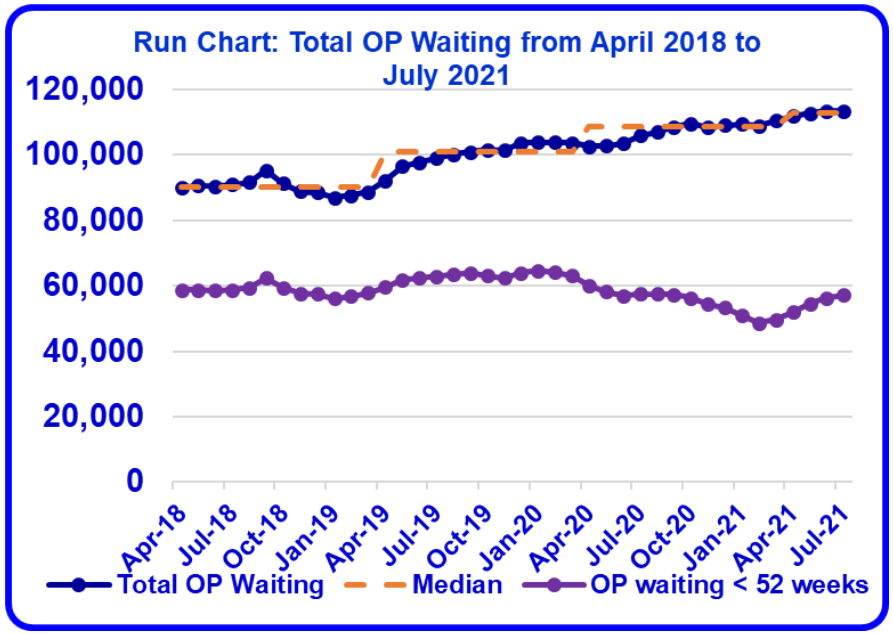
- The lowest activity was 2,471 attendances week ending 11th April 2020.
- Highest weekly attendances have occurred since April 2021, with activity exceeding 10,000 in nine weeks, and exceeding 11,000 in 3 of those weeks.

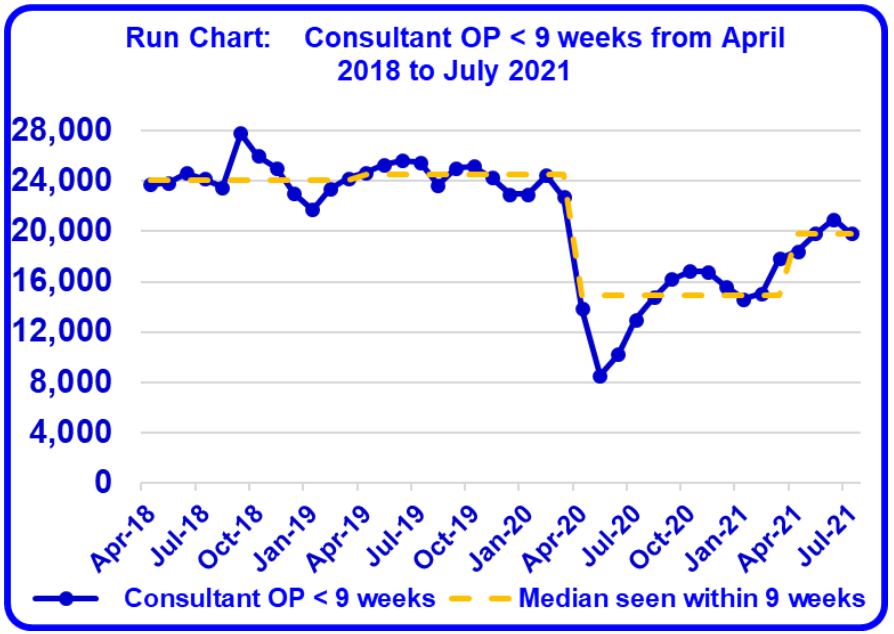
Non-consultant activity (Nurse, ICATS and other activity)

- The lowest activity was 1,443 attendances week ending 11th April 2020.
- Overall non-consultant weekly attendances have been broadly consistent in the last 18 months, with decreases in Nurse activity offset by increases in ICATS activity, and have averaged 5,200 between April and August 2021.

Outpatients

CPD: 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks

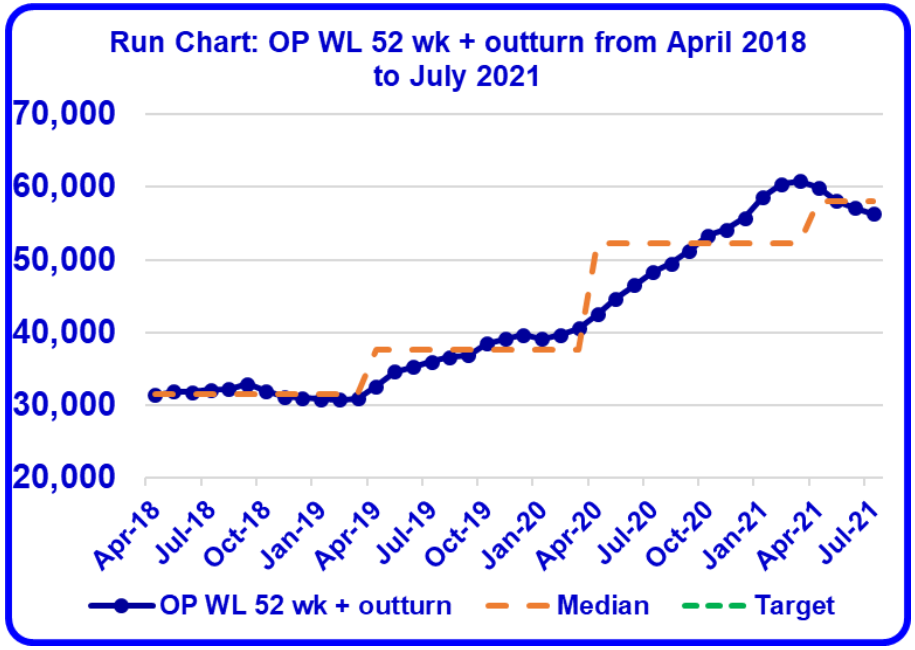


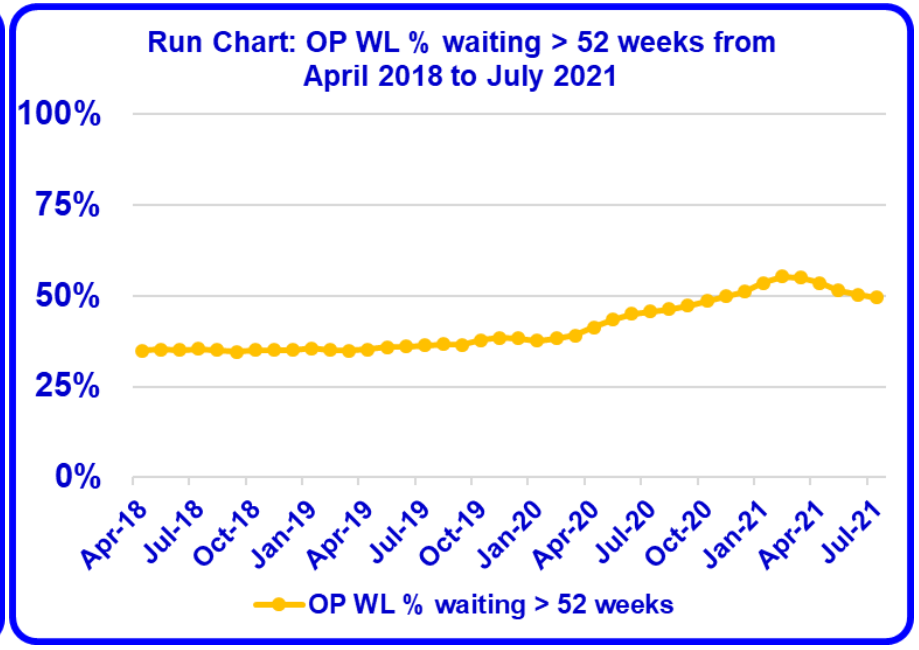


- At the end of July 2021, there were 113,534 patients waiting for an OP appointment, an increase of 7.2% compared to 105,958 in July 2020.
- 19,840 patients are waiting less than 9 weeks in July 2021, an increase of 6,878 (53%) from 12,962 in July 2020

Outpatients

Outpatient Waiting List - By Month (Consultant)





- 56,323 patients are waiting more than 52 weeks at July 2021. This equates to 49.6% of the 113,534 total Outpatient waiting list. At July 2020 there were 48,332 patients waiting longer than 52 weeks.

Outpatients

Outpatient Modernisation Programme – Summary of Approach

BHSCT Outpatient Modernisation Programme - Summary of Approach

Capture – Baseline scoping/use of QI methodology to develop understanding of current service model

- Understanding of key data, waiting lists, benchmarking information
- Location of clinics/accommodation
- Workforce – consultant/nurse-led/AHP
- Process mapping to understand current processes and identify opportunities for improvement
- 'What did we achieve by bringing someone to Outpatients?' - Audit / sample of 'review' patient files to establish value of review appointment and alternative pathways/outcomes that should be explored going forward
- More in-depth focus on a number of specialties as part of a rolling programme - Rheumatology, Dermatology, Gynae, ENT, urology, colo-rectal & regional projects in ophthalmology & orthopaedics

Challenge – sharing learning within and across services, identifying opportunities/focusing efforts for greatest impact

Programme of Work Underway/Testing Solutions

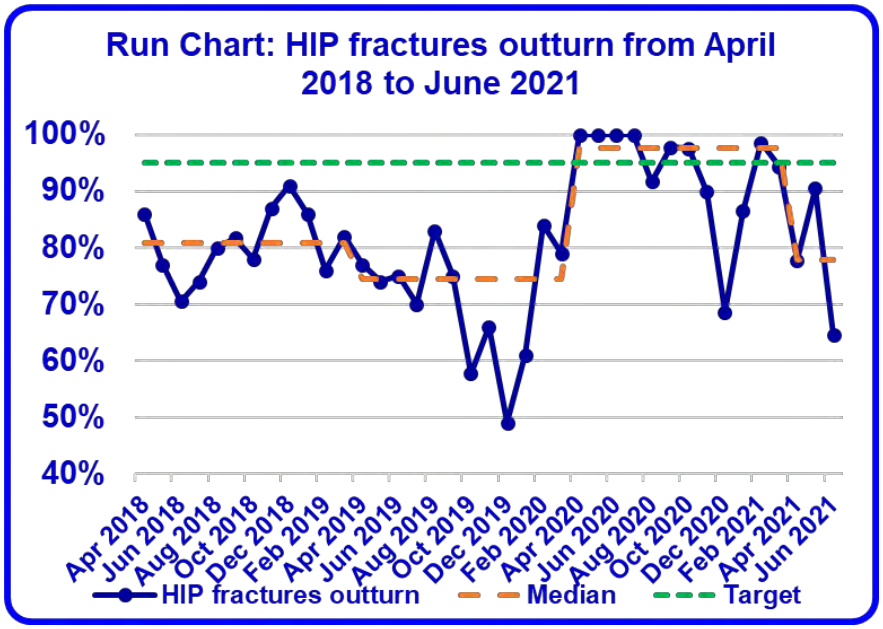
- Changes in pathways/processes/clinical practice
- Changes in roles including staff/skill mix
- Education & training
- Governance & safety – addressing recommendations from RQIA Review of Governance in Outpatients
- Digital solutions
- Communications

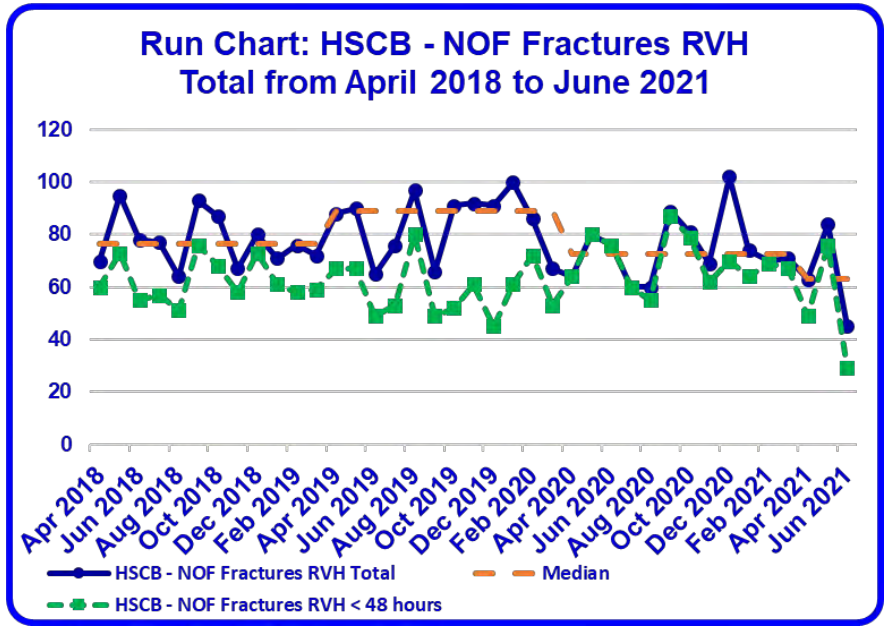
Demonstrate Improvement – Measure progress and report on outcomes - impact on waiting lists / times and staff and patient experience

Hip Fractures

MAHI - STM - 302 - 352

CPD: 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures





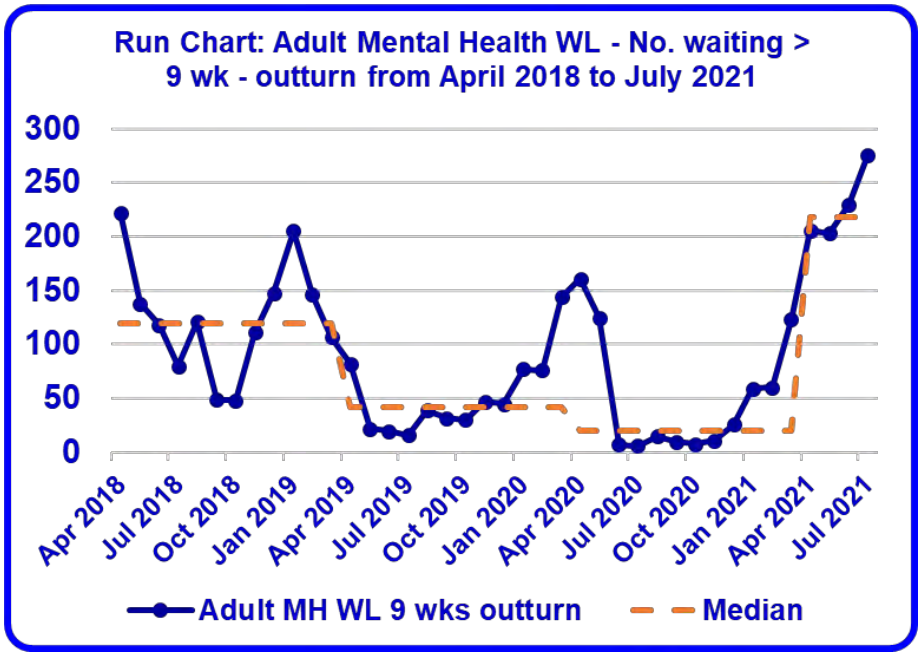
- Performance is 64% in June 2021. During 2020/21 the average was 94%. Performance had remained over 90% since April 2020, with the exception of 69% in December 2020 and 86% in January 2021. In 2021/22 it has been 78% in April and 64% in June 2021.
- There were 45 NOF fractures presenting at RVH in June 2021, 31 less (-41%) than in June 2020. There were 29 fractures which waited < 48 hours for treatment.

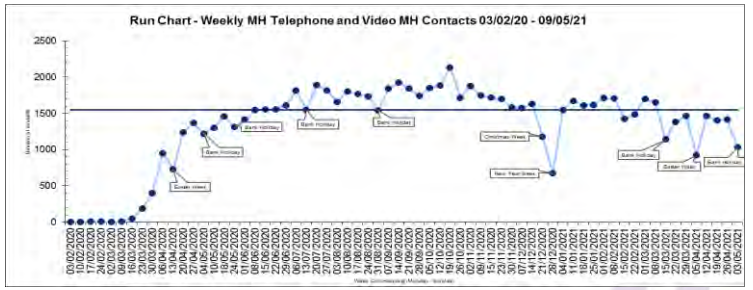
Mental Health

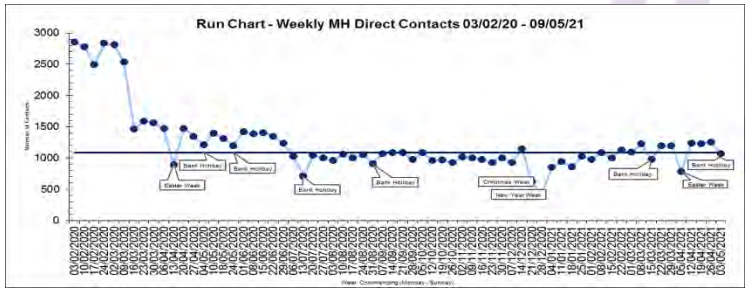
Adult Mental Health

CPD: No patient waits longer than 9 weeks to access adult mental health services

- **Patients waiting > 9 weeks**: 276 in July 2021 compared to 6 in July 2020
- Reduced excess waits from June to November, increased from December 2020.
- **Total patients waiting:** Reduction to 389 in May 2020. Increasing again to 1,116 in July 2021.





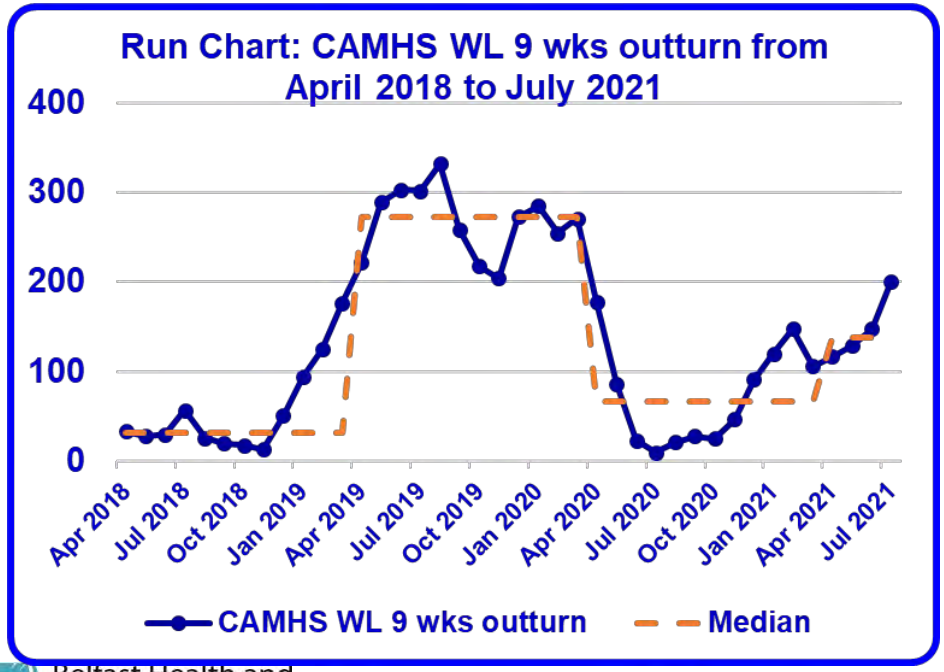


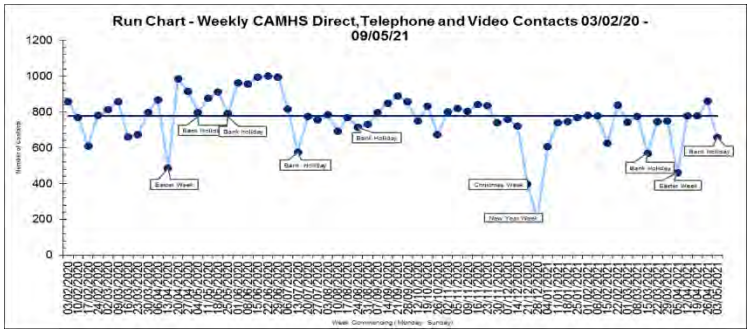
Mental Health

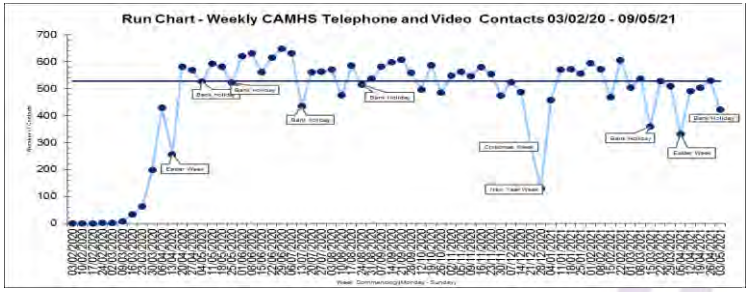
Child and Adolescent Mental Health (CAMHS)

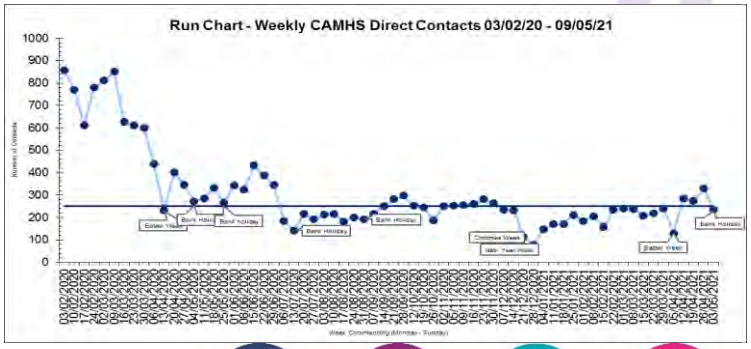
CPD: No patient waits longer than 9 weeks to access adult mental health services

- **Excess waits** : March 2020 = 271; July 2021 = 201
- The waiting list reduced to 180 in June 2020 and has increased to 453 in July 2021.
- **CAMHS step 3** has increased over recent months to 320 in July 2021 with 172 waiting more than 9 weeks.









Belfast Health and Social Care Trust
caring supporting improving together

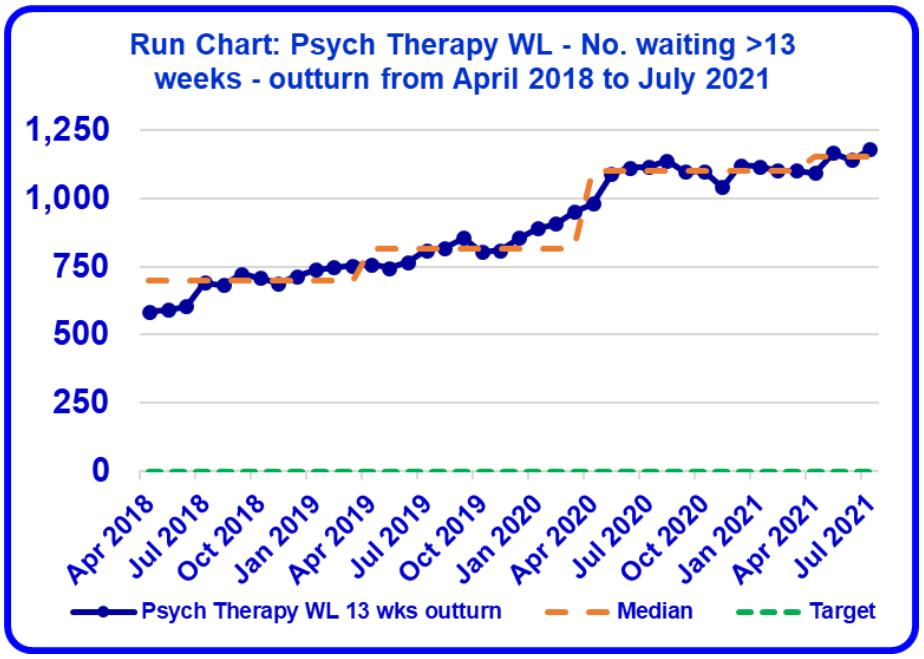
Working together · Excellence · Openness & Honesty · Compassion

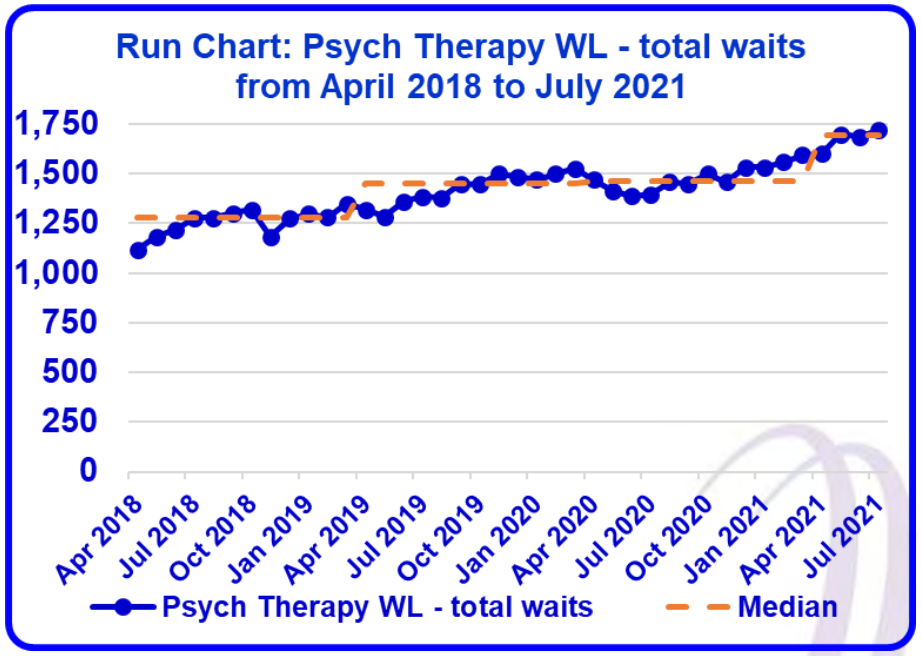
Mental Health

MAHI - STM - 302 - 355

Psychological Therapies

CPD: No patient waits longer than 13 weeks to access psychological therapies (any age)





Of the 1,719 patients waiting at the end of July 2021, 1,180 patients were waiting in excess of the 13 week target. There were 764 patients were waiting for more than 52 weeks for Psychological services, compared to 633 in July 2020.

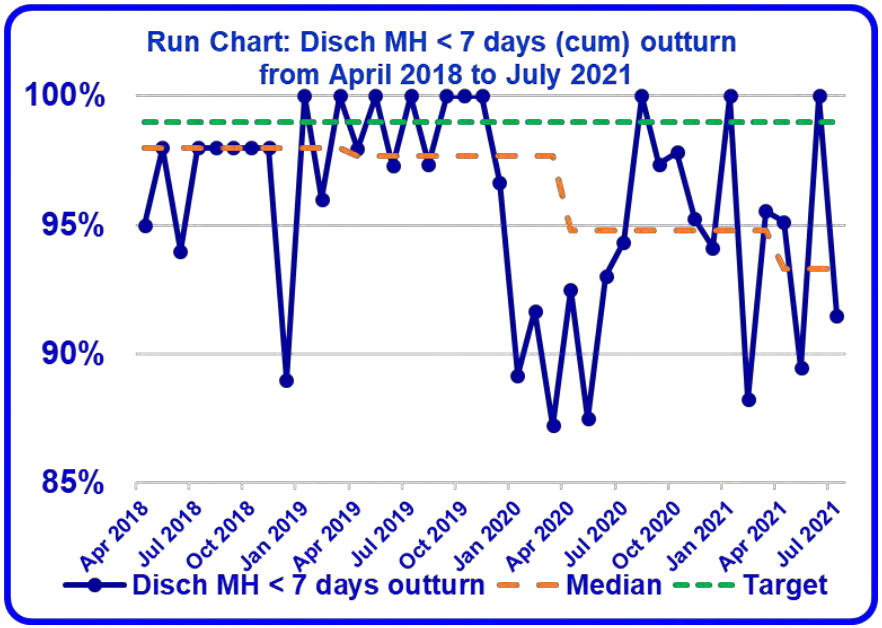
Mental Health

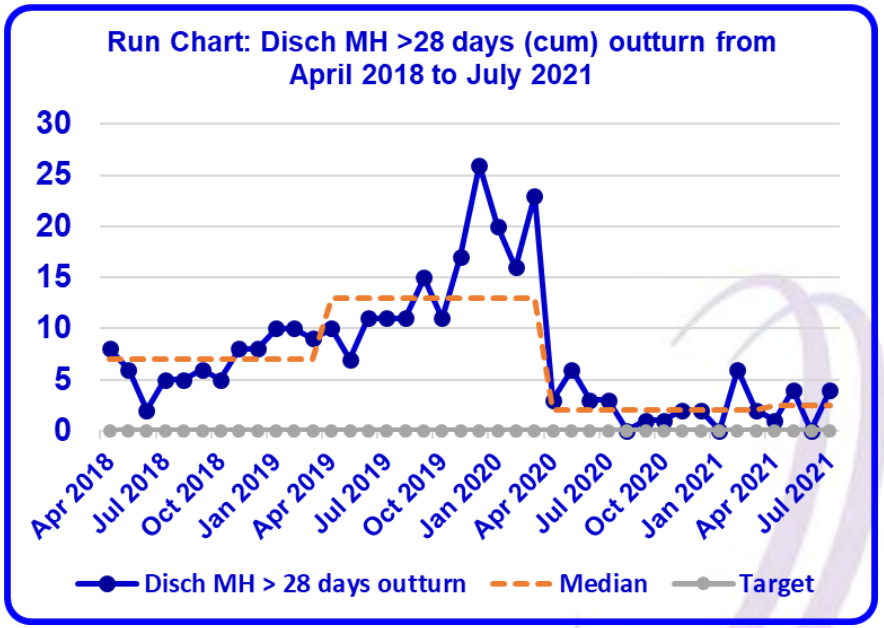
MAHI - STM - 302 - 356

Mental Health discharges

CPD: Ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge

CPD: No discharge takes more than 28 days for mental health patients assessed as medically fit for discharge.

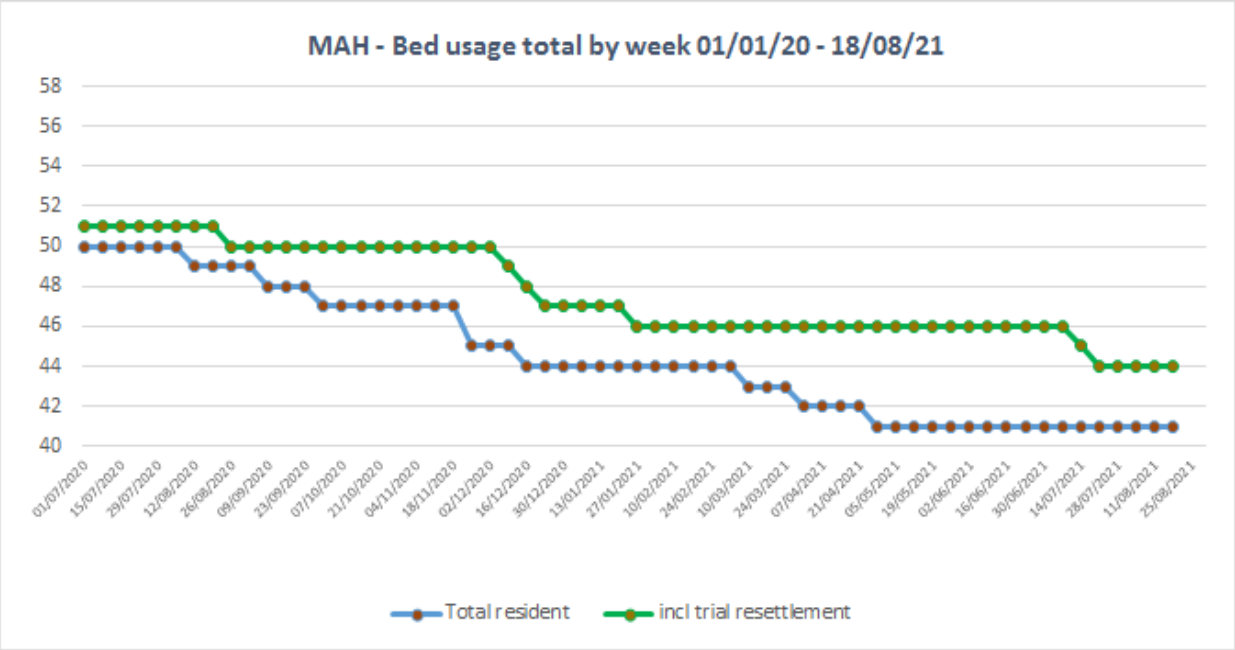




- The percentage of patients discharged within 7 days at July 2021 = 91%, compared to 93% at July 2020.
- At the end of July 2021 there were 4 patients discharged in more than 28 days compared to 3 for July 2020.

Muckamore Abbey Hospital

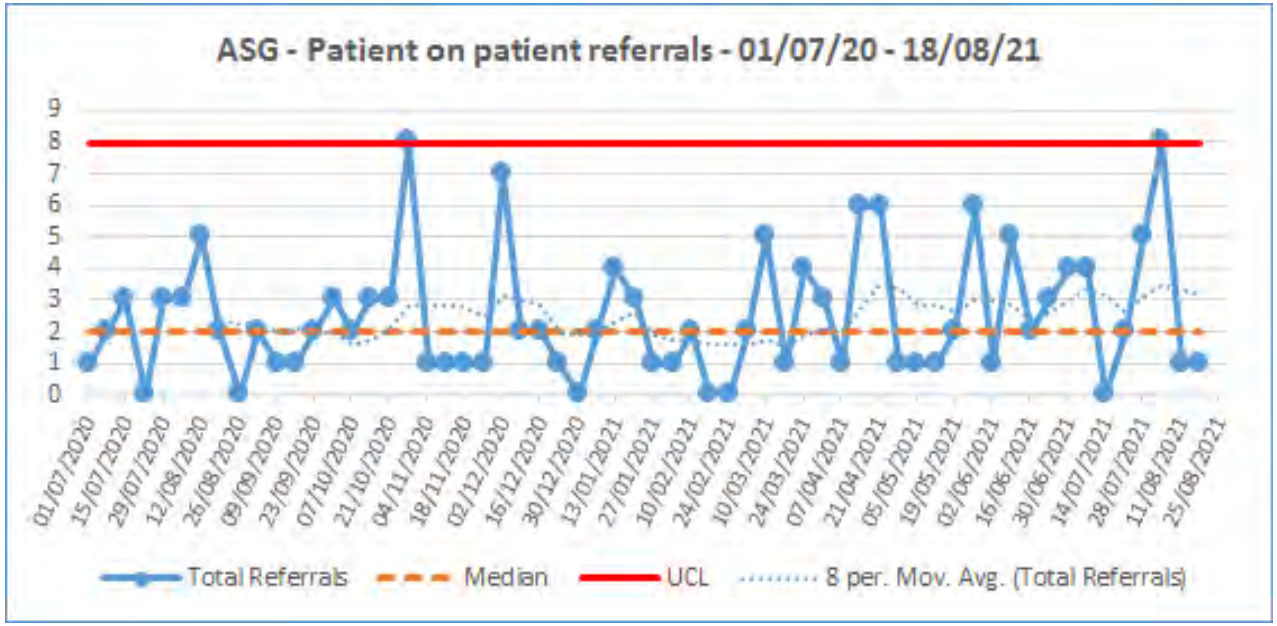
Numbers in residence – 18th August



The numbers of patients in residence, including those in trial resettlement, had remained unchanged from February 2020 up to 11th Nov 2020, and has reduced since, with 44 patients in residence, of which 5 are on trial resettlement, at 18th August.

Muckamore Abbey Hospital

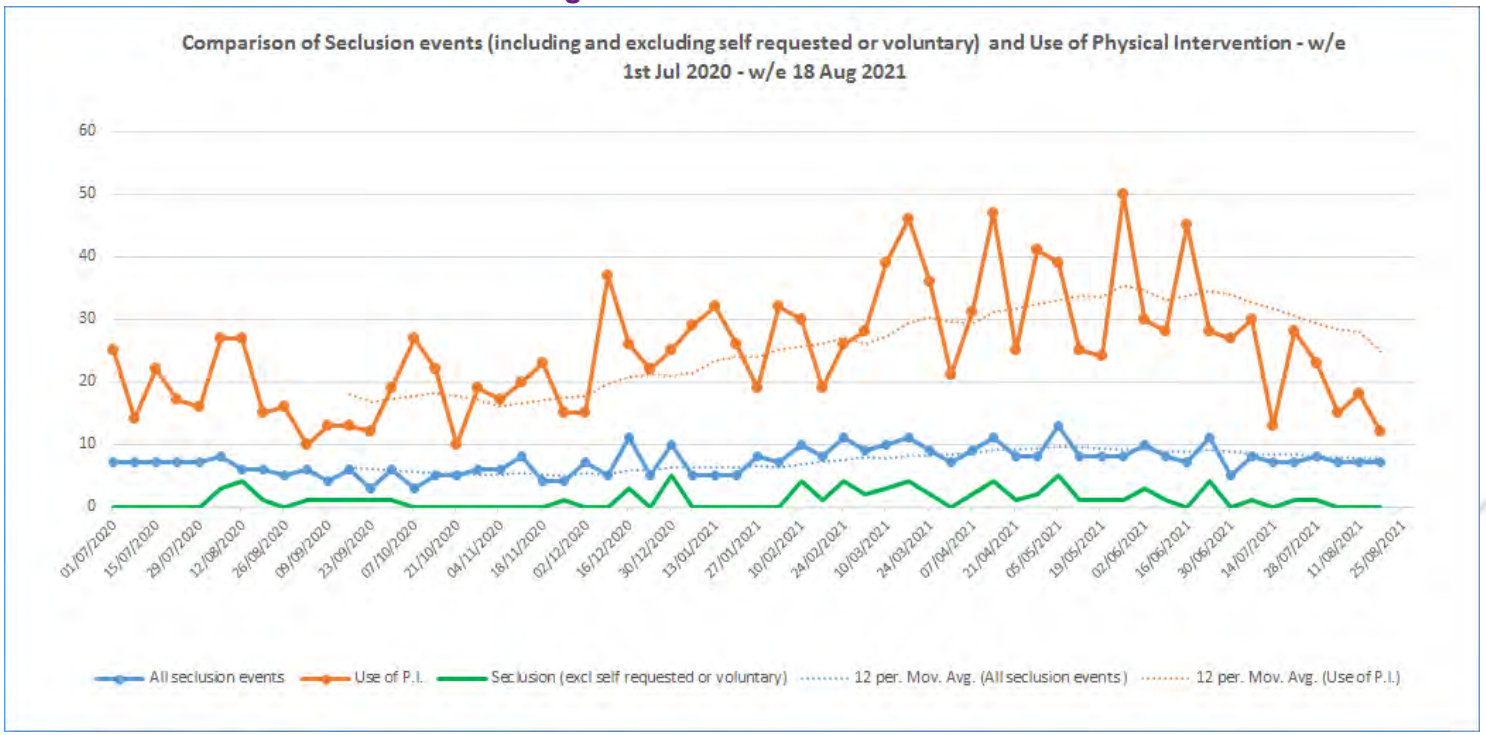
Adult safeguarding – patient on patient referrals -18th August



Patient on patient referrals are reported weekly and average just over 2-3 per week. Within the MAH Safety report both patient on patient and staff on patient Adult Safeguarding referrals are reported in detail. Numbers of patient on patient referrals since the last report show high variation, and the 8 week average since April is higher than in the previous 6 month period.

Muckamore Abbey Hospital

Physical intervention and Seclusion – 18th August

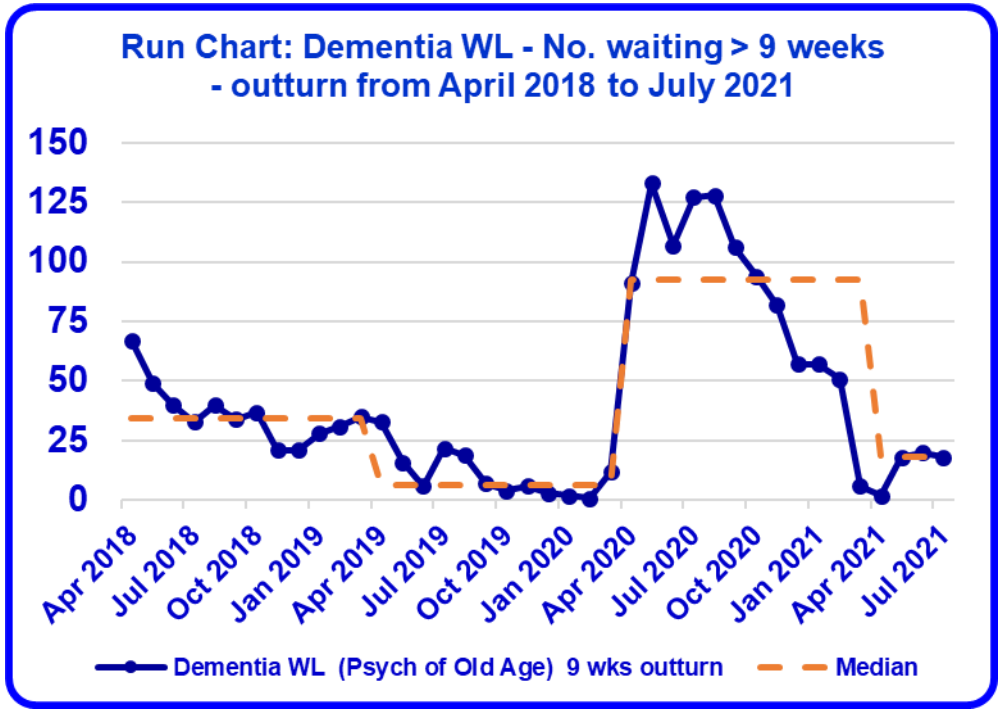


- There has been a sustained reduction in the use of seclusion events over the last 2 and a half years.
- There was a concern on site at a point in time that a reduction in the use of seclusion events may lead to an increase in the need for physical intervention. This has not been demonstrated in the data, although there was an increase in the 3 month rolling average in the 6 months to June. Use of physical intervention since mid-June has reduced significantly

Older People's Services - Dementia

Dementia

CPD: No patient waits longer than 9 weeks to access dementia services



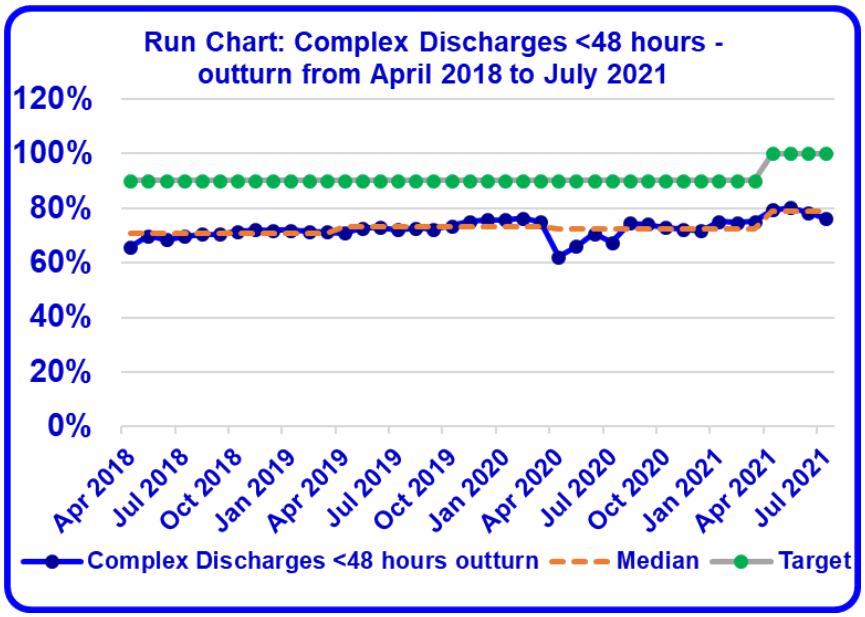
- The waiting list had grown from 169 in March 2020 to 434 at the end of July 2020.
- In July 2021 there is a total of 250 people waiting, 229 in Psychiatry of Old Age and 21 in Community MH.
- There has been a sustained improvement. There are currently 18 patients now waiting in excess of the 9 week target in April 2021, in Psychiatry of Old Age.

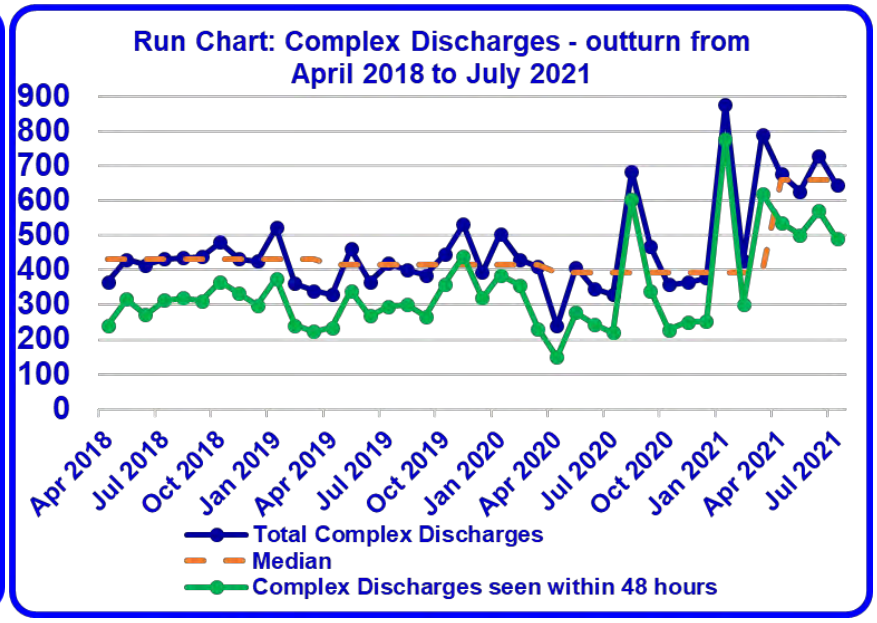
Older People - Complex Discharges

MAHI - STM - 302 - 361

Delayed Discharges

Complex discharges <48 hours - *CPD: Ensure that 90% of complex discharges from an acute hospital take place within 48 hours*





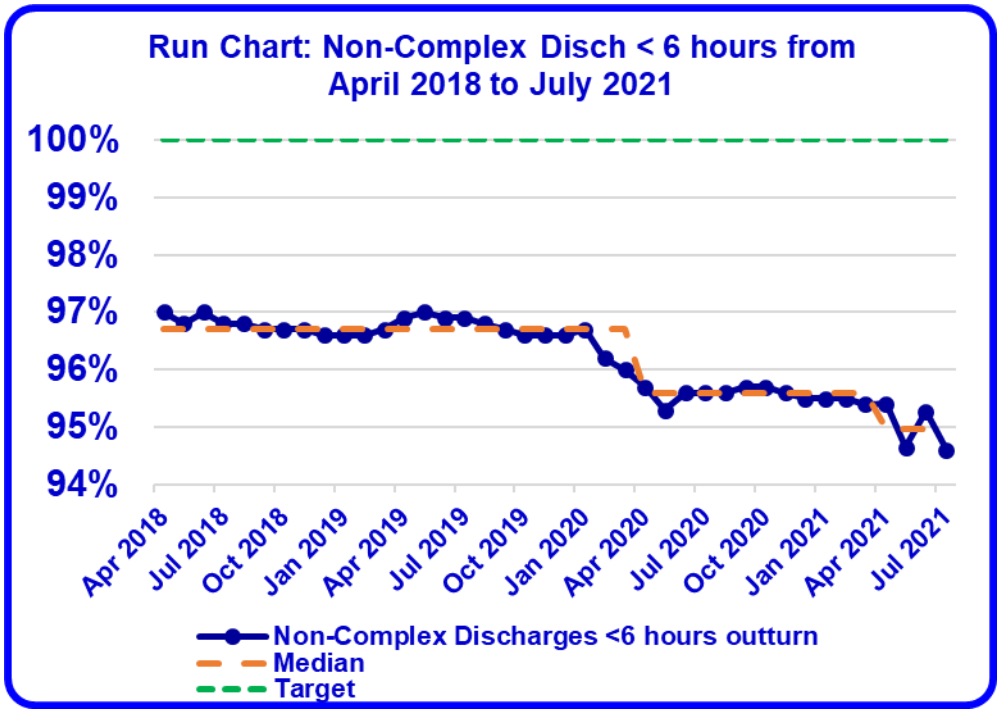
- Performance against the target reduced from 75% to 62% between March and April 2020.
- This gradually improved through 2020/21 to 95.1% in March 2021.
- In July 2021, 76.1% of the 644 complex discharges met the target, compared to 67.4% of 330 complex discharges in July 2020.

From Jan 19 - Information Source for Complex Discharges - is the HSCB Daily Report (Not Web Portal)

Older People Non-complex Discharges

Delayed Discharges
Non-complex discharges <6 hours

CPD: Ensure that all non-complex discharges from an acute hospital take place within 6 hours



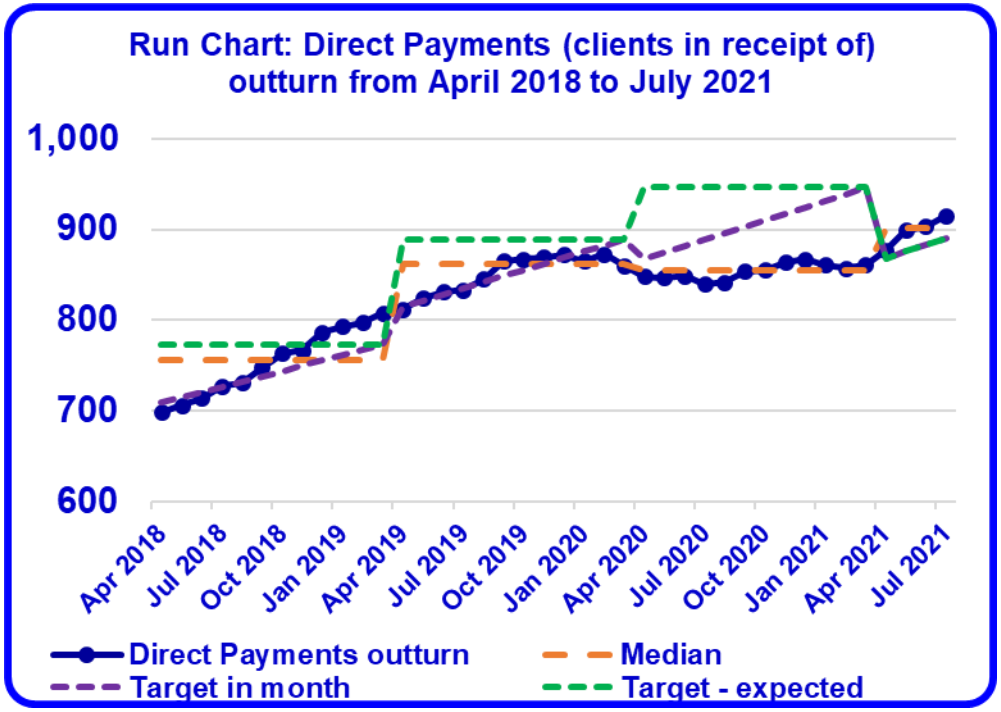
- The performance has consistently been 95% or above since April 2020 and in April 2021. In July 2021, 94.6% of non-complex discharges met the 6 hour target.

Direct Payments

MAHI - STM - 302 - 363

CPD: Secure a 10% increase in the number of direct payments (DPs) to all service users, based on 2020/21 outturn = 947.

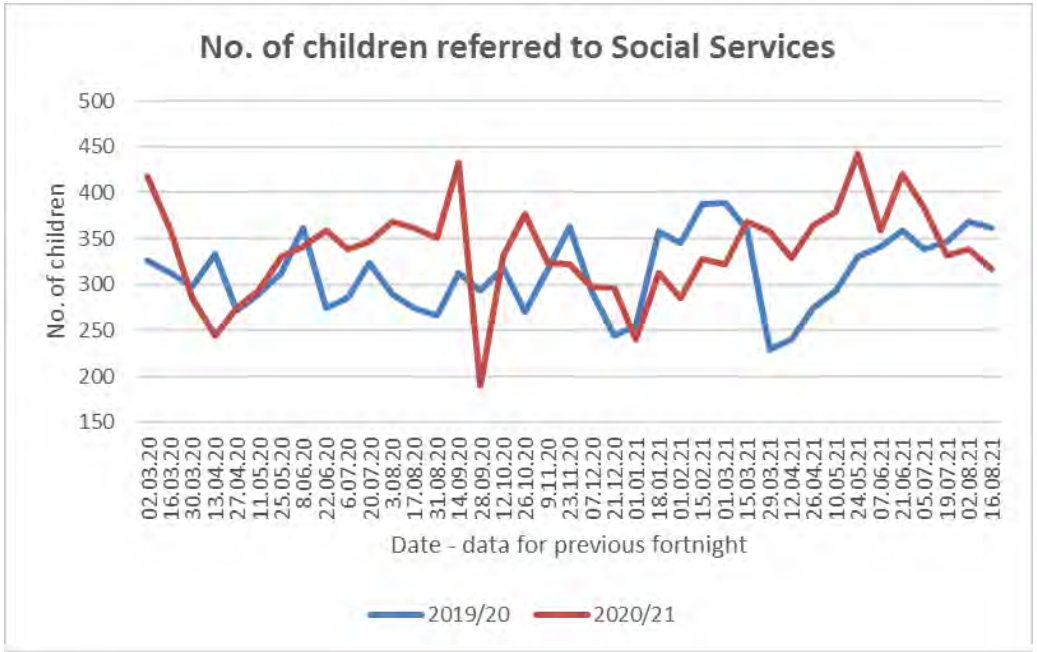
At the end of March 2021 there were 861 clients in receipt of Direct Payments (DP's). The 2021/22 target has been set as 10% above outturn at 947, an increase of 86 on March 2021 outturn (an average increase of over 7 packages per month).



- The uptake at the end of July 2021 is 915, 75 more than 2020/21 outturn.
- July outturn is 25 above the target level for July 2021 of 890.
- In April-July there are 88 new packages and 34 ceasing. and 52 are currently suspended.

Children's Community Services

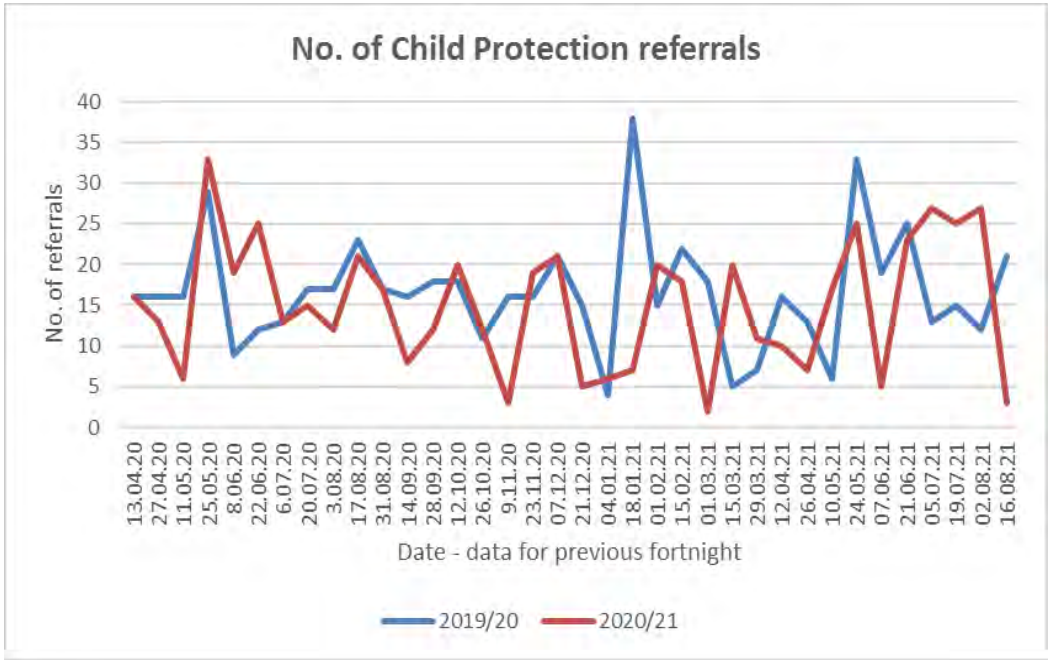
Children referred to social services – information to 16th August



The number of children referred to social services was generally higher on average in 2020/21 than in the same period in 2019/20. In early 2021 the numbers were lower than for the same period last year on average. Referrals since March are in excess of the same period last year, when the lockdown restrictions began, although there has been a reduction since mid-June

Children's Community Services

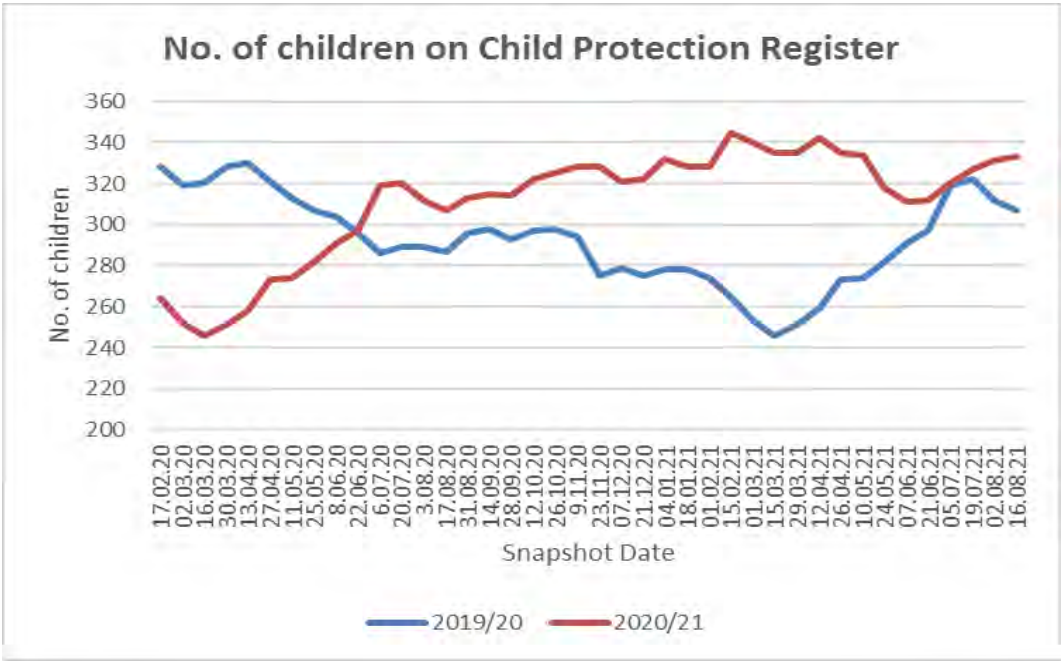
Number of Child Protection referrals - information to 16th August



The number of fortnightly child protection referrals shows significant variation, and referrals in the last 2 weeks are at their lowest since March, after 2 months of higher than average rates.

Children's Community Services

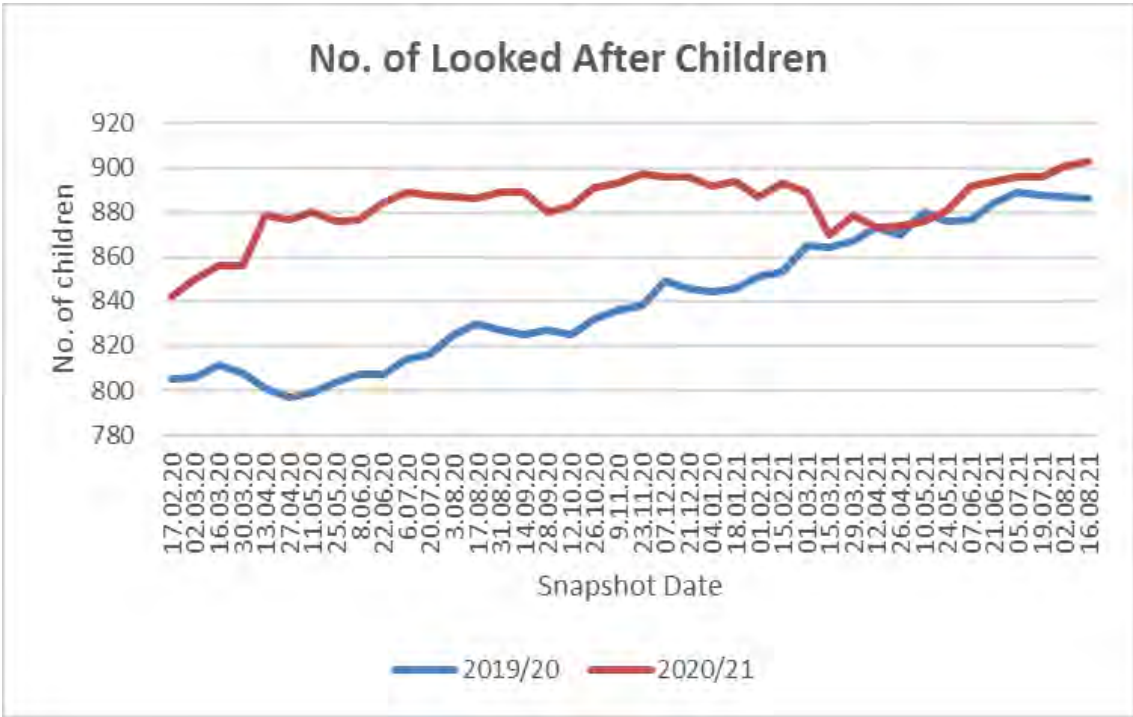
Number of Children on Child Protection register - information to 16th August



There are 15% more children on the child protection register compared to the same point last year. Following a sustained growth for 12 months numbers on average had fallen for 3 months to June and have now shown a consistent increase in the last 10 weeks

Children's Community Services

Number of Looked after Children - information to 16th August



There had been a steady rise in the number of looked after children in the period March 2020 to mid-January, most significant around the beginning of the 1st lockdown. After a reduction and levelling off between February and April 2021, numbers have risen and now stand at just over 900.

Efficiency

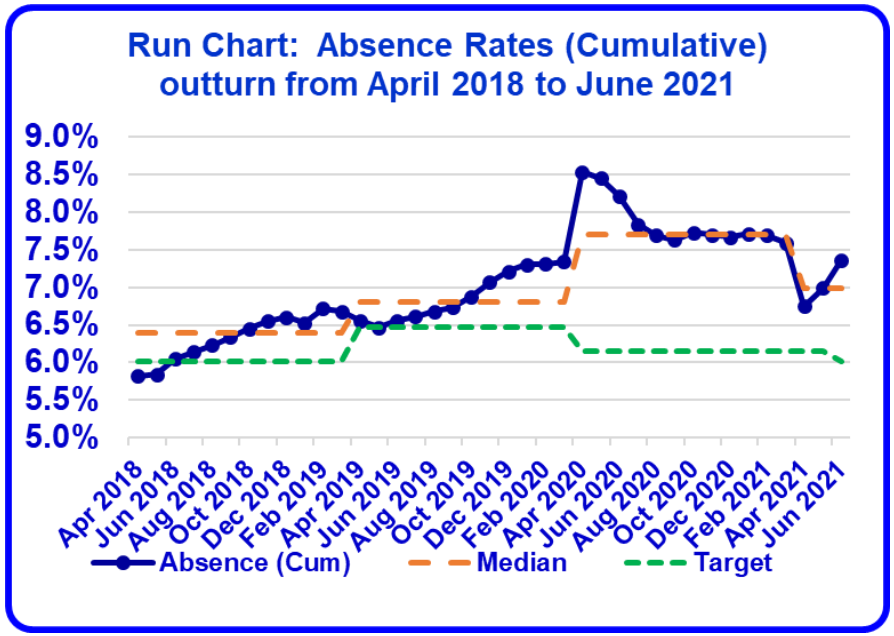
HR Update

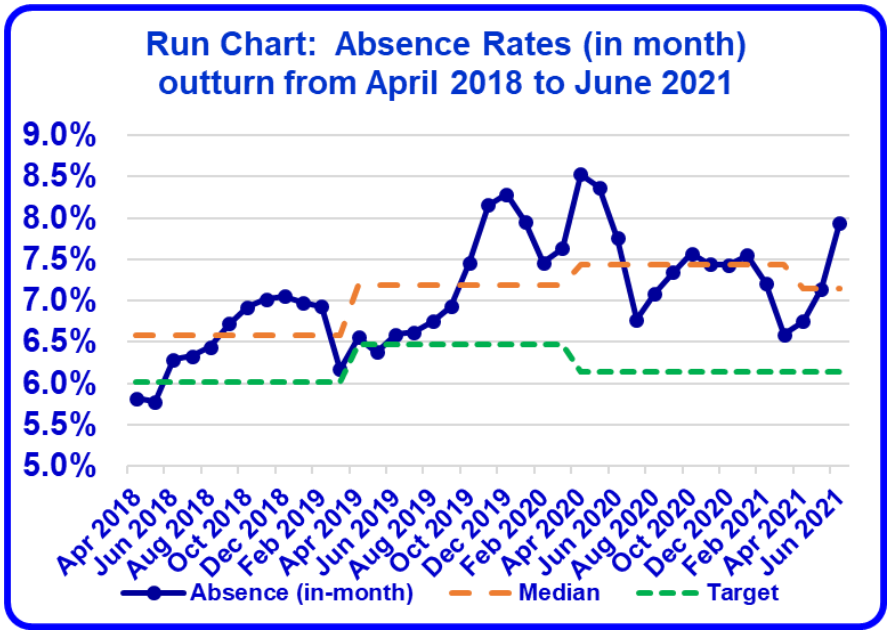
MAHI - STM - 302 - 369

Sickness & absenteeism

CPD: To reduce Trust staff sick absence levels by a regional average of 5% compared to 2020/21 outturn figure. (2021/22 CPD Target 7.23% *)

- April to March 2020/21, Trust absence = 7.6%
- June 2021, Trust absence =7.4%, target 7.23%*





- The absence rate during June 2021 was 7.9% and 7.4% cumulatively to the end of June 2021.
- In June 2020, the absence rate was 7.8% in-month and 8.2% cumulative to the end of June 2020.

** Target for 2021/22 assumed as 7.23%, to be confirmed*

HR Update

MAHI - STM - 302 - 370

Staff Engagement Scores

The table below shows the engagement scores by Directorate based on the results of the 2019 Regional Staff Survey.

2019 HSC Staff Survey Key Findings Data by Organisational Staff Directorate - Overall Engagement scores												
HSC OVERALL	Belfast HSCT Overall	Adult Social & Primary Care	Children's Comm-unity Services	Corporate Communica tions & Chief Executive Combined	Finance	Human Resources	Medical Dir-ectorate	Nursing & User Exp-erience	Perfor-mance, Plan & Info	Specialist Hospital, Women's Health	Surgery & Specialist Service	Acute & Uns-cheduled Care
3.78	3.77	3.8	3.77	4.14	3.78	3.89	3.72	3.68	3.7	3.74	3.78	3.79

Active requisitions

Vacancies can also be reported on the basis of active recruitment activity. The table below shows active requisitions by Directorate and by job type at the end of April 2021, with 49% of all requisitions relating to Nursing and Midwifery posts.

Active Requisitions at 18 August 2021	Admin & Clerical	Estates	Multi-professional	Nursing & Midwifery	Professional & Technical	Social Care	Support Services	Grand Total
ADULT SOCIAL & PRIMARY CARE DIRECTORATE	5		3	47	15	86		156
CHIEF EXECUTIVE DIV	1							1
CHILD HEALTH & NISTAR DIRECTORATE	14			29	100			143
CHILDRENS COMMUNITY SERVICES DIRECTORATE	10		1	16	1	89		117
FINANCE DIRECTORATE	12	2						14
HUMAN RESOURCES DIRECTORATE	9			4	1	3		17
MEDICAL DIRECTORATE	18		1	7	1			27
MH & INTELLECTUAL DISABILITY DIRECTORATE	8		8	130	20	30		196
NURSING & USER EXPERIENCE DIRECTORATE	9			291	4	7	26	337
PERFORMANCE, PLAN & INFO DIRECTORATE	32					1		33
SURGERY & SPECIALIST SERVICE DIRECTORATE	40		1	62	140			243
TOR, MAT, ENT, DENTAL,GYNAE DIRECTORATE	14			80	4			98
UNSCHEDULED CARE DIRECTORATE	25		1	174	73			273
Total Active Requisitions	197	2	15	840	359	216	26	1655
Percentage of Total	11.9%	0.1%	0.9%	50.8%	21.7%	13.1%	1.6%	100.0%

HR Update

Statutory Mandatory Training

The table below shows the Trust position of the Core 10 Mandatory Training areas from April 2019 to July 2021.

Overall Trust Performance (April 19-Jul 2021)	30.04.19	30.06.19	30.09.19	30.11.19	31.01.20	30.04.20	31.07.20	30.09.20	31.12.20	31.03.21	31.07.21	Higher / lower than March 2021
Adverse Incident Reporting	33%	41%	43%	46%	48%	42%	46%	45%	44%	45%	48%	↑
Corporate Induction	79%	83%	84%	81%	84%	82%	79%	77%	77%	79%	77%	↓
Data Protection	53%	57%	57%	57%	62%	61%	56%	53%	50%	48%	49%	↑
Equality for All Staff	34%	35%	38%	37%	41%	40%	38%	36%	37%	35%	33%	↓
Fire Safety	46%	48%	49%	52%	52%	47%	36%	32%	31%	33%	53%	↑
Health and Safety	9%	11%	11%	38%	37%	36%	36%	40%	43%	49%	52%	↑
Infection Prevention Control	78%	67%	80%	83%	82%	80%	80%	80%	82%	79%	80%	↑
Manual Handling	28%	29%	28%	30%	26%	24%	20%	27%	35%	33%	34%	↑
Quality 2020 L1	62%	64%	70%	69%	68%	69%	73%	66%	70%	67%	65%	↓
Safeguarding	78%	67%	86%	80%	82%	78%	80%	79%	80%	82%	81%	↓

- Directorates are provided with their own performance data monthly, and attention is focused on areas where performance is low, or reducing.
- Directorates are asked to maximise the e-learning opportunities available, for completion of training

HR Update

Further Indicators which will form part of QMS reporting include:

WORKFORCE CAPACITY

Report 1: Substantive Workforce
- Staff in Post and Funded staffing levels

Report 2: Full Workforce
- Substantive + Agency + Bank (may be difficult but could try)

Report 3: Vacancy Levels
- As per Recruitment Shared Service (active requisitions)

WORKFORCE COSTS

Report 1: Overall Pay Costs

Report 2: Temporary Workforce Expenditure
- Agency and Bank Spend

Report 3: Sickness Absence
- Overall Trust
- By Division
- By type

WORKFORCE EFFICIENCY

Report 1: Turnover
- Trust (rolling)
- By Division

Report 2: Recruitment
- Time to Fill

Report 3: Engagement

Report 4: Culture/Leadership

WORKFORCE COMPLIANCE

Report 1: Mandatory Training

Report 2: Appraisal
- Medical
- Non-Medical
- By Division

Finance Update – Month 4 – July 2021

Budget projections

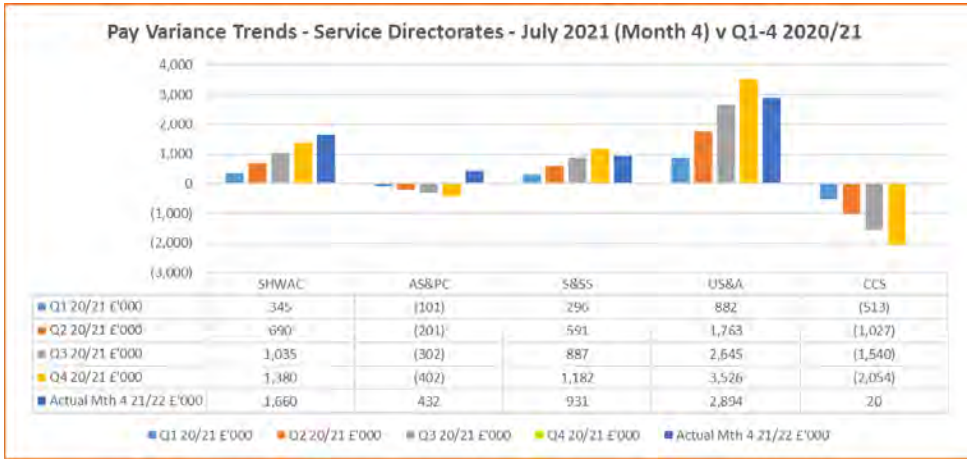
The Month 4 position is a £18.5m deficit and the forecast for the year is a deficit of £52m in line with the draft financial plan. Spend this year to date on COVID-19 is £23.6m, including £10.4m PPE, £3.5m additional staffing costs and £4m service delivery costs. The spend on transformation projects is £5.2m including £1m on mental health transformation, FYE forecast is £17.7m.

No further income has been assumed in terms of additional non-recurrent funding from in-year Departmental Monitoring Rounds or additional centrally held slippage which have both provided significant in-year monies in previous years and have been a major factor in achieving breakeven in the HSC and the Belfast Trust in the past. At this point, unless additional funding is received, the Trust is clear that financial balance could not be achieved through efficiency alone and a breakeven plan would require savings to be generated from service downturn

Finance Update – Month 4 – July 2021

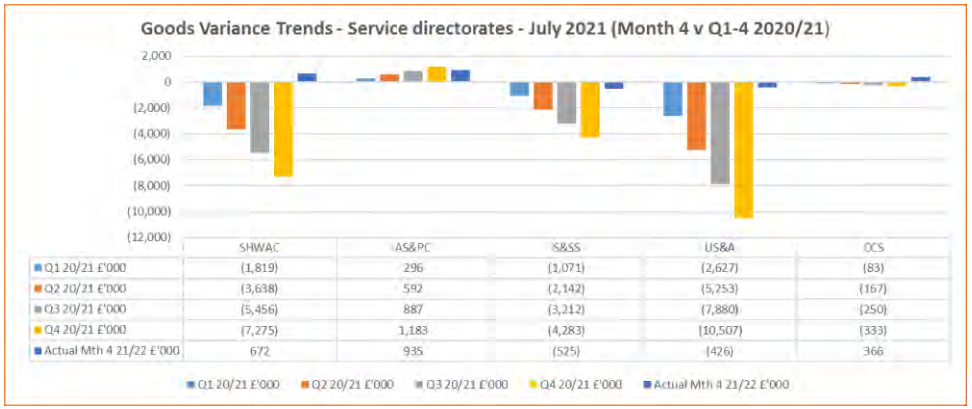
Budget position

Pay variance



	SHWAC	AS&PC	S&SS	US&A	CCS
Q1 20/21 £'000	345	(101)	296	882	(513)
Q2 20/21 £'000	690	(201)	591	1,763	(1,027)
Q3 20/21 £'000	1,035	(302)	887	2,645	(1,540)
Q4 20/21 £'000	1,380	(402)	1,182	3,526	(2,054)
Actual Mth 4 21/22 £'000	1,660	432	931	2,894	20

Non-Pay Variance



	SHWAC	AS&PC	S&SS	US&A	CCS
Q1 20/21 £'000	(1,819)	296	(1,071)	(2,627)	(83)
Q2 20/21 £'000	(3,638)	592	(2,142)	(5,253)	(167)
Q3 20/21 £'000	(5,456)	887	(3,212)	(7,880)	(250)
Q4 20/21 £'000	(7,275)	1,183	(4,283)	(10,507)	(333)
Actual Mth 4 21/22 £'000	672	935	(525)	(426)	366

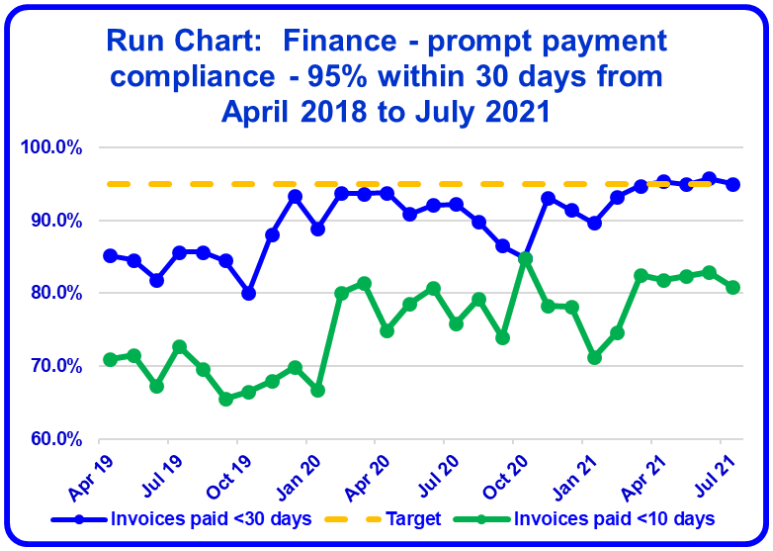
Finance Update – Month 4 – July 2021

MAHI - STM - 302 - 375

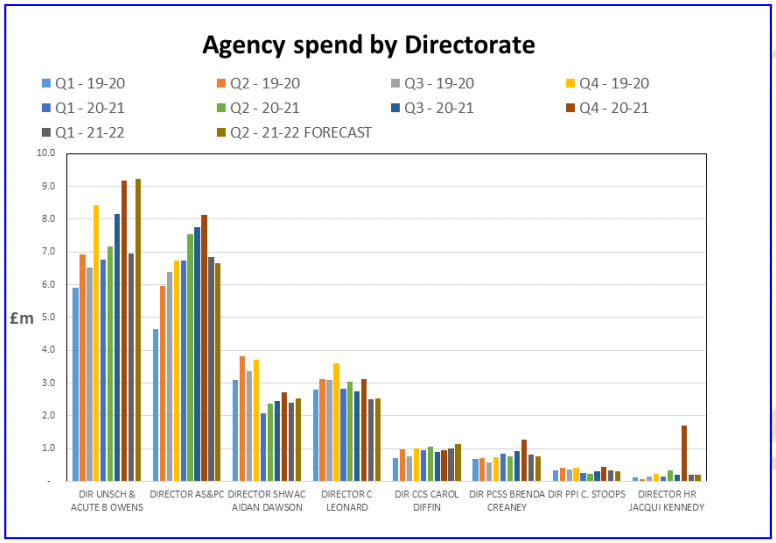
Prompt Payment policy – M04. July 2021

The Trust delivered 95% against DoH 30 day target and 81% against the internal target of 10 days in July 2021.

The Department of Health's target for Prompt Payment of invoices is set at 95% for payment within 30 days. The Trust averaged over 90% in 2020/21 and is achieving 95% each month April to July 2021.



Agency Spend – The ongoing pressure in relation to workforce continues in 2021/22. Agency is £800k (3%) higher than the first four months of last year with significant increases being seen in nursing (£402k, 2%), admin (£450k, 15%) and social services (£225k 10%). This would represent a significant increase pay overspend for the year if this rate of spend continues. The graph below shows agency costs for quarter 1, 2, 3, and Q4 2019/20 & 2020/21 against Q1 and forecast Q2 2021/22.

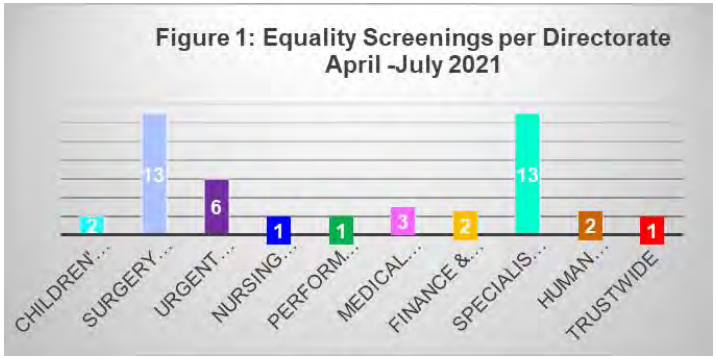


Equity

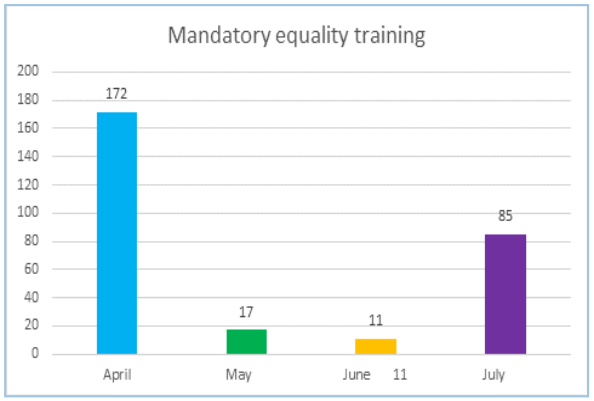
Update on progress in relation to Equity

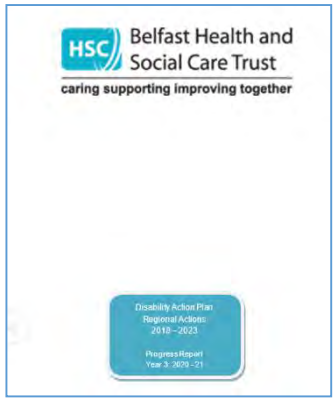
Trust commitment to equity and equality is unequivocally articulated in our Equality Scheme

During the period of April- July 2021, **45** equality screenings were undertaken and completed. In accordance with the Trust's statutory equality responsibilities, the quarterly screening outcome report is published online in the interest of openness and transparency. **Figure 1** shows the breakdown of screenings by Directorate



The Trust has developed its 14th Annual Progress Report to the Equality Commission for Northern Ireland and this will be submitted to the Equality Commission by 31st August. This report illustrates compliance with our Equality Scheme and implementation of our statutory Section 75 duties to promote equality of opportunity amongst the 9 protected groups and to promote good relations amongst the 3 protected groups. In addition to the progress report, the Trust will submit an update in regard to year 3 of its 5 year Disability Action Plan and a further update in regard to its progress against year 3 of its 5 year Disability Action Plan. These all provide assurance to the Executive Team, Trust Board, Equality Commission and any interested stakeholders.





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Appendix 1: Phase 6 Delivery Plan– to 31st July 2021

Delivery Plans - Phase 6 (July to September 2021)						
		JULY 2021				
Trust: Belfast	Update as at 31st July 2021	July 2019 Activity	Delivered Activity 1st-31st July 2021	Projected Activity 1st-31st July 2021	Variance - Delivered against Projected	% of July Projection Delivered
SERVICE AREA	METRIC					
OUTPATIENTS - CONSULTANT (including Urology, Pain management						
New	Face to Face	12,973	7,239	8,303	-1,064	87%
	Virtual	734	2,427	3,467	-1,040	70%
	Total	**13,707**	**9,666**	**11,770**	**-2,104**	82%
Review	Face to Face	32,157	17,654	19,291	-1,637	92%
	Virtual	499	7,985	11,868	-3,883	67%
	Total	**32,656**	**25,639**	**31,159**	**-5,520**	82%
	Overall total	**46,363**	**35,305**	**42,929**	**-7,624**	82%
OUTPATIENTS - NURSE (excluding preassessment & nurse activity						
New	Face to Face	1,521	882	938	-56	94%
	Virtual	24	218	322	-104	68%
	Total	**1,545**	**1,100**	**1,260**	**-160**	87%
Review	Face to Face	5,945	4681	4,673	8	100%
	Virtual	1,469	2,380	3,317	-937	72%
	Total	**7,414**	**7,061**	**7,990**	**-929**	88%
	Overall total	**8,959**	**8,161**	**9,250**	**-1,089**	88%
Inpatients and Daycases (theatre cases)						
Elective Admissions		1,686	1161	1,449	-288	80%
Daycases		5,587	3,990	4,675	-685	85%
Endoscopy (4 scopes)		949	507	757	-250	67%
CANCER SERVICES						
14 day	% performance planned	100%	100%	100%	0%	100%
31 day	% performance planned	90%	88%	90%	-2%	98%
62 day	% performance planned	41%	56%	45%	11%	124%
DIAGNOSTICS						
MRI	MRI	2,272	3,038	2,865	173	106%
CT	CT (includes Cardiac CT)	5,667	5,851	5,170	681	113%
Non Obstetric Ultrasound		4,172	3,642	3,711	-69	98%
ECHO		1,977	1,609	1,650	-41	98%
	Total	**14,088**	**14,140**	**13,396**	**744**	106%

Appendix 1: Phase 6 Delivery Plan– to 31st July 2021

ALLIED HEALTH PROFESSIONALS	Elective /Scheduled Contacts					
Physiotherapy	New	3,240	1,469	1,424	45	103%
	Review	6,136	5,977	5,072	905	118%
Occupational Therapy	New	1,251	864	854	10	101%
	Review	3,485	3,648	3,284	364	111%
Dietetics	New	280	91	100	-9	91%
	Review	537	976	1,000	-24	98%
Orthoptics	New	195	82	142	-60	58%
	Review	526	271	150	121	181%
Speech&Language Therapy	New	453	278	326	-48	85%
	Review	1,167	1,350	1,085	265	124%
Podiatry	New	685	562	420	142	134%
	Review	4,249	3,564	3,906	-342	91%
	Total	**22,204**	**19,132**	**17,763**	**1,369**	**108%**
MENTAL HEALTH	**Contacts**					
Adult Mental Health (Non Inpatient)	New	705	556	705	-149	79%
	Review	7,601	6,590	7,493	-903	88%
Dementia	New	136	108	80	28	135%
	Review	498	570	662	-92	86%
CAMHS	New	207	123	207	-84	59%
	Review	2,705	2,205	2,705	-500	82%
Psychological Therapies	New	246		200	-200	0%
	Review	1,909		2,000	-2,000	0%
Autism Children's	New Diagnostic	37	14	15	-1	93%
	New Intervention	74	53	35	18	151%
Autism Adults	New Diagnostic	3	0	1	-1	0%
	New Intervention	0	0	1	-1	0%
	Total	**14,121**	**10,219**	**14,104**	**-3,885**	**72%**

Appendix 1: Phase 6 Delivery Plan– to 31st July 2021

DAY CARE AND DAY OPPORTUNITIES							
Day Centre Attendances	ELD & PSD		8,075	2,321	2,342	-21	**99%**
	LD		8,621	3393	3,500	-107	**97%**
ADULT SOCIAL CARE							
Domiciliary Care	Hours Delivered (Stat)		40,784	36103	36,500	-397	**99%**
	Hours Delivered (Ind)		130,653	174,683	171,100	3,583	**102%**
	Total		**171,437**	**210,786**	**207,600**	**3,186**	**102%**
COMMUNITY NURSING							
District Nursing	Contacts		21,657	15,657	21,000	-5,343	**75%**
Health Visiting	Contacts		6,720	6011	6,600	-589	**91%**
			28,377	**21,668**	**27,600**	**-5,932**	**79%**
Community Paediatrics	New		286	182	123	59	**148%**
	Review		2,044	1,840	1,860	-20	**99%**
	Total		**2,330**	**2,022**	**1,983**	**39**	**102%**
Community Dental	New		113	92	55	37	**167%**
	Review		654	316	385	-69	**82%**
	Total		**767**	**408**	**440**	**-32**	**93%**
Mental Health	Admissions		35	51	35	16	
CHILDREN'S SOCIAL CARE							
Child Protection Referrals	Referrals		41	61	40	21	**153%**
CPR Visits	Visits		NA	919	900	19	**102%**

Appendix 2: Performance against Business Plan Objectives / Targets – June/July 2021

Trust Performance against CPD Targets as at 31st July 2021

Key	TOTALS	
RAG (Red, Amber, Green) rating	**RAG**	**CPD**
Target / tolerance not met **RED**		21
Within target / tolerance (10%) **AMBER**		7
Target met **GREEN**		3
Other : resettlement, funded activity		4
Total		35

Appendix 2: Performance against Business Plan Objectives / Targets – June/July 2021

TRUST PERFORMANCE REPORT RAG SUMMARY - 30th June 2021		RAG STATUS
CPD Ref	Outcome area	CPD
1.0	HCAI - MRSA 7.5% reduction of episodes regionally	
2.0	HCAI - C.Difficile 7.5% reduction of episodes regionally	
3.0	GP OOH - Urgent calls 20 minute triage	
4.0	ED 4 hours - Trust - All sites. CPD target = 95%	
5.0	ED 12 hours - Trust - All sites. CPD target = 0	
6.0	ED triage < 2 hours CPD target 80%	
7.0	Hip fractures < 48 hours.	
8.0	Urgent diagnostics < 2 days	
9.0	Breast Cancer urgent patients < 14 days	
10.0	Cancer urgent patients < 31 days	
11.0	Cancer urgent patients < 62 days	
12.0	Outpatients waiting > 9 weeks for first Appt	
13.0	Outpatients waiting > 52 weeks for first Appt	
14.0	Diagnostic test. Waiting > 9 weeks	
15.0	Diagnostic test. Waiting > 26 weeks.	
16.0	IPDC waiting no longer than 13 weeks for treatment	
17.0	IPDC waiting > 52 weeks for treatment	
18.0	CAMHS waiting > 9 weeks.	
19.0	Adult MH waiting > 9 weeks.	
20.0	Dementia waiting > 9 weeks.	
21.0	Psych Therapies waiting > 13 weeks.	
22.0	Direct payments (SDS) 10% increase	
23.0	AHP's waiting > 13 weeks	
24.0	LD discharges < 7 days	Resettlement Plan
25.0	LD discharges < 28 days	
26.0	MH discharges < 7 days	
27.0	MH discharges < 28 days	
28.0	Carers Assessments	
29.0	Complex Discharge < 48 hours.	
30.0	Complex Discharge > 7 days	
31.0	Non-Complex Discharge < 6 hours	
32.0	Funded activity - IPDC CPD	n/a
32.0	Funded activity - OP CPD	n/a
32.1	Endoscopy waiting > 9 weeks	
33.0	Absence - Cumulative (one month behind)	

2.048

Belfast Health and Social Care Trust

Minutes of the Confidential Trust board Meeting
Held on 2 April 2015 at 9.00 am
in the Boardroom, Trust Headquarters
Belfast City Hospital

PRESENT:

Mr Peter McNaney	Chairman
Mr Les Drew	Non-Executive Director
Mr James O'Kane	Non-Executive Director
Dr Michael McBride	Chief Executive
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 Brian Barry	Director Specialist Hospitals and Women's Health
Mr Shane Devlin	Director Performance, Planning and Informatics
Mr Damian McAlister	Director Human Resources/ Organisational Development
Ms Catherine McNicholl	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Specialist Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

APOLOGIES:

Mr Tom Hartley	Non-Executive Director
Mr Charles Jenkins	Non-Executive Director
Dr Cathy Jack	Medical Director

Mr McNaney welcomed everyone to the meeting.

07/15 Minutes of the Previous Meeting

The minutes of the confidential Trust Board meeting held on 5 February 2015 were considered and approved.

08/15 Matters Arising

There were no issues raised.

09/15 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interests reported.

b. Non-Executive Director Vacancies – Update

Mr McNaney thanked Mr Drew, Mr Hartley and Mr Jenkins for agreeing a further extension to their role to the end of June 2015, pending the appointment of the new Non Executive Directors'. He advised that it was hoped the Minister would announce the new appointees in the near future.

10/15 Chief Executive's Business

a. Letter of Concern – Nursing Staff, Musgrave Park Hospital

Mr Barry briefed members on a letter of concern received from nursing staff within Musgrave Park Hospital (MPH) which had received media coverage. The issues raised include concerns regarding orthopaedic patients being transferred to MPH in the evening and the cancellation of elective orthopaedic procedures.

Dr McBride advised that the issues raised were being looked at by management. He indicated his disappointment that the BBC had published the story without establishing the facts.

Mr Drew and Mr O'Kane referred to a similar incident in the press in early 2014 relating to the transfer of an elderly patient at night and assurance given by management that procedures had been reviewed to prevent late night transfers of patients.

Mr McNaney asked that Trust Board be fully briefed on the outcome of the Trust review of the issues.

Decision: - Letter of Concern – Nursing Staff, MPH noted

b. RGH Phase 2B: Critical Care Building: Update

Mr Dillon reminded members of the issues previously reported regarding damaged pipework in the new Critical Care Building on the RVH site and the impact on the completion of the building. There had been a series of meetings with the contractor to guarantee the building was completed to the required specification to ensure a safe environment to provide health care.

10/15 **(Contd.)**

Mr Dillon advised that it was anticipated the building would be handed over to the Trust on 10 April 2015.

However, due to the current financial situation the HSCB had indicated that the commissioning of the Critical Care building could be delayed because of financial constraints in 2015/16. Mr Dillon advised that there were on-going discussions with HSCB regarding the high priority services transferring to the new building.

Dr McBride advised that it was important the HSCB fully understood the risk implications delaying the building opening.

Mr Dillon said the Trust was proceeding with its plans to at least transfer the ED services to the new building.

Members expressed concern at any delay in the new building becoming fully operational.

In response to a question from Mr McNaney, Mr Dillon advised that plans were well advanced to expand the Ambulatory Care provision into the temporary ED building once it was vacated were well.

Following a question from Mr O'Kane, Mr Dillon advised that the Trust would only take procession of the new building when the Trust's Design Team had signed the Certificate of Practical Completion.

Following a question from Mr Drew, Mrs Owens advised that the Trust was currently recruiting staff in preparation for the new Critical Care building becoming operational.

In noting the position members expressed concern at any delay in the commissioning of the new building Mr McNaney suggested the Permanent Secretary be invited to a briefing on the IMPACT project.

Decision: - RGH Phase 2B: Critical Care Building Update noted

c. Morbidity and Mortality Figures – Update

Dr McBride advised that due to a higher number of deaths in older age groups in January and February compared with previous years an Early Alert had been submitted to the DHSSPS. He explained that evidence would indicate a similar pattern across England and Wales. However, the Trust was undertaking a review of every death as part of the Mortality and Morbidity Review System and would also be looking at significant random samples within medical wards. The Trust would also carry out a benchmarking exercise with peer Trusts.

10/15 **(Contd.)**

In noting the position Mr McNaney asked that Trust Board receive an update when review had been completed.

Decision: - Morbidity and Mortality Figures – Update noted

d. Tissue Pathology – Update

Mrs Welsh briefed members on an Early Alert/SAI within the Tissue Pathology service as a result of a technical malfunction.

Members noted that the fault had been identified quickly to limit the impact to patients. A review was currently being carried out and a further update would be given at a future meeting.

Decision: Tissue Pathology – Update noted

11/15 **Deputy Chief Executive/Director Finance, Estates and Capital Planning**

a. Draft Reform and Savings Plans for 2015/16

Mr Dillon presented an update of the draft Reform and Savings Plans for 2015/16 which had been presented at the Extraordinary Confidential Trust Board in January. He explained the main changes were that there was now clarity on the proposals which are "supported" and/or "supported in principle" by the HSCB, LCG and PHA; the total yield expected from these proposals is estimated at £17m for 2015/16; the gap of approximately £23m against the total Trust target of £40m remains unresolved, therefore, further direction was awaited from the HSCB on the options to achieve the statutory duty to breakeven.

Mr Dillon advised that the plan had also been informed by internal deliberations, legal advice and discussions with the HSCB and DHSSPS, regarding adherence to statutory and good practice guidance in respect of equality and consultation processes.

Mr Dillon explained that the main risk within the plan related to the implementation of the Social Care Reform proposals, which will be of major public and political interest, and will require time to ensure that due process is followed within the planning processes, including full and meaningful consultation exercises.

Mr McAlister advised that a preliminary equality screening of the overall Reform and Efficiency Plan had been completed and given its strategic nature, the outcome of this was to subject the Plan to on-going screening. On the basis of the information currently available a number of the proposals will need to undergo public consultation and engagement process.

11/15 **(Contd.)**

Mr O'Kane expressed his frustration with the way in which the Health budget was allocated and the implications for Trusts trying to manage and provide efficient services whilst addressing the Reform and Modernisation agenda.

Mr Dillon said he shared Mr O'Kane's frustrations and his further concern was that there was no provision for service developments within the current system wide financial plan.

In considering the contents of the plan members' expressed concern regarding the proposal to withdraw the "financial rewards" system for day centre clients in Muckamore Abbey Hospital and the impact on very vulnerable people. Following discussion it was agreed that this proposal should be removed from the draft plan.

Mr McNaney reminded members that the Reform and Savings Plans for 2015/16 would be considered at the public meeting for formal approval.

Decision: **Draft Reform and Savings Plans for 2015/16**

12/15 **Any Other Business**

There were no further items of business raised.

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*
- sensitive & personal data *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

caring supporting improving together

Minutes of the Trust Board Meeting
Held on 3 September, 2015 at 10.00 am
in the Boardroom, Trust Headquarters
Belfast City Hospital

PRESENT:

Mr Peter McNaney	Chairman
Professor Martin Bradley	Non-Executive Director
Dr Paddy Loughran	Non-Executive Director
Mr James O'Kane	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Michael McBride	Chief Executive
Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Dr Cathy Jack	Medical Director

IN ATTENDANCE:

Mr Brian Barry	Director Specialist Hospitals and Women's Health
Mr Shane Devlin	Director Performance, Planning and Informatics
Mr Damian McAlister	Director Human Resources/ Organisational Development
Ms Catherine McNicholl	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Specialist Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Dr Julian Johnston	Policy and Legislation Unit, DHSSPS
Mr David Best	Policy and Legislation Unit, DHSSPS
Mr Barney McNeany	Co-Director,

APOLOGIES:

Mrs Miriam Karp,	Non Executive Director
Dr Val McGarrell	Non Executive Director
Ms Anne O'Reilly	Non Executive Director
Mr Cecil Worthington	Director Social Work/Children's Community Services

Mr McNaney welcomed everyone to the meeting with a special welcome to Dr Paddy Loughran attending his first meeting following his recent appointment as Non Executive Director.

33/15 Minutes of Previous Meeting

The minutes of the Trust Board meeting held on 4 June, 2015 were considered and approved.

34/15 Matters Arising

There were no items raised.

35/15 Chairman's Business

a. Conflicts of Interest

Professor Bradley referred to the agenda items relating to the future delivery of Learning Disability and Mental Health Day Services and wished to record a potential conflict of interest as he had served as Chair on the NI Association for Mental Health.

b. Non Executive Director Appointments – Update

Mr McNaney was pleased to report that Mrs Miriam Karp had been appointed as Non Executive Director for a 4 year term commencing 1 September, 2015.

c. Trust Board Sub-Committees/Panels

Mr McNaney tabled a paper outlining Non Executive appointments to the Trust Board Sub-Committees for information.

d. Chairman's Awards

Mr McNaney advised that the Chairman's Awards would be announced at an event being held in the Belfast City Hall on the evening of 5 November, 2015 and encouraged everyone to attend. He also thanked the Non Executive Directors who had sat on the judging panel and attended the follow up visits to each of the projects.

Mrs McKeagney, Dr Loughran and Professor Bradley said they had been impressed with the high standard of applications and had found the visits very useful in getting an understanding of the services provided by the Trust.

36/15 Chief Executive's Business

i. Emerging Issues

a. Critical Care Building, RVH

Mrs Owens reported on the successful transfer of the ED, RVH to the new Critical Care building on 19 August, 2015.

36/15 **(Contd.)**

Dr McBride was pleased to report that initial indications were that the new models of care had seen an improvement on the performance targets and a reduction in the number of admissions. He further advised that he would be writing to the Permanent Secretary and Chief Executive, HSCB to thank both organisations for their support and confidence in the Trust to allow the Trust to deliver a step change in the efficiency of patient flow in unscheduled care and maximise the safety and effectiveness of unscheduled care services offering a much improved patient experience.

Mr Dillon paid tribute to all grades of staff involved in the preparation and transfer of the ED and advised that the Executive Team would be hosting a recognition event at lunchtime on 30 September, 2015 to acknowledge the important role they had played in the successful transfer of services to the new building.

Mr McNaney, on behalf of Trust Board, wished to record grateful thanks to all staff involved in the transfer and service improvements, resulting in better patient experience.

It was agreed that arrangements should be made for the Non Executive Directors to visit the new Critical Care building.

ii. Annual Report 2014/15

Dr McBride presented the Annual Report for 2014/15 which had been considered by the Audit Committee on 2 June 2015.

Mr McNaney paid tribute to all staff involved in the publishing of the report, which he reflected provided an excellent summary of the work of the Trust.

Mrs Dalzell advised that in addition to publishing copies of the Annual Report an electronic version would be available on the Trust website. Also a series of video clips highlighting specific Trust services would be featured on the intranet site.

37/15 **Safety and Quality**

a. Performance Report

Mr Devlin presented the Performance Report for the period ending July 2015, indicating that of the 37 standards and targets the Trust was delivering/slightly behind/expected to achieve the required level of performance in 19. The remaining targets were currently and would continue to be a challenge for the Trust to achieve.

37/15 **(Contd.)**

Miss Creaney referred to the performance in relation to HCAIs and explained that significant work was being done to focus on areas where poor performance was being reported.

In response to comments from Professor Bradley and Dr Loughran, Miss Creaney advised that all patients are monitored for HCAIs on admission and individual Root Cause Analysis carried out on each case.

Mrs Welsh gave an overview of action taken by the Trust to improve performance in the 14 day breast cancer target. A recovery plan had been developed to manage the increased level of referrals into the service, whilst dealing with key staff absences. Mrs Welsh explained that that the Trust continued to liaise with the HSCB regarding regional capacity issues and the impact on the 62 day Inter Trust Transfer (ITT) target.

Mr Devlin referred to the Elective Care Diagnostic Waiting Times and explained the targets within this area remained a challenge not only due to additional investment being required but also capacity issues. He explained that currently funding was not available for additional activity resulting in an increase in waiting times for a number of specialties. An Elective Improvement Project had commenced to identify opportunities to optimise performance.

Mr McNaney stated that given the current HSCB position regarding the use of the Independent Sector it was inevitable that waiting lists would continue to increase.

Mrs McKeagney sought clarification in relation the number of cancelled out-patient appointments.

Mr Devlin explained that whilst an appointment may be cancelled the figure in the report does not reflect those appointments rearranged. Detailed reports of reasons for cancellations by speciality and consultant are reviewed and the Out-Patient Modernisation Groups are focusing on identifying actions to support a reduction in cancellations for 2015/16.

Decision: Performance Report noted for Assurance.

b. Regional Mortality and Morbidity Review

Mr McNaney welcomed Dr Julian Johnston and Mr David Best, Death Certification Policy and Legislation Unit, DHSSPS to the meeting.

37/15 **(Contd.)**

Dr Johnston explained that commencing August 2016, the Regional Mortality and Morbidity Review system (RM&MRs) will be introduced throughout hospitals in NI. He pointed out that among recommendations from the Francis report(s) is a requirement that clinical teams review and learn from issues surrounding the deaths of their patients.

Dr Johnston advised there are about 170 hospital deaths in the BHSCT each month. Until recently, there was no systematic method of collecting the details entered onto the paper Medical Certificate of Cause of Death (MCCD) or reported to the Coroner and no Trust-wide, guaranteed, routine assurance that every death was clinically reviewed.

Since the spring 2013, the Belfast Trust had used a computerised system (M&MRs), accessed via the Intranet HUB, for recording all hospital death details which are then checked by Consultant staff and reviewed at Trust wide Morbidity and Mortality (M&M) meetings.

The M&MRs allow the routine:-

- collection of details entered onto the MCCD, Stillbirth Certificate, and Coroner.
- review by Consultant Staff and M&M meetings of the deaths,
- recording of discussion, learning lessons and actions plans from these discussions,
- collection of information at M&M meetings for appraisal purposes. and will establish universal M&M meetings as a foundation of local clinical governance.
- evolve into multidisciplinary M&M meetings.

The functionality of the Belfast Trust M&MRs will form the basis of the RM&MRs.

Dr Johnston advised that the process will challenge the Trust in, continuing support for this Regional initiative; and aiding the funding of and support to M&M leads; blending and incorporating this reinvigorated 'frontline' clinical M&M review of patients deaths into the already developed 'corporate' Clinical Governance and incident reporting work. He pointed out that benefits realised will be two directional and ultimately should be become a unified 'governance' workflow - from top to bottom and vice versa.

Dr Jack explained that Dr Stevens, former Medical Director, had lead on the established the M&MRs in 2013 and the system was well embedded within the Trust.

37/15 **(Contd.)**

In the discussion which followed members endorsed the introduction of the M&R system, but noted the need for resources to be available to support the system.

Dr McBride pointed out that the M&MRs was in line with the statutory requirements of the Coroners Act.

Mr McNaney thanked Dr Johnston and Mr Best for their attendance and they then left the meeting.

c. Safetember

Dr Jack explained that during September the Trust was running the Safetember campaign with emphasis on improving programmes/ initiatives around safety and quality for services users. There would be a number of events held throughout the Trust to provide staff with an opportunity to share their safety and quality improvement work and also a listening day for patients and clients to share their suggestions as to how care could be delivered to make them feel safer.

Members welcomed the initiative.

38/15 **Deputy Chief Executive/**
Director Finance, Estates, Capital Development

a. Finance Report

Mr Dillon presented the finance performance report for the period ending 31 July 2015. He referred to the draft Trust Delivery Plan (TDP) presented at the June Trust Board workshop, which provided an outline of the Trust's draft financial plan which projected a year-end deficit of £13.5m. This £13.5m comprised a savings shortfall of £9m in relation to unmet acute reform savings carried forward from 2014/15, and £4.5m of 2014/15 cost pressures which, although not contested by the HSCB, remained unfunded.

Mr Dillon explained in the intervening period, detailed discussion and collaborative planning had taken place between Trust and HSCB resulting in a revised financial plan, showing a reduced deficit of £4m, has been developed. This revised plan was submitted to HSCB as an addendum to the TDP on 30 July 2015. The revised TDP deficit reflected a reduction in anticipated cost pressures, slippage on in-year investments, additional savings and an accounting adjustment in relation to holiday pay.

38/15 **(Contd.)**

Members noted that in order to achieve the 2015/16 TDP forecast position, the Trust must fully deliver its 2015/16 savings target of £20.3m. In addition, the Trust must continue to maintain workforce savings of approximately £18m in 2015/16. Furthermore, any new unavoidable pressures emerging in 2015/16 need to be fully funded by the HSCB. At the end of July 2015, the Trust was reporting a deficit of approximately £5.1m, which was in excess of the expected position at this stage of the year.

Mr Dillon pointed out that whilst it was early in the financial year, the current position is nonetheless concerning and immediate action must be taken by Directors to ensure that they recover budgetary and savings shortfalls and bring workforce levels back to the £18m target in the remaining months of the year. He advised that the Trust would continue dialogue with the HSCB to resolve the residual in-year deficit.

Members noted the financial position.

Decision: Finance Report – 31 July 2015 – Noted

39/15 **Director of Adult Social and Primary Care**

Ms McNicholl explained that Trust Board approval was being sought to proceed to public consultation in relation to the future delivery of learning disability and mental health day services for people living in Belfast and invited Mr McNaney, Co-Director, Mental Health and CAMHS, to brief members.

a. Delivery of Learning Disability Services for People living in Belfast – Proposed Consultation and EQIA

Mr McNeany gave an overview of the proposal and explained the future service provision would have two aspects:

- Day Care for people with complex needs, which will be largely based in Day Centres and
- Day Opportunities- a package of community based day time activities.

As more Day Opportunities are developed in areas such as further education, training, supported employment and social activities the demand for centre based places will reduce allowing for the closure of some smaller centres.

The Trust vision is about delivering support to Learning Disability Service Users with less complex needs through a range of Day Opportunities as opposed to traditional Day Centre care delivered solely by health and social care.

39/15 **(Contd.)**

Instead the focus is on service users and staff working together to develop and implement individual person centred plans and utilising activities and resources available through a range of agencies. It is envisaged that in the longer term, across Belfast there will be Day Centre services in each locality North, South, East and West of the city, together with a developing range of Day Opportunities provided by satellite services. The Trust will consult further, as required, on the reconfiguration of Day Centre services across the city as Day Opportunities increase and individual's assessed needs change.

It is proposed, therefore to merge day centre services currently provided from the Suffolk, Mica and Fallswater Centres in West Belfast. It is proposed that Fallswater Day Centre, the smallest of the three would merge with the Suffolk and Mica Centres, resulting in moving from three Day Centres to two in West Belfast. A full range of services would still be provided, with enhanced day opportunities offered within the remaining seven centres (hubs) and in partnership with the community and voluntary sector (satellites). Individual needs assessment and person centred planning with service users and carers will be central. It was noted that an EQIA would be included as part of the consultation process

Following a question from Professor Bradley, Mr McNeany advised that day centre services would continue to be available for users with more complex needs.

Mrs O'Reilly said the proposal was innovative and was about better provision of services.

In the discussion which ensued members expressed the view that the proposal would create an opportunity for service users to receive more person centred care.

Decision: Delivery of Learning Disability Services for People living in Belfast – Proposed Consultation and Equality – Approved.

b. Delivery of Mental Health Day Services for People living in Belfast – Proposed Consultation and EQIA

Mr McNeany referred to the significant reform of mental health services in line with the Bamford Review of Mental Health and Learning Disability (2007); with services aiming to promote empowerment, choice and recovery for those with mental health needs. Belfast Trust Mental Health Services are committed to working in partnership to deliver quality services which facilitate personal recovery and support and sustain individuals with mental health problems to live as full a life as possible. The consultation outlines a proposal to modernise the way Mental Health Day Services are currently delivered in Belfast.

39/15 **(Contd.)**

Mr McNeany explained that in recognising that changes to the current model may be difficult for those individuals who have been attending services for a long time; and that it will take time for the wider development of mental health services to be completed, therefore a stepped approach was being proposed for the creation of Mental Health Day Opportunities service. He advised that it was it was envisaged reducing current day centre based service capacity to focus on those most in need. The Trust will provide such services for the duration individuals require a day centre service, which will work on promoting quality of life, independence and social inclusion and access pathways to other resources and organisations.

Mr McNeany advised that the Trust would ensure that current service users' needs were reviewed, individualised recovery plans drawn up, in partnership with them and their families/carers and support would be provided in cases where clients would be moving on. Where individuals require continued centre-based care, we will support them in the transition to the Day Opportunities model and in the longer-term to access services best meeting their needs.

Members were advised that the Trust realised that this may mean a significant change for current service users and the Trust would ensure that each service user had a robust individualised assessment of their current needs and receive support to devise their personal recovery plans for the way forward. The Trust would support service users, whose needs are currently met by on-going centre based care, and their families and carers, in any transition that is required, ensuring that they can avail of a service best matched to their needs. In relation to the existing day centre service users in North Belfast (Everton) or Whiterock, should there be a change in location of where they usually attend, the Trust will consider providing transport solutions for a limited period of time based on individual need.

Mr McNeany advised that it was the belief of the Trust that the proposed model would better meet the demand for Day Opportunities and allow for staff and resources to focus on better meeting the needs of our service users rather than on maintaining multiple buildings. The proposed model would allow services to be more flexible and socially inclusive.

In response to a comment from Professor Bradley, Mr McNeany advised that with the development of alternatives to day centre care such as educational placements day centre attendances were reducing.

In the discussion which followed members endorsed the proposal, welcoming the more person centre approach offering more sociable opportunities for service users and less institutional type care.

39/15 **(Contd.)**

Decision: Delivery of Mental Health Day Services for People living in Belfast – Proposed Consultation and EQIA - Approved

40/15 **Director of Human Resources and Organisational Development**

a. Equality Scheme Section 75 Annual Progress Report
b. Disability Action Plan
c. Section 75 Action Based Plan - Updates

Mr McAlister presented the eighth annual progress report to the Equality Commission for the reporting period 1 April 2014 to 31 March 2015, which fulfils statutory requirements as outlined in the Trust's Equality Scheme and detailed progress in regard to Section 75 of the NI Act 1998 and Section 49A of the Disability Discrimination Order 2006, together with the Disability Action Plan and the Section 75 Action Based Plan updates.

The reports provided an overview of the strategic commitment and top level support of the equality and disability agenda, including the significant programme of training, communication and information provided to ensure that statutory duties are mainstreamed.

Mr McAlister referred to the first edition of "Equality Bites" newsletter which was designed to give a flavour of some of the positive things going on within the Trust in relation to Equality and Human Rights.

Mr McNaney acknowledged that the reports were very comprehensive and welcomed the introduction of the newsletter which was particular useful in highlighting the good work going on within the Trust in respect of equality.

Following consideration members approved the Annual Progress Report, the Disability Action Plan and Section 75 Action Based Plan, which would be forwarded to the Equality Commission for formal approval

Decision: Equality Commission NI – Annual Progress Report, Disability Action Plan and Section 75 and Disability Action - Approved

41/15 **Director of Surgery and Specialist Services**

a. Business Case – 100K Genomes Project – to develop a NI Genomic Medicine Centre

Mrs Welsh referred to the 100Kk Genomes Project a regional proposal, partially led by the NI Pathology Network and now with Belfast Trust as the lead and the organisation which will ultimately host the NI Genomic Medicine Centre (GMC).

41/15 (Contd.)

She advised that DHSSPS had requested the Trust to formally submit a business case.

Mrs Welsh explained the NIGMC would co-ordinate the collection of DNA and health records data for consenting patients with cancer and rare diseases. The sequencing of their genomes and analysis of records would mean that these patients will have a more rapid and accurate diagnosis and therefore a shorter pathway to appropriate treatment and care. Ultimately, patients should need fewer clinical appointments and the cost of testing will be reduced. The data will be included in a UK-wide anomyised data bank for analysis by disease specific Clinical Interpretation Partnerships (CIPs) to develop new tests and treatments that can be targeted to individual patient needs.

Mrs Welsh advised that the business case had to be submitted to DHSSPS with part of the funding also sought from Medical Research Council (MRC). MRC deadlines led to some haste in seeking approval for the business case. Due to the timing of Trust Board meetings over the summer the Chairman and Chief Executive had approved the business case for submission to DHSSPS in early July, subject to retrospective approval being given by Trust Board.

Following consideration members gave retrospective approval to Business Case – 100K Genomes Project to develop a NI Genomic Medicine Centre.

Decision: Business Case – 100K Genomes Project to develop a NI Genomic Medicine Centre – Retrospective Approval

b. Precision Medicine Catapult

Mrs Welsh referred to a recent announcement by the UK Government regarding the creation of a Precision Medicine Catapult and explained that this would be developed on a hub and spoke basis with five Centres of Excellence.

Mrs Welsh was delighted to report that Northern Ireland will be one of the Centres of Excellence, following a successful bid to the sponsoring organisation Innovate UK. She explained that the key component of the NI bid was the Molecular Pathology Laboratory (NIMPL) which is a joint venture between the Trust and QUB.

NI will play a significant role in the collection and analysis of clinical data at scale, testing and validation of new precision medicine ready clinical trial models and the development of HSC/NHS adoption routes for precision medicine.

41/15 **(Contd.)**

Mrs Welsh advised that the ultimate vision was the development of robust clinically validated new molecular diagnostic tests and the potential for Industry to scale up in Northern Ireland.

Members welcomed the Trust's involvement in the Precision Medicine Catapult and congratulated all staff involved in Northern Irelands successful bid.

42/15 **Audit Committee – Minutes 23 April 2015**

Members noted the contents of the minutes of the Audit Committee meeting held on 23 April 2015.

43/15 **Assurance Committee – Minutes – 5 May 2015**

Members noted the contents of the minutes of the Assurance Committee meeting held on 5 May 2015.

44/15 **Any Other Business**

There were no items raised.

45/15 **Date of Next Meeting**

Members noted the next meeting was scheduled for 5 November, 2015.

1.034

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Belfast Health and Social Care Trust
caring supporting improving together

Minutes of the Confidential Trust Board Meeting
Held on 5th May, 2016 at 9.30 am
in the Boardroom, King Edward Building
Royal Victoria Hospital

Present

Mr Peter McNaney	Chairman
Dr Michael McBride	Chief Executive
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
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
Dr Cathy Jack	Medical Director
Mr Cecil Worthington	Director Social Work/Children's Community Services

In Attendance:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health (Interim)
Mr Shane Devlin	Director Performance, Planning and Informatics
Mr Damian McAlister	Director Human Resources/ Organisational Development
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
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Ms Joan Wells	Co-Director Specialist Hospitals/Women's Health
sensitive & personal data	Service User
Mrs Angela Muldoon	Minute Taker

Apologies

Professor Stuart Elborn	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mrs Bernie Owens	Director of Unscheduled and Acute Care

12/16 Minutes of the Previous Meeting

The minutes of the previous meeting held on 3 March, 2016 were considered and approved.

13/16 Matters Arising

There were no items raised.

14/16 Chairman's Business

a. Conflict of Interest

There were no conflicts of interest report.

b. Trust Board Development Programme

Mr McNaney thanked members for their participation in the recent two day workshop as part of the Board development programme, highlighting how successful this had been. It was agreed that the Trust Board workshop scheduled for 9 June would provide an opportunity to begin taking forward four workstreams identified during the workshop.

Mr McAlister agreed to draft a letter thanking the facilitators for their assistance with the Board Development programme on behalf of Dr McBride and Mr McNaney.

15/16 Chief Executives business

a. Glenmona Resource Centre

Dr McBride invited Mr Worthington to provide an update in relation to the Glenmona Resource Centre

Mr Worthington provided a verbal summary of progress on the established work streams to oversee the transfer of services to Belfast Trust and range of forums in place.

Mr Worthington highlighted concerns raised via Whistle Blowing a year ago which had resulted in staff dismissal, an appeal ongoing which in relation to this whilst, Glenmona management had indicated this could not be heard within the timeframe leading up to transfer of services, the Trust had made it clear transfer would have to be delayed to accommodate completion of this process. The Directorate of Legal Services and Glenmona solicitors were have been in ongoing communication regarding the process.

Mr McAlister advised that under Transfer of Understanding (Protection of Employment (TUPE), Glenmona must process the appeal, liability [redacted]

[redacted] LEGAL ADVICE PRIVILEGE

Mr McNaney asked if there was a written document detailing what undertakings were included and what was not post 30 June, giving an example of pensions for existing staff.

Mr Worthington advised communication with the HSCB, Trust representatives including Mr McAlister and Mr Dillon was concluding and will confirm what is being transferred to the Trust.

Prof Martin Bradley queried what the due diligence report covered, Mr Worthington stated three workstreams were taking forward a due diligence process which included an estates report.

Following a further query regarding any outstanding HR issues, Mr Worthington advised an independent report had been completed which reviewed practice; no serious practice concerns had been flagged.

Mrs Miriam Karp queried about the system for monitoring performance and quality commenting that there may be learning from such an important service.

Mr McNaney queried who the contractual relationship is between.

Mr Dillon advised the HSCB commissioned these services from the Trustees on behalf of the Region; from 1 July 2016 this will be commissioned from BHSCT.

Mr McNaney asked that a written document be provided to Trust Board setting out full liabilities to ensure clarity and complete understanding with an opportunity for Trust Board to consider. Mr Worthington confirmed this was being progressed and will be presented to Glenmona Trustees for sign off , together with the HSCB and DHSSPS.

Dr McBride advised sign off must include the DHSSPS and HSCB and cover due diligence, Finance, Estates, Workforce (historical and current) and that this will be required to provide assurance.

Mr McNaney added that the Trust Board will require the heads of organisations involved in this transfer to sign the document discussed.

Mr Worthington undertook to advise the key stakeholders what is required by the Trust Board.

b. Congenital Heart Disease Network Update

Dr McBride invited Mr Dillon to provide an update.

Mr Dillon drew Trust Broad member's attention to the update provided in papers and summarised the key risks highlighted. He further advised members that the DHSSPS had issued a press statement recently which had included a timetable against actions.

Projection for this calendar year was 15 children transferred to Dublin compared to 22 children who received treatment in 2015/16. There had been a proposal that another group of children could be accommodated at Dublin to help build public confidence however Dublin had some reservations.

Dr McBride added that the current service level agreement was for urgent cases which last year was 22-23. The low number this year was due to a lower number requiring urgent surgery and that Dublin were within their rights in relation to the agreed SLA and some negotiation would be required.

Following a query from Prof Martin Bradley, Dr McBride clarified that the business case is accepted in principal and money is not the issue, the main difficulty is a staffing issue, whilst this is a concern this cannot be resolved by the Trust..

Miss Creaney outlined work completed and further explained the nurse staffing issue across all Dublin hospitals with staff migrating elsewhere over many years.

In response to a query from Mr Smyth, Miss Creaney advised there had been discussion regarding incentivising but the market is currently very open and Dublin very expensive, a number of options remain under consideration but the big issue remains supply of nurses .

In response to a query from Mrs Karp, Dr McBride confirmed that the arrangements where well stablished and earlier concerns around transfer and serious adverse incidents had been addressed.

Dr Jack added that the last SAI had been 18 months ago with no recurrence and the service for urgent cases is consistent and without concern.

Dr McBride further highlighted the successful transfer of the now established service in relation to Paediatric Cardiology at Dublin, commending the team for their work in relation to this.

Mr Dillon further summarised the project plan into 2018 -2019 and explained that parents remain anxious

Further discussion followed in relation to negative media and it was agreed that the Trust would continue to redress the balance as appropriate with positive news stories.

Mr McNaney confirmed the report and actions had been noted by Trust Board

c. Future Delivery of Mental Health Day Services and Learning Disability Services to the People of Belfast – Public Consultations

Dr McBride invited Ms McNichol to provide a verbal update on the process to date.

Ms McNichol briefly recapped on the process of the two pubic consultations in respect of the Future Delivery of Mental Health Day Services and Learning Disability Services to the People of Belfast. The public consultation had commenced in September and concluded on 10 December 2015. Ms McNicholl confirmed there had been significant level of feedback in relation to proposals via a number of channels, including individual contact, petitions and public meetings. Currently the teams were analysing this information and had sought legal advice in preparing a report which was now being finalised. The next step would be to present a final draft of recommendations to Executive team before bringing this the final document to a Public meeting of Trust Board for approval for onward submission to the HSCB.

Mr McNaney sought clarity around timescales and after discussion it was agreed that this item should be brought to a single agenda item Extraordinary Trust Board public meeting, preferably before July 2016.

Ms McNichol agreed to action.

16/16 Report of Remuneration Committee – 5 May 2016

Mr McNaney excused Directors' for this item of business.

Mr McAllister advised that the Remuneration Committee had met on 25 April 2016 and presented a report of the meeting for consideration.

i. Performance of the Chief Executive 2014/2015

Mr McAlister advised that consideration had been given to the Chief Executive Performance report from the Chairman which noted that for the reporting period in question the position had been held by 3 individuals. In terms of this overall assessment the Committee had noted and accepted the Chairman's recommendation that no assessment be made for Mr Donaghy as he was only in post for three months, that Mr Dillon's performance be assessed as fully acceptable and that the four month period that Dr McBride held the post be taken forward and included within the Chairman's performance assessment for 2015/16.

Mr McNaney added the monumental contribution both Mr Dillon and Dr McBride had made during this period should be noted.

ii. **Performance of the Senior Executives 2014/2015**

Mr McAlister confirmed the Remuneration Committee had considered the recommendations from the Chief Executive in relation to the performance of the Directors and found the Directors' performance to be fully acceptable.

iii. Senior Executive Pay Award 2015/2016 - HSC (SE) 1/2016

Mr McAlister referred to the Departmental Circular HSC(S) 1/2016 regarding Senior Executive pay and explained that:

1. This Circular provided details of the level of pay progression based on performance for Senior Executives in the period 1 April 2015 to 31 March 2016.

2. The performance levels as set out in Circular HSS (SM) 3/2001 2/2003 were amended as follows:

Performance Rating	Pre 23 December 2008 contracts	Post 23 Dec 2008 contracts
Fully Acceptable	2% consolidated	1% non-consolidated
Incomplete	0.5% consolidated	0.5% non-consolidated
Unsatisfactory	0%	0%

Members noted that where an individual, who is entitled to an increase under the terms of this circular, has reached the maximum of the pay band they will receive a non-consolidated payment equal to the value of pay award. HSC Employers are also reminded that there is no automatic entitlement to the maximum increases for the performance banding awarded.
On the basis of the performance assessment reports presented by the Chairman and Chief Executive to the Remuneration Committee today this Circular would be applied as follows to those Senior Executives employed within the Trust at 1 April 2015.

iv. **Salary of the Interim Director of Specialists Hospitals and Women's Health**

Mr McAlister referred to the appointment of Mr. Aidan Dawson to the post of Interim Director of Specialist Hospitals and Women's Health on 1 March 2016. Mr Dawson is substantively employed as a Co-Director band 8D with a regular on-call availability allowance.

Following correspondence with the DHSSPS the Committee noted that that the 10% increase on promotion applies only to basic salary.

The Committee noted that it is likely Mr Dawson will challenge this as he was in receipt of a superannuable allowance for on-call while a Co-Director and therefore may assume this would have been included in the calculation.

v. **Salary of the Director of Acute Unscheduled Care for 2013/14**

Mr McAlister referred to the meeting of The Remuneration Committee in September 2015 when it met to consider the Directors Performance Assessment for 2013/14 had been asked to note that as Mrs. Owens had only been in post for less than 6 months there was no formal performance assessment carried out.

Mr McAlister confirmed the Trust had queried with the DHSSPS whether this fact prevented Mrs. Owens from benefitting from the application of the pay award. The DHSSPS duly responded that in these circumstances Mrs. Owens should be considered as having an **incomplete performance assessment**.

As, and with reference back to the relevant Circular HSC (SE) 1/2015 Mrs. Owens would be entitled to a non-consolidated pay award of 0.5% on her salary in payment at 1 April 2014.

Following comments from Trust Board members expressing concern regarding the low pay band in respect of the Director of Nursing and Director of Performance, Planning and Informatics, Mr McAlister agreed to further correspondence being issued on its behalf to the Director of Workforce Policy at the Department.

Trust Board approved the recommendations of the Remuneration Committee in relation to Senior Executives pay awards.

vi. Terms of Reference – Annual Review

Mr McAlister presented the Remuneration Committee Terms of Reference which had been subject to annual review and highlighted minor amendments to the document.

Members noted and approved the Terms of Reference.

Belfast Health and Social Care Trust

Minutes of the Extraordinary Trust Board Meeting held on Tuesday 21 June 2016 at 12.30 pm in Knockbracken Hall, Knockbracken Healthcare Park

PRESENT:

Mr Peter McNaney	Chairman
Dr Michael McBride	Chief Executive
Mrs Miriam Karp	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Martin Bradley	Non-Executive Director
Dr Cathy Jack	Medical Director
Mr Cecil Worthington	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Damian McAlister	Director Human Resources/ Organisational Development
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
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Miss Marion Moffett	Minute Taker

APOLOGIES:

Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health (Interim)
Mr Shane Devlin	Director Performance, Planning and Informatics

Mr McNaney welcomed everyone to the meeting particularly the service users, carers, local politicians and staff side representatives.

31/16 Chairman's Business

a. Conflicts of Interest

Mr McNaney invited members to declare any conflicts of interest.

There were no conflicts of interest noted.

b. Format of Meeting/Order of Business

Mr McNaney acknowledged the high number of requests for speaking rights. He explained that Trust officers would present the outcome reports of the public consultations in relation to the future delivery of Mental Health Day Services and Learning Disability Day Services for people living in Belfast, following which he would invite those granted speaking rights to address Trust Board.

32/16 Director Adult, Social and Primary Care

Ms McNicholl introduced Mr Barney McNeany, Co-Director Mental Health Services (MHS) who would present the report of the public consultation in relation to the future delivery of Mental Health Day Services for people living in Belfast and Mr John Veitch, Co-Director, Learning Disability Services (LDS), who would present on the outcome of the public consultation in relation to the future delivery of Learning Disability Day Services for people living in Belfast.

a. Outcome Report of the Public Consultation on the Future Delivery of Mental Health Day Services for the People Living in Belfast

Mr McNeany referred to the significant reform of MHS in recent years, in line with the Bamford Review and the Regional Mental Health Care Pathway – You in Mind; with services aiming to promote empowerment, choice and recovery for those with mental health needs.

He explained that Trust MH Day Services had traditionally been centre based and designed to meet people's needs by providing meaningful daytime occupation in specific facilities. Whilst there had been very worthwhile developments within Day Services in recent years, throughput had remained static and demand from Service Users continued to reduce. In 2012 occupancy across all centres had been close to 60%. When the consultation had been launched in September 2015 an average of 43% and currently it was lower that 40%.

Mr McNeany pointed out that the Equality Impact Assessment had indicated fewer women and younger service users wanted to use Day Centres.

He explained that whilst there had been a decrease in Service Users attending Day Centres the Trust's Community Support Service, which offers personalised care in the person's own community had become much more popular with services users.

Mr McNeany advised that a pre-consultation exercise had been undertaken across MH Day Services when the Trust's lead Occupational Therapists for MH had carried out a review of service users within existing day centres, which had indicated that many service users could avail of more individualised care. However the Trust had been very clear during the consultation that there would always be a need for Day Centre Care.

Mr McNeany then explained that what had been proposed in the consultation was that the Trust would reconfigure services in a two stage process – the first stage would be to amalgamate all Day Centre Care in Ravenhill Day Centre, closing Whiterock and Everton Centres whilst building day opportunities and strengthening the Community Support Team; the second stage would be to close Ravenhill and transfer all Day Centre services into a city centre facility with the Community Support Team and the Recovery College.

There had been a significant response to the public consultation which had been held from 3 September to 10 December 2015. During which time the Trust had undertaken a series of meetings with Service Users, Carers, Political Representatives, Trade Union colleagues and the general public. The Trust had welcomed and encouraged people to respond and was delighted that so many people took the time to engage in meetings and public forums. Throughout the consultation the Trust had consistently asked for responses with a total of 755 respondents.

Due to the significant response it was important for the Trust to ensure that there was a robust and objective process to interpret and analyse the comments received, which took considerable time.

Mr McNeany advised that all responses were collated and themed with a panel of 6 individuals established to consider the responses, identify themes and the key issues highlighted by respondents. The panel included lead professionals from nursing, social work and occupational therapy from within MHS, together with colleagues from the Trust's Equalities Team. This was undertaken to minimise any bias individuals might bring to the process and culminated in a series of draft outcome papers leading to the recommendations being brought forward for Trust Board's consideration.

Mr McNeany indicated that overwhelmingly the responses to the consultation opposed the key proposals. Therefore the proposal being brought forward had been significantly altered to reflect both the key elements of the Trust's proposals and the responses received:-

- Balance need and pace of change
- Embed recovery ethos
- Advocates support care planning
- Build a range of Day Opportunities
- Develop a Day Opportunity Fund
- Retain provision at each site – i.e. Whiterock, Everton and Ravenhill
- Establish a Day Service Group
- Involve Service Users and Carers
- Jointly produce a centre plan: to meet individual need; to set the number of day support required in each centre; to fully utilise resources
- Communicate through regular newsletters
- Equality, good relations and human right be fully considered

In concluding Mr McNeany sought Trust Board approval to:

1. Maintain Day Centre provision in each of three centres at Ravenhill, Whiterock and North Belfast (Everton) in keeping with individualised care plans.
2. Establish a Day Services Planning and Implementation Forum with all Key Stakeholders to shape the model of Day Opportunities going forward and jointly produce a centre plan for each of the three sites to address the need, frequency and duration of provision for the future.
3. Develop a Day Opportunities Investment Fund to extend the range of Day Opportunities available across the City.

b. Outcome Report of the Public Consultation on the Future Delivery of Learning Disability Day Services for People Living in Belfast

Mr Veitch explained that in bringing forward the proposals for the future Delivery of Learning Disability (LDS) for people living in Belfast consideration had been given to the core values within the Bamford Report including Social Inclusion, Citizenship, Empowerment, Working Together and Individual Support. The consultation was also informed by the Patient and Client Council Report "My Way My Day" and the HSCB/PHA Regional model which was produced following extensive public consultation.

He explained that the Trust had reviewed the current configuration of Day Centre placements and Day Opportunities in the statutory and community/voluntary sectors alongside the needs of individual service users across Belfast and on the basis of this analysis had proposed to merge Fallswater Day Centre with the Suffolk and Mica Centres as the uptake in day opportunities increased.

Mr Veitch advised that the public consultation had been held from 3 September to 10 December 2015. During which time there had been a number of meetings with Service Users, Carers, Political Representatives, Trade Union colleagues and the general public. The Trust had welcomed and encouraged people to respond and was delighted that people took the time to engage in meetings and public forums, with a total of 2048 responses received.

He advised that there had been an overwhelming 87% of respondents opposed to the Trust's proposals. These included comments expressing concern at the potential impact of change on vulnerable Service Users' health and well-being and the loss of relationships and security within Day Centre settings. Assurance had also been sought in relation to the sustainability of Day Opportunities. There had been concern about staff expressed, despite assurances being given regarding the availability of redeployment options. A significant number of responses also commented on the potential impact on Services Users from Fallswater transferring to the Suffolk and Mica Centres. Additionally there was a strong opinion that the proposals were finance driven.

Mr Veitch explained that all responses had been collated and themed, by a multi-disciplinary panel of 6 individuals established to consider each response, identify themes and the key issues highlighted by respondents. The panel included lead professionals from nursing, social work and occupational therapy from within LDS, together with colleagues from the Trust's Equalities Team. This was undertaken to minimise any perception of bias which might be brought to the process and culminated in a series of draft outcome papers leading to the recommendations being brought forward for Trust Board's consideration.

Mr Veitch indicated that overwhelmingly the response had been to reject the key proposals. Therefore, the proposal being brought forward had been significantly altered to address the following components of the consultation document and the responses received by the Trust:-

- Ensure needs led planning continues involving service users' and carers' views
- Maintain the current day centre provision at existing centres
- Further extend a range of Day Opportunities include a Day Opportunities Fund
- Any changes for Service Users will involve Trial Periods, Reviews and the engagement of Advocates
- Through a Day Services Group including Service Users and Carer representatives produce a cross city plan taking account of individual needs, the location of services and the use of resources.
- Involve Service Users to improve information on Day Opportunities including newsletters
- Equality, good relations and human rights to be fully considered

In concluding Mr Veitch sought Trust Board approval to:

1. To maintain Day Centre provision in West Belfast at current centres.
2. To establish a Day Services Planning and Implementation Forum with all key stakeholders to shape the model of Day Opportunities going forward and jointly produce centre plans across Belfast to address the need, frequency and duration of provision for the future.
3. To develop a Day Opportunities Investment Fund to extend the range of Day Opportunities available across the City.

c. Deputations

Mr McNaney invited the following to address Trust Board.

Mental Health Day Services

- sensitive & personal data **Service User**

sensitive & personal data spoke on behalf of sensitive & personal data sensitive & personal data and sensitive & personal data Service Users, MHS.

sensitive & personal data asked that the Day Centres remain open and that referrals be made to them. She sought assurance that the needs of Services Users and Carers would be fully addressed.

Mr McNeany explained that the revised proposal was for MHS Day Centres to remain open and that a programme of Day Opportunities would be developed in co-operation with Service Users and Carers. He advised that if individuals requested placement in a Day Centre this would be available. He pointed out that any future decision on Day Centres would be subject of a further public consultation.

Learning Disability Day Services

- sensitive & personal data **and** sensitive & personal data

sensitive & personal data explained that her sister attended Fallswater, and expressed concern at the way in which the Trust had managed the public consultation process and the impact on the most vulnerable in Society and their Carers, many of whom, like her mother, were elderly. She paid tribute to Carers, local communities and local political representatives who had united together to oppose the proposals. sensitive & personal data questioned the Trust's values and appealed for the Trust to develop comprehensive plans to ensure appropriate provision from the "Cradle to the Grave" for people with learning disabilities to safeguard the most vulnerable in Society. sensitive & personal data advised that she had travelled from Norway to support her mother at the meeting.

sensitive & personal data said as an elderly carer for her daughter, who attends Fallswater, there was something very wrong about the Trust proposals. The process had had a detrimental effect on her health and had caused her daughter stress worrying about what was going to happen to her and her friends when their centre closed. She referred to the three day centres within West Belfast and commended the care and support provided by staff, which give carers the support and confidence that their loved ones were being looked after in a safe environment. sensitive & personal data questioned the way in which the consultation meetings had been managed, without compassion for users or carers. She concluded by thanking her daughter sensitive & personal data for travelling from Norway to attend the meeting to support her.

- sensitive & personal data

sensitive & personal data advised that he had travelled from England to speak on behalf of his 63 year old sister a Fallswater Service User. He expressed concern at the long drawn out process, ongoing since September 2015, and the psychological damage caused to Service Users worrying about what was going to happen to them if the centre closed. He commended the staff working in the centre and the trust and close relationships service users had with them.

sensitive & personal data referred to the proposal to develop Day Opportunities within education, sports, recreation, etc., and pointed out these would take time to

establish and needed to be properly resourced and verified and not reliant on the private sector. He referred to the Trust's Duty of Care and need to be compassionate and respect the human rights of the most vulnerable in Society.

In concluding sensitive & personal data advised that he was supportive of the revised proposals. He said he was optimistic that Trust leaders would ensure appropriate services were in place and he would continue to monitor developments. He looked forward to the Trust being a future world leader in Mental Health and Learning Disability Services.

- sensitive & personal data

sensitive & personal data advised she was speaking for her daughter who attends Fallswater and referred to the Trust's projected savings if the proposals were to go ahead. She challenged the Trust that the Day Opportunities currently provided within the Trust were not fit for purpose, with services users spending their time wandering around shopping centres or being taken to fast food outlets. sensitive & personal data stated that instead of closing Day Centres the Trust should be building more to support vulnerable people and those bringing forward the proposals should be ashamed of themselves.

- sensitive & personal data

sensitive & personal data advised she was speaking on behalf of her brother, a service user, who had been attending Fallswater for over 20 years. She stated that the proposal were detrimental not only to service users, but also from a carers' perspective. sensitive & personal data referred to the role of a carer being 24/7 and Day Centres provided respite for them. She suggested there should be an independent review as the Trust could not be trusted.

- sensitive & personal data

sensitive & personal data said her daughter also attended day centre care and had been very distressed at the proposal to close any centre.

sensitive & personal data referred to the local community and the historical links the centre had for people with LD and their families. She appealed for the new Minister of Health and local political parties to ensure the most vulnerable in society are looked after. She asked Trust Board members to reflect on what they wanted to be their legacy.

- sensitive & personal data

sensitive & personal data Service User emphasised the importance to her of her attendance at a day centre and she did not wish any day centre to close.

- sensitive & personal data

sensitive & personal data advised she was speaking on behalf of her mother a Service User who attends both Whiterock and Fallswater. She referred to the proposal to merge the centres and was vehemently opposed to this. She said that if her mother did not have Fallswater to go to she would not go anywhere. sensitive & persona sensitive & personal d said she had been shocked when she had heard of the proposal to close Fallswater for those service users who attend it is their lives. She expressed the view that the proposal did not address Equality, Good Relations or Human Rights.

- **Gerry Carroll, MLA, People Before Profit Alliance**

Mr Carroll, MLA, said as a member of the Health Committee he had been concerned at the Trust proposals and referred to the need for MHS and LDS day centres to remain open in Belfast. He stated that the day centres were in areas of deprivation and that Day Opportunities needed to be properly suited to Service Users. He pointed out that that there had been a strong campaign uniting communities within North, West and East Belfast in opposing the Trust's proposals.

Mr Carroll expressed concern at the length of time taken to present the outcome report of the public consultations which had caused further anxiety for service users and carers. He appealed to Trust Board members to reinstate referrals to the day centres in West Belfast and stop referrals to private organisations. In concluding he wished to commend all those who had got behind the campaign to retain the day centres and said that they would be back if there were any future threats to day centres.

- sensitive & personal data **Carer**

sensitive & personal data explained she was speaking on behalf of her son who attends Whiterock. She advised that approximately 10 years ago her son had been transferred from Fallswater to Whiterock where he was to be given day opportunities in the community. This had resulted in her son spending time walking around shopping centres and being taken to fast food outlets, which did not comply with the Trust's eating healthy campaign. Her son had obesity problems and whilst she tried to encourage a healthy diet the Trust was neglecting its Duty of Care by encouraging visits to fast food shops.

sensitive & personal data said the facilities in Whiterock were limited with service users having restricted access to a small room with activities not providing adequate stimulation for service users.

- sensitive & personal data **Chair, Friends of Edgcumbe Society**

sensitive & personal data advised that she was speaking as Chair of the Friends of Edgcumbe Society and as a mother in her 70s who cares for her 46 year daughter with severe learning disability and very complex needs requiring help and support 24/7. Her daughter, like all vulnerable service users

depends on others to make the right decisions for her. Unfortunately the most vulnerable could not be at the meeting.

sensitive & personal data questioned the Trust's commitment to Bamford and outlined her long history of campaigning for the Human Rights of people with Learning Disability. Elderly carers continue to worry about what will happen to their children after they die, indeed some pray for their son or daughter to go first so they are not left to fend for themselves.

sensitive & personal data asked what decisions the Trust had made to improve the quality of life for people with learning disability and their carers? She referred to the proposed new model of Day Opportunities and stated that this would require resourcing and transport for service users. For some Service Users Day Opportunities would never be an option as they require day centre type provision.

In concluding sensitive & personal data referred to the 87% of respondents who did not agree with the proposals and appealed to Trust Board members to consider very carefully the proposals put forward in relation to day services.

sensitive & personal data said that carers were every bit as vulnerable as services users and paid tribute the support and care they provide to their loved ones. He stated that the Government needed to look ahead to the future as children with more complex needs will need to be looked after. He stated that more fit for purpose day centre and residential type provision needed to be developed. He asked that the Trust treat carers and their children honestly and fairly.

- sensitive & personal data

sensitive & personal data spoke as a career and volunteer at Orchardville Business Centre and emphasised the importance and value carers place on day centre provision. She shared her experience of Orchardville Business Centre which provided training for service users and enhanced their lives and created employment opportunities. She paid tribute to Edgcumbe Training Centre which created a community hub for students/trainees to support each other. In relation to the Day Opportunities model, she emphasised the importance of these being appropriate for service users and the need for Carers to be involved in the development. Further she stated that when considering Day Opportunities it was essential that service users have appropriate educational activities designed to meet their need and transitional period to ensure they are appropriate.

- **Fra McCann, MLA, Sein Fein**

Mr McCann, MLA, Seinn Fein, advised that he welcomed the Trust's revised proposals and the use of service users and cares in developing services. He had been cynical of the consultation process as he had thought the Trust had already agreed what would be done and it was just a tick box exercise. However, having heard the earlier presentation he had been reassured that

the Trust had listened to service users and their careers and revised the proposals in light of their comments. Mr McCann emphasised the role of day centres in the local communities.

- **Councillor Tim Attwood, SDLP**

Mr Attwood referred to the consultation process bringing together services users, their families, Trade Union and local political representatives in opposing the proposals. He acknowledged the important role carers have in society caring for their loved ones and he emphasised the need to take time to listen to the views of the service users, carers and staff affected by both consultations.

Mr Attwood said he had visited the Day centres in West Belfast and listened to the extremely anxious parents, carers and staff who care and support people with learning disabilities and mental health problems. He pointed out that the three day centres in West Belfast cater for the unique needs of their users the elderly, the more active and others with varied and complex needs. He expressed the view that the day centres were vital to the users providing social contact and stimulation, reducing isolation and loneliness and maintaining their independence. Equally they provide an important break for carers who look after their loved ones 24/7

Mr Attwood advised that service users report that day centres help them in many domains (accommodation, cleanliness, meals, safety, occupation, control, dignity and anxiety). Whilst, there may be a view that such services are an outdated model of service provision that does not fully meet the needs of people with learning disabilities, there is still substantial evidence that many users, especially older people, choose to stay in day centres.

Mr Attwood said that service users and carers were concerned about the proposed closure of Fallswater Day Centre and he welcomed the Trust's revised proposal for the centres to remain open along side the development of day opportunities.

Mr Attwood referred to the consultation on LD Day Services promoting a person-centred approach to enable people to make choices and follow activities that are meaningful to them. However, there is an argument that it is better to personalise day opportunities for each individual user. There is certainly scope for increasing the personalisation of support within a quality day service setting, especially for new users. However, there is substantial evidence that many users, especially older people, want to stay in local day centres.

Mr Attwood expressed the view that whilst voluntary sector bodies may be able to develop additional day opportunities the Trust will first have to negotiate a sustainable funding package with such providers. He indicated that Belfast Trust was required to make cuts and expressed concern that the casualties would be vulnerable people with learning disabilities and mental health problems.

Mr Attwood quoted Steve Goodier, Trade Union Activist: *"Who doesn't want to know that we notice them and value them? And who might respond to us better when they feel that they matter? It probably cannot be overstated – it matters...that people matter."*

In concluding he asked that the Trust ensure there is adequate capacity to support and care for those with MH and LD problems, the most vulnerable people in society.

- **Pat Lawlor, NIPSA Branch Officer**

Mr Lawlor, at the outset of his presentation wished to congratulate staff, services users and carers, who had responded to the public consultation process resulting in the Trust revising the proposals to ensure Day Centres will not close. He expressed concern at the way in which the public consultation had been managed and the prolonged process causing unnecessary stress to service users, their families and staff.

Mr Lawlor referred to the strategic policy drivers mentioned in the consultation documents, including the Bamford Review and the consultation the HSCB carried out on a regional basis in relation to the future of day services for adults with a learning disability, both of which NIPSA formally responded to at the time these consultations took place. NIPSA had expressed concerns about the impact on the real world choices available to service users and their carers that would flow from the subversion of the Bamford principles that this consultation represented. The person centred ideals framed in Bamford were, in NIPSA's view, sliced and diced into little more than a rationale for an inept cost driven assault on existing provision without the investment and bridging finance to develop the suite of less institutional high quality provision the Bamford service framework envisaged. Furthermore NIPSA believes that divorcing the need for adequate resources from the ideals and rhetoric in Bamford on the range of day service provision that should be available for individuals with a learning disability amounts to a licence to cut, privatise and marginalise and is a confidence trick of the most cynical kind on one of the Cinderella services of the HSC.

Mr Lawlor referred to the consultation documents and said it had unfortunately, done nothing to assuage this view and stated from the outset that NIPSA had no criticism of any Trust employees currently delivering a high quality service whether this is in a Day Centre setting or in the Day Opportunities Service. However it was particularly unhelpful in the context of the review both day centres and day opportunities are portrayed as two distinct services with no crossover in how one interacts with the other. The inextricable linkages in terms of assessments of placements and the movement of service users back and forward between the two service delivery models is well understood by staff at all grades within the programme.

Mr Lawlor said it was a well-established maxim that all change processes are challenging. For groups such as Trade Unions with members working in existing service models being subjected to change and challenge are indeed difficult at times.

NIPSA believes that service changes and reconfigurations should be underpinned by a clear exposition of the needs of service users and a transparent process that ensures that changes are supported by a robust evidence base focussed on objective need and assurance that the best service possible is to be offered. Such key bench marks are absent in the process, particularly in relation to the evidence base for Day Opportunities Services.

Mr Lawlor said that in discussions with various stakeholders the question was asked why Fallswater Centre had been chosen for closure. Obviously NIPSA is aware of the Belfast Trust's proposals through various corporate targets set for programmes such as LDS to save money. Yet the consultation document had not detailed savings targets set, or the 'savings' that would come to the programme by forcing through these closures. NIPSE feels this is completely disingenuous. If money is needed to be saved why this wasn't factored into the rationale in an open and transparent way so that a mature debate could take place. This apparent lack of transparency has led many NIPSA members to express the view that this proposal is informed not by a needs assessment process but by an assessment of a different sort - the targeting of those least able to effectively organise against a cuts driven agenda, which in this case is some of the oldest service users in the programme who are least able to advocate for themselves. In addition NIPSA members and others formed a perception of the advocacy capacity of the carers of the service users at Fallswater compared to the strong advocate voices in other centres.

Given it is generally accepted Fallswater Day Centre has an older clientele attending, NIPSA was concerned about how 1closure of the centre would impact on individuals who have built up social networks over many years. We have seen the concern expressed across society and the political institutions in relation to the closure of statutory and more recently privately elderly residential homes and the impact this will have on people. Yet it was the view of many people NIPSA consulted with this issue was not dealt with in any sensitive or structured way. On top of this some individuals attending the centre had already moved from the likes of Suffolk Day Centre only a number of years ago and that Fallswater had been specifically upgraded to accommodate the physical needs of these clients and significant amounts of public money was invested in the centre, on the basis of it having a viable longer term future. The same cannot be said for buildings used for the Day Opportunities Service as there appears to be little thought given to issues like the quality of the environment, space, chairs, bathrooms etc. in current buildings.

It is NIPSA's firm view that current Day Centres provide a high quality service to those who utilise its services. Having a base to work from is a boost for service users whilst also day centres offer greater flexibility to meet the changing needs of clients. Therefore given the complex needs of people with a learning disability as they age how do we justify reducing specialist capacity and instead rely on a cobbled together one size fits all approach for the most vulnerable. Indeed members in Day Opportunities felt the Trust had for a number of years failed to properly resource the service through a central funding approach as very often it is left to members to pay for services which created an inequity among the haves and have not's currently using the service.

NIPSA is also concerned that the proposal lacks detail in relation to the BHSCT position on the range of service offers to be made to young people emerging from the education system over the next five years. It is not clear from the document what discussion on both raw numbers and the projected needs of individual school leavers have been completed in liaison with the Department of Education to inform the consultation or indeed whether the Education Authority has been engaged at all on the service delivery changes suggested. In the absence of published information NIPSA can only assume that this consultation is an example of siloed thinking by BHSCT rather than the integrated planning which the policy and legislative framework expects. NIPSA believes this approach could lead to a potential lack of appropriate service options being available to young adults in the future who will require a high level of support.

- **Mr Ray Rafferty, UNISON**

Mr Rafferty, wished to record appreciation, on behalf of UNISON, to everyone who had taken the time to attend the meeting. He also paid tribute to the work and commitment and care they provide 24/7 to their loved ones.

Mr Rafferty appealed to the Trust to invest in services and make sure there are adequate services available for people with MH and LD.

- sensitive & personal data **Carer**

sensitive & personal data Carer, whose sister attends a day centre, said her sister had been very stressed when she had learned of the proposal to close her day centre and had suffered a heart attack the next morning. sensitive & personal data held the Trust responsible for causing her sister's heart attack. sensitive & personal data referred to the 24/7 care provided by carers and the importance of this being respected.

- sensitive & personal data

sensitive & personal data said that whilst there was a need to develop Day Opportunities, these need to be available alongside Day Centres, which provide much needed respite for families.

- sensitive & personal data

Referred to the proposed new premises to develop a day centre and asked that these plans did not proceed.

Mr McNaney thanked all those had taken time to share their views with Trust Board. Mr McNaney offered his sincere apologies, on behalf of members' for any stress and suffering caused to service users and their carers due to the proposals, public consultation and prolonged process. He said that during his time as Chairman he had been privileged to work with staff genuinely committed to caring about the people they serve. He himself had been humbled by the many acts of compassion and caring he had witnessed.

Dr McBride, wished to thank all service users, carers, staff, organisations and local representatives who had contributed to the consultation. He fully appreciated how difficult the process had been for service users and carers and wished to sincerely apologise for the prolonged exercise, which had caused further stress. However, he said it was important to fully reflect on the responses to the public consultation and identify issues raised, which had resulted in the Trust revising its proposals. Subject to Trust Board approval, he looked forward to the establishment of the planning and implementation groups with all key stake holders represented, to co-design future services for both MH and LD Day Services.

Ms McNicholl apologised for the distress caused to Service Users and their Carers and hoped that the revised proposals would allow the Trust to develop fit for purpose services in partnership with key stakeholders. She advised that the decision taken by Trust Board would be subject to approval by the HSCB and the Minister.

Mr McNaney invited Trust Board members to comment.

Ms O'Reilly acknowledged the upset caused by the process and said it was important that the proposal had been revised from "postpone" closure of Day Centres to "maintain" Day Centres. She referred to the important support and security Day Centres provide for Service Users. Ms O'Reilly said the planning groups would play an important role in shaping future services, in line with the Trust's values and it was important that Services Users, Carers and Staff were at the centre of the planning.

Mrs Karp concurred with Ms O'Reilly's comments and said she too was very sorry for the anxiety, hurt and distress caused to Service Users and Carers. As a carer herself she appreciated the importance of day care provision for families. She said it was important that the Trust had listened to Carers views and revised the proposals being brought forward for consideration. In relation to the future development of Day Opportunities, Mrs Karp emphasised the importance of these being developed to support, educate and provide stimulation for service users.

Mrs McKeagney said that the statements from Carers and Services Users had been very moving and the Trust had learnt from the consultation process and she felt the revised proposals reflected the learning. She acknowledged that there was a lot to do, but was encouraged that key stakeholders would be involved in the planning process moving forward.

Professor Bradley, endorsed the comments from Non Executive Director colleagues' and welcomed the involvement of key stakeholders in the proposed planning groups. He emphasised the importance of appropriate Day Opportunities for Service Users. Professor Bradley, acknowledged the huge resource Carers provide and emphasised the need to ensure they are supported.

Dr Loughran said it was important that Trust Board members apologise for the distress caused to Service Users and Carers. He was reassured the Trust had listened to their concerns and the recommendations had been revised.

Mr McNaney invited Mr McNeany to remind members of the proposal being made in respect of the Outcome Report of the Public Consultation on the Future Delivery of Mental Health Day Services for the People Living in Belfast.

Mr McNaney advised that in light of the comments received Trust Board approval was being sought to:

1. To maintain Day Centre provision in each of three centres at Ravenhill, Whiterock and North Belfast (Everton) in keeping with individualised care plans.
2. To establish a Day Services Planning and Implementation Forum with all key stakeholders to shape the model of Day Opportunities going forward and jointly produce a centre plan for each of the three sites to address the need, frequency and duration of provision for the future.
3. To develop a Day Opportunities Investment Fund to extend the range of Day Opportunities available across the City.

Members approved the proposal as outlined above.

Mr McNaney invited Mr Veitch to remind members of the proposal being made in respect of the Outcome Report on the Public Consultation on the Future Delivery of Learning Disability Services for the People Living in Belfast.

Mr Veitch advised that the proposals in respect of LD had been revised and he was seeking Trust Board approval:

1. To maintain Day Centre provision in West Belfast at current centres.
2. To establish a Day Services Planning and Implementation Forum with all key stakeholders to shape the model of Day Opportunities going forward and jointly produce centre plans across Belfast to address the need, frequency and duration of provision for the future.
3. To develop a Day Opportunities Investment Fund to extend the range of Day Opportunities available across the City.

Members approved the proposals as outlined above.

Mr McNaney advised that the Trust would submit the recommendations to the HSCB for endorsement and onward transmission to the Minister for consideration.

In concluding the discussion Dr McBride thanked all those in attendance, he said he hoped that the process had demonstrated that the Trust had listened and learnt from the response to the public consultations.

In response to comments from the audience, Ms McNicholl undertook to prepare a factsheet for sharing with Service Users and Carers.

Mr McNaney thanked everyone for attending, with particular thanks to all those who had shared their concerns and hoped they had been reassured that they had been listened to.

Belfast Health and Social Care Trust
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TRUST BOARD
SUBMISSION TEMPLATE

MEETING	**Trust Board - Confidential**	**Ref No. 5.2 d**
DIRECTOR	**Interim Director Adult Social and Primary Care**	**1 October 2020**
Muckamore Abbey Hospital - Update		
Purpose	This paper provides an update in respect of Muckamore Abbey Hospital.	
Corporate Objective	• Safety and Quality	
Key areas for consideration	Safe care in Muckamore Abbey hospital	
Recommendations	• For Information	

Briefing for Extraordinary Trust Board – 1 October 2020
Muckamore Abbey Hospital

Patient Numbers

At 22 September 2020, there were 49 patients in residence in Muckamore Abbey hospital and 1 patient on trial resettlement. Two of the 49 patients remain on home leave at the request of families in light of the Covid-19 pandemic.

Table 1.1 : Inpatients (inclusive of patients on home leave) and Patients on Trial Resettlement

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	21	0
Belfast HSC Trust	18	1
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	1	0
Total	**49**	**1**

Resettlement

The Interim Director has established a Resettlement Steering Group which met for the first time on 25 September 2020. The purpose of this group is inclusive, but not limited to, the following

- Ensure that the process of resettlement is carried out to an agreed standard
- Oversight of progress against resettlement plans and reporting of variances
- Identification of barriers and risks and escalation of same for action
- Alignment of needs assessment with plans for housing

The Trust has recently received a letter of 15 September 2020 from Sean Holland, Chief Social Work Officer, Department of Health; a key extract is as follows :

> *'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.'*

Work is underway to develop proposals as requested.

Patient Safety

A weekly Safety Report sets out performance against a range of patient safety metrics. This Report is reviewed by the senior management team in Muckamore Abbey Hospital, shared with the multi-disciplinary team and shared and discussed at the fortnightly Directors' Assurance Meeting, chaired by the Chief Executive. There is also a weekly Live Governance call for all clinical areas to feedback on the previous week's incidents and any other governance issues. The Safety Report and the Live Governance calls have continued during the Covid-19 pandemic.

The most recent Safety Report, Report No 79, week ending 16 September 2020 is enclosed.

Staffing

Nurse Staffing
Current nurse staffing levels, with the combination of substantive nursing staff, long-term agency staff and nurse bank staff, are currently providing a safe level of care, supported by use of the nursing model. This remains under regular review as it has been and remains a very challenging period due to staff absence and vacancies.

The fundamental vulnerabilities of the workforce remain which are the temporary (agency) nature of 40% of the workforce, combined with an ongoing PSNI investigation which may result in further substantive staff being suspended.

However, the Trust continues to actively pursue all avenues of nursing recruitment. Thirteen Senior Nurse Assistant permanent posts have been offered to successful candidates at recent recruitment exercises. These candidates are undergoing pre-employment checks at present and start dates are awaited. Additionally there were 7 transition students allocated to Muckamore Abbey at the start of the Covid-19 pandemic. All 7 were interviewed and offered posts. Four of the seven have chosen to stay and take up post on site; the remaining 3 have elected to accept other posts, 2 of which are outside Northern Ireland.

As at 22 September 2020, there are 62 members of nursing staff who are precautionary suspended - 30 are registrants, and 32 are non-registrants. The total number of arrests associated with Muckamore Abbey Hospital is currently 10. Processes are underway to commence disciplinary investigations in relation to a number of staff.

Social Work Staffing
The MAH social work team have 2 social worker posts vacant which are currently being progressed through recruitment. These are backfilled by two agency staff. There are two other social workers in post on site who are in permanent positions. The senior social worker post in Muckamore had been vacant for over 12 months but has recently been recruited to with the appointee taking up post in June 2020. In addition, a senior manager with overarching responsibility for social work across learning disability services took up post in September 2020.

The aim is to consolidate this team through recruitment to the two vacant posts, and to review and develop the role of the social worker in the hospital to ensure that these key staff are fully engaged with families and carers.

Covid-19
There have been no further patients test positive since the outbreak was stood down on 12 May 2020. The management team and staff in Muckamore Abbey Hospital continue with their focus on the protection of patients and staff from Covid-19, including the safe management of family visiting on site.

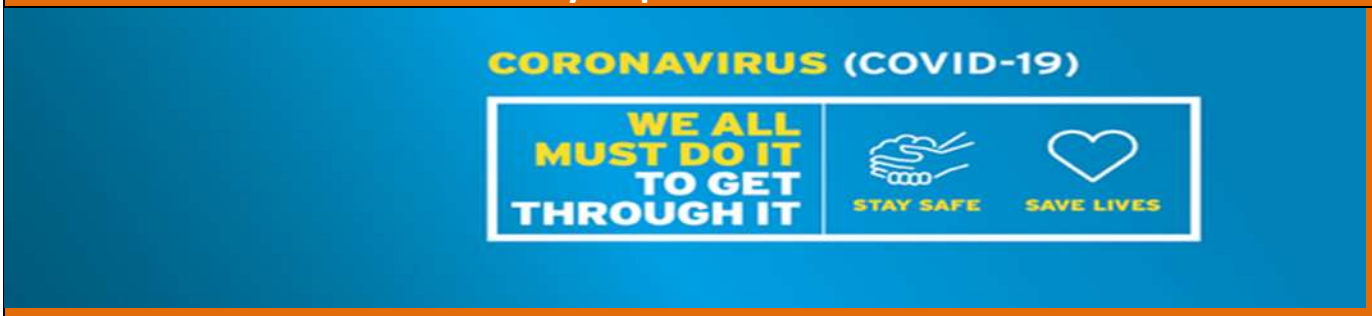
Carers and Families
Contact has been maintained between families and patients via ward teams using the telephone, photographs and/or FaceTime or zoom. In addition, visiting is being supported in line with the current Trust guidance.

The management team have received a range of feedback from families and via the Patient Client Council and the Health and Social Care Board indicating clearly that there is a need to improve our engagement, and secure their involvement and ongoing input with the service management team in Muckamore. A local engagement strategy has now been drafted and will be shared with families for review and further discussion prior to finalising.

Gillian Traub
Interim Director
Adult Social and Primary Care Directorate

Date:	**Information w/e Wednesday 16/09/2020**
Lead:	**Dr Joanna Dougherty**
Email:	**joannae.dougherty@belfasttrust.hscni.net**
Tel:	**02895042900**
Alternative contact:	**Tracy Kennedy**
Email:	**Tracy.Kennedy@belfasttrust.hscni.net**
Tel:	**02895048192**

Weekly Report Number - 79



1) Key Patient Activity Issues

1.1 MAH Inpatient Numbers

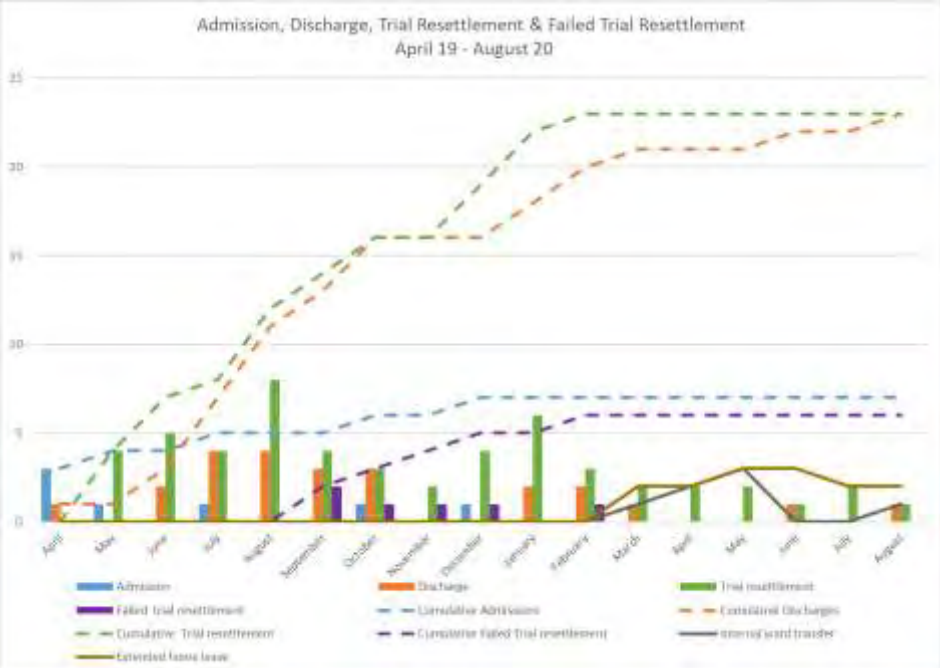
The number of patients in residence remains at 49. The number on trial resettlement remains at 1. Two patients are on extended home leave at the request of families. The graph below displays the number of inpatients resident in Muckamore Abbey Hospital and the number of patients on trial resettlement. –

Patients in Muckamore Abbey Hospital by Trust of Residence are as follows : -

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	21	0
Belfast HSC Trust	18	1
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	1	0
Total	**49**	**1**

1.2 Monthly MAH Admissions, Trial Resettlements and Discharges

The graph below plots the monthly, and year to date, number of patients admitted, discharged, on trial resettlement or having returned from an unsuccessful trial resettlement.



Admission: admitted during month — Discharge: discharged during month

Trial resettlement: pts on TR on last day of month (not included if discharged/failed trial resettlement during the month)

Failed TR: Returned to MAH during the month

Cumulative Admissions: Number of actual patients — Cumulative Discharges: Number of actual patients

Cumulative Trial resettlements: Number of actual patients — Cumulative failed TR: Number of actual patients

Internal ward transfer: No of pts transferred within the month — Extended home leave: Pts on EHL on last day of the month

1.3 Failure Rate of Resettlement – 2020/21 updated

The failure rate of resettlement in the year 2019/20 was 23%. The table below shows the year to date position for 2020/2021 :

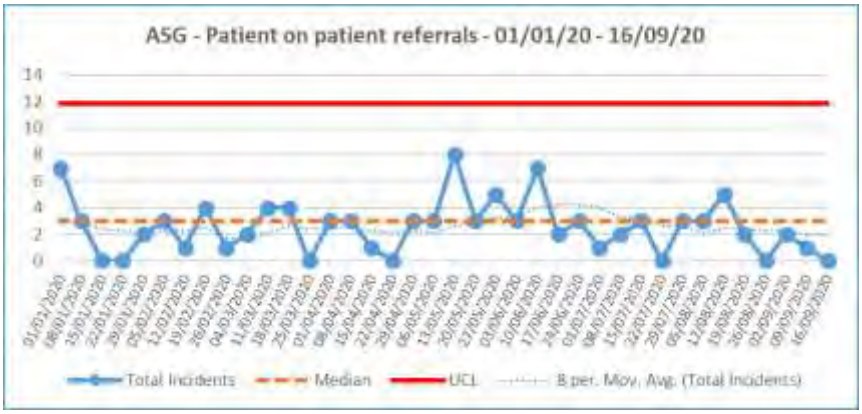
	2020/21			
	Successful Resettlement - patient discharged	**Failed Resettlement** - patient returned	**Ongoing Resettlement**	**Success Rate**
BHSCT	1	0	1	**100%**
NHSCT	0	0	0	**N/A**
SEHSCT	1	0	0	**100%**
WHSCT	0	0	0	**N/A**
Total	**2**	**0**	**1**	

(2) Safeguarding

2.1. Patient on Patient Adult Safeguarding Referrals – w/e 16 Sep 2020

There were no patient on patient ASG referrals reported during the period.

Trend Analysis for Patient on Patient ASG Referrals, Jan 2020 to date :



2.1 Staff on Patient Adult Safeguarding Referrals – w/e 16 Sep 2020

There were 4 staff on patient ASG referrals reported during the period.

16/09/2020								
Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
CF 1	tv room	1	12/09/2020	12-4pm	same day	same day	ASGR(PP)	Physical
Erne	own pod	2	13/09/2020	4-8pm	+1 day	same day	ASGR(PP)	Physical
Ardmore	own room	3	14/09/2020	12-8am	same day	same day	ASGR(PP)	Physical
CF 2	unknown	4	14/09/2020	8am-12pm	same day	same day	ASGR(PP)	Emot/Psyc

(3) Weekly governance review - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.

3.1 Incidents

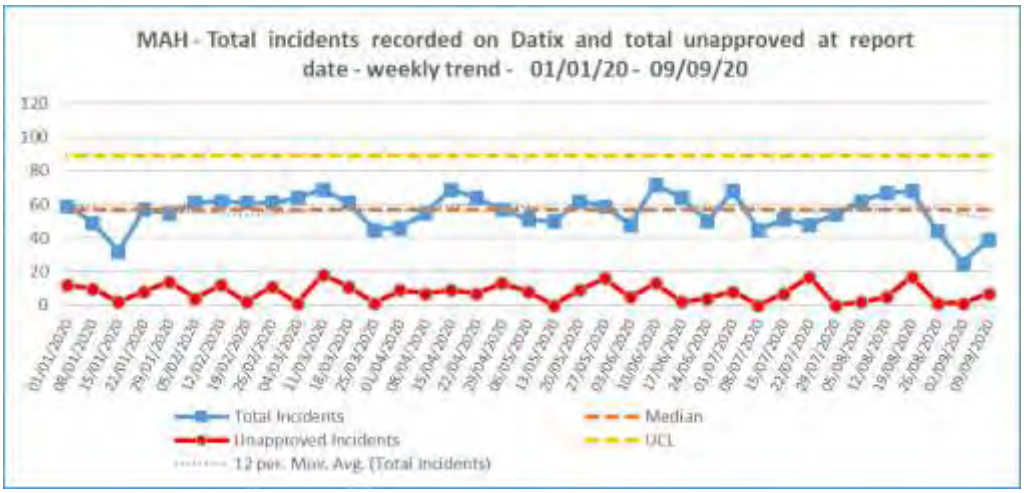
Incident reporting relates to the period week ending 9 September 2020, as approved at 17 Sep 2020.

A total of **39** incidents were recorded, of which 7 across all wards / areas remains unapproved. This analysis covers the **32** approved incidents.

The following table shows approval status by ward / location of incident:

Approval status 03/09/20 - 09/09/20 (app. 17/09/2020)	Ardmore	CF 1	CF 2	Erne	Sixmile A	Sixmile T	General walkways / grounds etc	Non Trust/ Non Healthcare setting	Road	Total
Unapproved, not viewed	0	0	0	5	0	0	0	1	1	7
Approved, investigation ongoing	1	1	0	0	1	1	0	0	0	4
Approved, investigation complete	6	11	7	0	2	1	1	0	0	28
Total	7	12	7	5	3	2	1	1	1	39

The chart below shows incidents recorded on Datix from 01 Jan 2020 to date.



Only the **32** 'approved' incidents can be further categorised by **those affected in the incident, by severity, by day of the week and by category/ type of incident.**

a) Those Affected

Those affected 03/09/20 - 09/09/20 (app. 17/09/2020)	Patient	Staff	Total
Absconded/left without informing staff	1	0	1
Contact/Collision with Objects (not sharps) - Fixtures/fittings	1	0	1
Suspected Slips/Trips/Falls (un-witnessed, Includes faints) - Movement to/from bed/stretcher	1	0	1
Other	2	0	2
Other self harming behaviour	2	0	2
Physical contact	0	18	18
Physical threat (no contact)	1	3	3
Self harm attempt/gesture	1	0	1
Verbal Abuse	0	1	1
Verbal abuse with racial content	0	1	1
Total	**9**	**23**	**32**
	28%	72%	

Highlighted incident types with >3 incidents per category

Incidents are discussed at Ward level PIPA Meeting and weekly Live Governance chaired by the Clinical Director.

b) Severity

The classification of the approved incidents for the period is shown in the table below.

Incidents by Severity 03/09/20 - 09/09/20 (app. 17/09/2020)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total
Totals:	**18**	**14**	**0**	**0**	**0**	**32**
	56%	44%	0%			

c) Incidents by Day by Location

Incidents by day of the week - 03/09/20 - 09/09/20 (app. 17/09/2020)	Ardmore	CF 1	CF 2	Sixmile A	Sixmile T	General walkways, grounds etc	Total
Thursday	1	3	0	0	0	0	4
Friday	0	1	2	1	0	0	4
Saturday	1	0	1	0	0	1	3
Sunday	1	0	0	0	0	0	1
Monday	1	3	3	1	0	0	8
Tuesday	3	4	1	0	0	0	8
Wednesday	0	1	0	1	2	0	4
Total	**7**	**12**	**7**	**3**	**2**	**1**	**32**

Highlighted locations with >3 incidents in a day

d) Type / Location / Severity

Incidents by Severity 03/09/20 - 09/09/20 (app. 17/09/2020)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total	% incidents
Ardmore	**5**	**2**	**0**	**0**	**0**	**7**	**22%**
Self harm attempt/gesture	1	0	0	0	0	1	
Other self harming behaviour	1	0	0	0	0	1	
Absconded/left without informing staff	1	0	0	0	0	1	
Physical contact	0	2	0	0	0	2	
Physical threat (no contact)	1	0	0	0	0	1	
Other	1	0	0	0	0	1	
Cranfield 2	**4**	**3**	**0**	**0**	**0**	**7**	**22%**
Physical contact	3	3	0	0	0	6	
Verbal abuse with racial content	1	0	0	0	0	1	
Cranfield 1	**5**	**7**	**0**	**0**	**0**	**12**	**38%**
Other self harming behaviour	1	0	0	0	0	1	
Physical contact	2	7	0	0	0	9	
Physical threat (no contact)	2	0	0	0	0	2	
General walkways, grounds etc	**1**	**0**	**0**	**0**	**0**	**1**	**3%**
Other	1	0	0	0	0	1	
Sixmile Assessment	**1**	**2**	**0**	**0**	**0**	**3**	**9%**
Contact/Collision with Objects (not sharps) - Fixtures/fittings	0	1	0	0	0	1	
Suspected Slips/Trips/Falls (un-witnessed, Includes faints) - Movement to/from bed/stretcher	1	0	0	0	0	1	
Physical contact	0	1	0	0	0	1	
Sixmile Treatment	**2**	**0**	**0**	**0**	**0**	**2**	**6%**
Physical threat (No contact)	1	0	0	0	0	1	
Verbal Abuse	1	0	0	0	0	1	
Totals:	**18**	**14**	**0**	**0**	**0**	**32**	
	56%	44%	0%				

Other Incidents
Ardmore Ward
03/09/2020

Incident description
A patient was left alone in her pod by a member of staff while she went to make the patient a cup of coffee. In doing so, the staff member had left the patient alone in the pod area for a short period of time. This was noticed by a senior nursing assistant who brought the issue of the patient being left along in the pod, and unable to leave (unauthorised seclusion) to the attention to the member of staff concerned.

Corrective action taken at time if incident
Discussion and debrief with member of staff. Protection plan put in place in relation to individual member of staff. Debrief with ward team re lessons learned. ASP1 completed, RQIA notified. ASP1 completed and adult safeguarding investigation ongoing.

Cranfield 1
05/09/2020

Incident description
Patient 1 was walking past another hospital ward and witnessed patient 2 in a state of partial undress with their trousers and pants down. Patient 2 was redirected and did not appear distressed. These two patients do not live together and usually do not have any social contact. ASP1 completed and investigation ongoing. The next of kin did not wish for any wider follow up. Incident discussed at the following PIPA with the team.

3.2 Medication Incidents

There were no approved medication incidents

3.3. Use of Rapid Tranquilisation during Physical Intervention.

=0 use of rapid tranquilisation reported during the period w/e 16 Sep 2020.

3.4. Use of Prone Restraint

=0 use of prone restraint reported during the period w/e 16 Sep 2020.

3.5 Use of Supine Hold

=1 use of supine hold reported during the period w/e 16 Sep 2020.

Use of supine restraint during physical intervention 10/09/20 - 16/09/20 (based on all incidents - approved/not approved 17/09/2020)	Date	Patient	Total
Sixmile Assessment	12/09/2020	P323	1
Total			1

3.6 Incidents of Physical Intervention (PI)

There were 13 incidents involving the use physical intervention w/e 16 Sep 2020, equating to 34% of all incidents.

Use of Physical Intervention 10/09/20 - 16/09/20 (based on all incidents - approved/not approved 17/09/2020)	NO - None used	YES - Holding only	YES - Dis-engagement only	YES - Dis-engagement and Holding	Total	% use of P.I.
Ardmore	6	1	0	0	7	14%
Cranfield 1	5	3	0	4	12	58%
Cranfield 2	2	1	1	3	7	71%
Erne	5	0	0	0	5	0%
Sixmile Assessment	2	0	0	0	2	0%
Sixmile Treatment	2	0	0	0	2	0%
General walkways, grounds etc	1	0	0	0	1	0%
Non Trust/ Non Healthcare setting	1	0	0	0	1	0%
Road	1	0	0	0	1	0%
Total	**25**	**5**	**1**	**7**	**38**	
	66%	13%	3%	18%		

Highlighted locations with >3 incidents of use of P.I. in a location

3.7 Seclusion and Voluntary Confinement

3.7.1 **Seclusion**

Seclusion was utilised once in this period ([redacted] - Sixmile Assessment).

Seclusion took place on 16th September 2020 between 11:15-11:45am in the patient's bedroom. Observation compliance was followed.

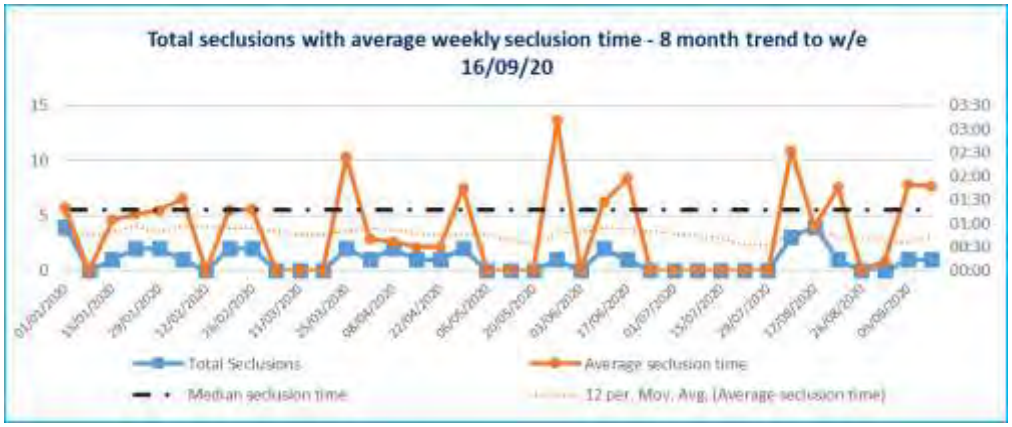
Daily Seclusion Trend (excludes voluntary confinement)

Comparison of Seclusion Events and Use of Physical Interventions

Seclusion Review Compliance

Seclusions with Average Weekly Seclusion Time

The graph below shows the trend of average weekly time in seclusion, per seclusion event :

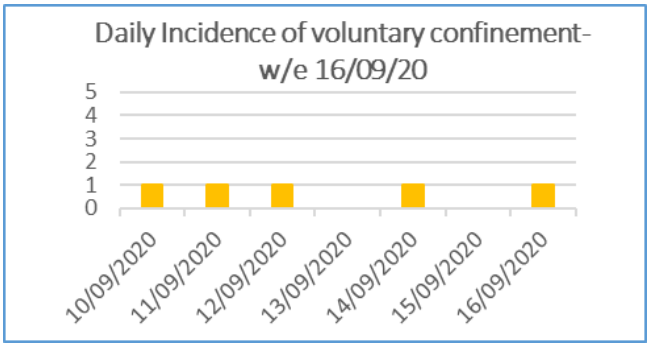


3.7.2 Voluntary Confinement

Voluntary Confinement was utilised on **5 occasions** in this period**,** in the management of 1 patient (MMcC) in Sixmile Assessment:

- Shortest duration of voluntary confinement – **50 minutes**
- Longest duration of voluntary confinement – **2 hour 45 minutes**
- Earliest commencement of confinement was **09:00am**
- Latest conclusion of confinement was **11:50pm**

Instances of Voluntary Confinement per Day of Week



Analysis by Patient of Voluntary Confinement

16/09/2020				
Patient ID	**Ward**	**Confinement Area**	**Reason**	**No. of VC's**
P60	Sixmile A	Patients bedroom	Voluntary	5

Number of Episodes

No episode ended later than **11:50am** and the earliest episode started at **09:00am**.

16/09/2020					
Time Vol Confinement Ended	7am - 12noon	12 noon - 5pm	5pm - 11 pm	11pm- 7am	**Total**
No. of VC's	5	0	0	0	5

Length of Time of Voluntary Confinement

In terms of the length of time voluntary confinement occurred, the table below details for each patient the length of time confinement lasted on each occasion by time band. The average time was **1 hour 48 minutes** for the period.

16/09/2020							
Pt. ID.	**<30mins**	**30 mins - 1 hr**	**1 - 2 Hrs**	**2 - 3 Hrs**	**3 - 4 Hrs**	**> 4 Hours**	**Total**
P60	0	1	3	1	0	0	**5**
Total	**0**	**1**	**3**	**1**	**0**	**0**	**5**

Observation Compliance

Voluntary confinement Observation compliance - w/e 16/09/2020				
Total Vol Confinement	15 min obs	4 hr medical assess	1 hr medical assess	Issue
3	5 of 5	n/a	n/a	

3.8 Complaints

No complaints received during the period

3.9. Risk Register Position

No change.

3.10. CCTV Viewing
(*References to Cx relate to camera numbers, e.g. C28)*

The CCTV system is monitored 24/7 by the external provider who installed the cameras as part of the contract. Any camera faults are identified in real time and the Ward area are advised. This then generates a maintenance request to follow up which includes an out of hour's service. Most faults are screen issues that don't effect the ongoing recording onto the hard drives meaning coverage is not lost at these times. It is rare for a fault to be a physical camera issue but in these instances it would affect recording from that camera at that particular time until the fault was fixed.

Please note that all CCTV viewing is now reviewed prior to publication in the Safety Report. On a weekly basis, an Assistant Service Manager and a Designated Adult Protection Officer will review the CCTV viewing reports to determine if any action is required – this is a new step, called the CCTV Viewing Quality Assurance (QA) Review Process.

The QA Review Process was completed on 21 September 2020 for the viewing reports included below, and comments are included if applicable.

There were no Actions from the previous week QA that needed to be brought forward to 21 September 2020

Erne 1 09/09/2020 14:00 – 22.00	**Viewer 1** - Three patients observed on ward – all being supervised by staff. Good ratio of staff to patients. Quiet shift. Low level of engagement between staff and patients observed. Patient care and dietary needs met. Camera 42 at 16.52, staff member observed sitting on chair whilst supervising patient, staff members body language very casual – observed sitting sideways on chair with legs over arm of chair. Minimal engagement with patient **Viewer 2** - Staff visible in patient, public areas. Evidence of interaction between staff and patients e.g. C42 at 9.10 nurse talking to patient on 1:1 basis in Day space, C4 at 20.56 nurse interacting with patient after giving him medications. Staff observed with patients when they were in day pace. Staff observed on bedroom corridors checking bedrooms.
Erne 2 09/09/2020 21.00 – 07.00	Yes staff were interacting with patients e.g. C4 @21.06 Yes, staff were attending to patient needs e.g. assisting patients take their medications and ensuring they were comfortable. Staff helped patients get ready for bedtime. One patient was asleep in dayroom and he was checked throughout the night.
Cranfield 1 10/09/2020 07.00 – 15.00	Staff very visible in day space, bedroom corridors and staff base. Very good interaction observed between staff and patients throughout the shift e.g. Charge Nurse interacting with patients on 1:1 basis C28 at 13.50 C20 at 11.44 nurse interacting on 1:1 basis with patient in day space Very good engagement observed between staff and patients. Staff observed doing practical activities with patients on 1:1 basis e.g. doing jigsaw with patient in C28 at 10.34, C25 at 14.11 playing football while patient in garden, patient in apartment left ward with Daycare staff. Charge Nurse very visible and involved in patient care. Student Nurse observed to be involved in patient care.
Ardmore 2 10/09/2020 15.00 to 21.00	Ward appeared busy and interactive. Five patients observed throughout shift. Staff members observed engaging with patients on a 1:1 basis in main dayspace or garden area with a patient (drawing, puzzles) chatting with patients and styling patients hair. Staff members appeared responsive to the needs of patients and positively engaged with patients. Two patients appeared to go off ward with staff and returning with food. Good atmosphere on ward and very good staff to patient ratio. Staff group appeared to work well as a team. Ward Manager also visible in main day space. System running slow – difficulty changing cameras, pausing system and regulating speed of cameras. Cameras at times also stopped running and reverted to original time. Camera 38 missing (computer system nearest door)
Cranfield 2 11/09/2020 07:00 – 12.00	**Viewer 1** Ward initially active with staff members assisting patients with personal care needs and breakfast. Staff members observed sitting with same patients while they are breakfast.

	Two patients also observed being accompanied by staff members and let ward . C9, 40, 43 at 10.45 and 11.06. Other patients observed walking around ward, standing at nursing station or spending time in garden area. Staff members observed positively interacting with patients and being responsive to care needs of patients. Good ratio of staff members to patients. **Viewer 2** Plenty of staff and patient interaction, which was ongoing	
Sixmile Assessment 11/09/2020 10.00 – 17.00	Staff visible in patient public areas. 5 patients observed within this time period staff observed at staff base sitting in adjacent chairs with patients in Day space and sitting with patients at dining table. Evidence of staff 1:1 interactions with patients medical staff observed on ward. C8 @12.27 staff talking 1:1 with patient who was pacing the floor in front of nursing stations patient who was pacing the floor in front of nursing station, patient appeared to be more relaxed following the interaction with staff. C8 at 11.51 – Patient approached staff member with his arms outstretched ? attempting to hit staff. Staff held both forearms, 2nd nurse came to patient and staff, each staff member held one of patient's forearms and walked patient to his bedroom. Patient returned to day space at 11.58 C14, patient runs at staff again, two staff take each of patient's arms and walk him to his bedroom again. Four staff in day space observed during this time. Ward Sister takes patient into interview room and spends time interacting with him on 1:1 basis. Ward Sister visible throughout the shift.	
Ardmore 2 12/09/2020 16.00-18:30 V1 18:30–20:00 V2	**Viewer 1** - Ward appeared calm and relaxed. Five patients observed throughout. Staff members visible in main day space positively engaging with patients e.g. sitting with patients assisting with food, attempting to engage in activity with patient or engaging in playful chat. Staff appeared responsive to the needs of patients. At the beginning of shift (C32 at 16.00) patient observed lying under shelving in activity room – staff member observed lying alongside patient providing comfort and reassurance. Patients appeared to respond positively to attention given by staff members. Staff members appeared caring and compassionate in their care of patients. System slow and unresponsive – difficulty changing cameras, pausing system, regulating camera speed etc. **Viewer 2** – Viewer inly observed 3 and a half hours of this shift. 3 patients observed – 2 of whom stayed in their bedrooms majority of the time. 1 patient spent time walking around Day space area, staff engaged well with her and took her out for a walk. Good ratio of staff to patients. Patients' needs responded to in a timely manner – no issues noted. Some issues with cameras on Ardmore 2. Response erratic. Slow at times to respond to camera changes. Cameras sticking and freezing at times, jumping to a single frame when not requested. Slow all round compared to previous viewing of Erne 2.	
Erne 2 12/09/20 07:00 – 15:00	Busy ward. 4 patients observed. Good ratio of staff to patients. Staff team worked well together. All staff actively involved with patients and worked hard to provide safe care. Patients engaged well with interaction provided. Patients' needs were recognised and responded well to. Staff appeared to know patients well and managed behaviours observed e.g. patient throwing items out of the window. Patient agitated and pacing. Patients' personal care needs met in timely manner. Staff team worked well together, busy shift, all staff appeared engaged with patients' behaviours and needs.	
Ardmore 2 13/09/20 18:30 – 23:00	Staff visible in public areas such as day space, staff base and in bedroom corridors checking bedrooms. On 2 occasions nurse observed taking patient in wheelchair into	

	garden. Evidence of nurses interacting with patients e.g. C29 20:28 talking to patients at staff base. C26 20:56 nurse sits at table talking to 2 patients. Staff observed wearing masks at all times. Ward appears to have relaxed atmosphere environment for patients**.**

Service Manager Comment re. CCTV Technology Issues

The IT issues highlighted in relation to CCTV camera and viewing in Ardmore 2 have been reported as a potential fault. Previous reporting of this type of issue has not highlighted any system problems.

(4) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback

4.1. Safety Brief
Ongoing on a daily basis on each ward, using agreed template.

4.2. Safety Quality Visits
The Assistant Service Managers have virtual catch up with ward teams.

4.3 Weekly Live Governance meetings ongoing
Chaired by Clinical Director and involving all wards.

4.4 Monthly ward clinical improvement groups
These have been stood down during the coronavirus pandemic. Plans have started to re-establish these groups and discussions have begun with the QI Manager in relation to datasets for these meetings.

4.5 Patient Experience Feedback
This work is currently paused as part of containment measures for the coronavirus pandemic. Discussions about restarting this have recently taken place as part of MAH wider Recovery Plan.

(5) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.

5.1. Staff Counsellor Sessions – 12 Sessions offered per week.

This service continues to offer support to staff.

5.2 Information from MAH Senior Nursing Team

The Senior Nursing Team continues to maintain a focus on workforce recruitment and retention. In addition the Senior nursing Team has been contributing to Resettlement discussions focussing on how to make the process even more patient focussed.

5.3 Lead Nurse/ASM recruitment
Appointment of 2 lead Nurse /Assistant Service Managers. One successful candidate from within Belfast Trust and the other from an external Trust. Official commencement dates are 01.10.20 and 01.11.20 respectively for both successful candidates for these permanent posts.

5.4 **Safetember – "Knowing Me Knowing You"- Staff Engagement Project**

This short life project is being piloted with the intention to roll out for all patients following evaluation. This initiative is directly aimed at staff providing a practical tool for day-to-day care and support for our patients . A pro forma has been developed to assist all care and support staff write down (no matter how small) things that contribute to the wellbeing of their patient.

It is planned that this information can be interpreted and used to better inform our knowledge of our patients across the whole staff care group measured against a set of successful outcome indicators that includes reduced patient on staff incidents. This project is supported by the newly appointed Quality Improvement Manager and went live on 7 September 2020. It is also intended that this tool will assist when patients are going through the resettlement process.

Two other projects are being highlighted through the Safetember platform, one in relation to Fire Awareness and the other focussing on staff safety and the use of Personal Protective Equipment.

(6) Emerging issues

Covid-19 Update (at time of report submission)
The Muckamore Abbey Hospital management team have raised the profile of Covid-19 awareness across the site. Updated guidance has been developed in relation to considering patient activites. Action Cards have been updated in respect of the "The Symptomatic Patient" and "Testing Guidance". Changes to visiting on site have been considered and will be implemented in line with the Belfast Trust position.

Erne Ward
Staff absence in Erne Ward continues to be addressed. Successful recruitment has been made for additional Band 5 and Band 7 nursing staff. A range of additional options are being reviewed. Estates review of building environment in relation to standards for facilities of people with Learning Disability and wheelchair users has been commissioned and report has been completed.

RQIA Whistleblowing
A number of concerns have been raised with RQIA anonymously which were responded to. MAH Senior Management team have requested an additional meeting with RQIA to discuss a range of issues which was due to take place on 17.09.20 but was rearranged at the request of RQIA to the 23.09.20

Trade Unions
Trade Unions are highlighting concerns regarding the increasing number of physical assaults on staff and support to staff and discussion with the management team are ongoing. Discussions continue with Union representatives with a focus on staff engagement strategies.

(7) Media and communications – FOIs, media enquiries etc.

As of 22nd September 2020:

- 1 media enquiries outstanding - regarding the building control and planning of seclusion room
- 1 constituency request for meeting - date being arranged.
- No Departmental enquiries outstanding , 8 enquires answered from 1 MLA within last week
- 2 FOI requests outstanding

(8) Financial Governance
BSO Internal Audit have provided a final audit report with an outcome of 'Satisfactory' and on 14 April 2020, RQIA wrote to the Trust to advise that the Improvement Notice had been lifted. An Action Plan is now in progress. An unannounced Finance Audit was completed on 15 July 2020. Generally there was a satisfactory outcome to how Patient finances are managed in line with Hospital Policy and Procedure. Audit outcome was shared with the ASM group and with the Ward Managers Group on 22 August 2020. Individual Action plans have been compiled between the Auditor and each ward management team in response to feedback and learning points.
(9) Next Steps/forward look – wider strategy update
Review of Leadership and Governance Muckamore Abbey Hospital 2012 – 2017 Following publication of this review, it is planned to seek feedback from those who participated in the review process in order to inform an overall response from the Trust to the Review.
(10) Other Issues requiring escalation for advice and senior decision making
None.

Belfast Health and Social Care Trust
caring supporting improving together

TRUST BOARD

MEETING	**Trust Board – Confidential**	**Ref No. 6.3**
DIRECTOR	**Interim Director Adult Social and Primary Care**	**1 April 2021**
Muckamore Abbey Hospital - Update		
Purpose	This paper provides an update in respect of Learning Disability Services – Muckamore Abbey Hospital	
Corporate Objective	• Safety and Quality	
Key areas for consideration	1. Muckamore Abbey Hospital - Resettlement - Workforce - Patient Safety - Staffing - Covid-19 2. Carer and Family Engagement and Involvement 3. What's Different About Muckamore	
Recommendations	• For Information	

Briefing for Trust Board
1 April 2021

Learning Disability Services

The purpose of this report is to provide an overview of issues pertaining to Learning Disability services inclusive of Muckamore Abbey Hospital

1. MUCKAMORE ABBEY HOSPITAL

1.1 Patient Numbers

As at 15 March 2021, there are 43 patients in residence in the Hospital with 2 patients on trial resettlement. One patient remains on extended home leave at the request of families in light of the Covid-19 pandemic.

Table 1: Inpatients (inclusive of patients on home leave) and Patients on Trial Resettlement

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	19	1
Belfast HSC Trust	15	1
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	0	0
Total	**43**	**2**

1.2 Resettlement

Of the patients on site only 1 currently is requiring active treatment - all other patients are delayed discharges. In the next six months, a further 5 discharges of Belfast Trust patients are expected to proceed.

1.3 Patient Safety

The most recent Safety Report, Report No 104, week ending 10 March 2021 is enclosed. This weekly Safety Report sets out performance against a range of patient safety metrics. This report is reviewed by the senior management team in Muckamore Abbey Hospital and shared with the multi-disciplinary team. There is also a weekly Live Governance call for all ward areas to feedback on the previous week's incidents, adult safeguarding referrals and any other governance issues.

1.4 Staffing

1.4.1 Nurse Staffing

Current nurse staffing levels, with the combination of substantive nursing staff, long-term agency staff and nurse bank staff, are currently providing levels of staffing in line with the nursing model. This remains under regular review given the inherent vulnerability of the workforce which comprises 75% agency registrant staff. In the last 2 weeks, 2 substantive staff have tendered their resignation from the Trust, and a number of agency staff have elected to take work elsewhere. Nurse staffing levels are reviewed daily on site, and are reported weekly across the senior management team and to the

Department of Health. The most recent staffing position of w/c 8 March 2021 can be found in Appendix 1.

On 18 March 2020, concerns were raised by a family member regarding staffing levels on site and the considerable pressure which staff are experiencing in maintaining safe levels of care. These concerns were shared with the Department of Health via an Early Alert and with RQIA and HSCB. A discussion with the family member highlighted that these concerns had been raised by staff in the context of feeling that there had been insufficient management support to address the staffing levels. In response to this communication, a series of open staff sessions hosted by the management team will take place over the next fortnight to encourage staff to come forward and share any feedback and/or concerns they may have. The management team are continuing to explore the introduction of more formalised trauma informed practice on site.

The Chief Executive has requested that a risk summit take place between the Department of Health, the RQIA, the HSCB and the Trust.

There are 69 members of nursing staff who are precautionary suspended. Of these 69, 33 are registrants and 36 are non-registrants and 43 hold substantive posts in Muckamore. There are 56 staff who have protection plans in place (supervision and training). Of these 56, 29 are registrants and 27 are non-registrants, and 26 hold substantive posts in Muckamore. The total number of staff who have been arrested associated with Muckamore Abbey Hospital remains 15.

1.4.2 Medical Staffing

The small team of 2.5wte Consultant Psychiatry team providing input to Muckamore Abbey Hospital reduced to 2wte due to the sick leave of one of the team. The 0.5 wte relates to single handed Consultant input to the inpatient forensic unit, Sixmile Ward. The service has been grateful for the additional support provided by the Division of Mental Health Services during this period of sick leave which ended on 15 March 2021 when the substantive Consultant resumed to work.

The residual risk in respect of medical staffing relates to clinical leadership with the current vacancy of the Clinical Director position, as well as the longstanding vacancy in the Chair of Division position. Unfortunately a recent recruitment exercise for the Chair of Division did not result in an appointment. Further options for both internal and external assistance are now being considered.

1.4.3 Adult Safeguarding Staffing

Staffing levels in the Adult Safeguarding service supporting Muckamore Abbey Hospital will be added to the service's risk register this month – this is due to ongoing DAPO and IO vacancies within the service combined with an increase in workload associated with historic concerns shared by the Patient Client Council (PCC). These have arisen from the PCC's engagement with families around the statutory public inquiry and many are particularly complex. To date there have been 19 separate sets of concerns raised with the Trust by the PCC which are currently being investigated by the diminished team supporting Muckamore. As a result, the quality and timeliness of adult safeguarding investigations relating to incidents in Muckamore, and the timeliness of communication in relation to these investigations, is not what it should be.

The Adult Safeguarding Lead post for Muckamore Abbey Hospital has been vacant since September 2020 and has only recently been recruited to, at the third attempt. The appointee will commence in post in June 2021. An action plan has been developed by the Divisional Social Worker and Adult Safeguarding Service Manager for Learning Disability and will be presented to Executive Team in due course.

1.5 Covid-19

All Covid-19 outbreaks on site have now been stood down. There remains a cohort of staff who are off sick due to Covid-19 but all patients who were Covid-19+ have now recovered.

2. CARER AND FAMILY INVOLVEMENT ACROSS LEARNING DISABILITY SERVICES

There are a range of ongoing initiatives to enhance the involvement of our carers and families in learning disability services. A summary is set out below :

- Carer Involvement and PPI Lead for Learning Disability services (adults) – this post has been advertised for a second time and the advert has recently closed.

- The Muckamore Carer's Forum continues to meet.

- A Family Questionnaire has been issued to families and carers seeking their feedback on their experiences with the service in Muckamore and in particular how satisfied they are in relation to the nature and quality of communication with them. The purpose of this questionnaire is to establish a new baseline in respect to family engagement and communication and to inform our next steps to making improvements.

- Community Zoom Sessions – these sessions with families of service users took place in February 2021 and 65 families, carers and services users took part. A report is currently being written up which will summarise the main issues which families and carers raised with the management team. These sessions were precursors to the reestablishment of a Learning Disability Forum, a co-production approach to learning disability services.

- Three meetings have taken place with representatives from Families Involved NI to develop Terms of Reference for a review of advocacy services. These Terms of Reference are at the final draft stage – the next step will be to share with HSCB and other Trusts, prior to progressing the review. A review of advocacy services is a recommendation of the Leadership and Governance Review of Muckamore Abbey Hospital, 2012-2017.

3. WHAT'S DIFFERENT ABOUT MUCKAMORE

Following last month's Trust Board presentation on 'What's Different About Muckamore Now', it is proposed to share the paper with the Department of Health.

Building on recent HSCB and tri-partite Trust discussions about inpatient bed provision, the Trust is now actively progressing discussions with the Department of Health and HSCB regarding the future model of service provision - in particular the options to progress to a social care model both in the medium term to address nurse staffing deficits, and in the longer term as an alternative model of service delivery. An initial meeting with DOH and HSCB has been convened for 25 March 2021.

Gillian Traub
Interim Director
Adult Social and Primary Care Directorate

Appendix 1 – Nurse Staffing Levels Muckamore Abbey Hospital w/c 8 March 2021

Ward	Patients	Nursing Plan	BHSCT Staff	Reg	Non Reg	Agency Staff	Reg	Non Reg	Other Backfill	Reg	Non Reg	Variance after Backfill	% achieved against plan
CR1	9	37.15	10.06	3.27	6.79	12.05	6.6	5.45	11.21	1.63	9.58	-3.83	89.70
CR2	8	34.72	14.01	2.85	11.16	14.07	11.21	2.86	6.23	1.63	4.6	-0.41	98.82
Ardmore	6	31.17	19.07	2.55	16.52	7.76	7.76	0	5.02	1.77	3.25	0.68	102.17
Sixmile	12	34.16	9.55	4.84	4.71	21.3	14.38	6.92	3.22	1.45	1.77	-0.09	99.74
Erne	8	46.67	13.57	2.78	10.79	24.78	17.4	7.38	8.11	1.1	7.01	-0.21	99.56
Total	43	183.87	66.26	16.9	49.97	79.96	57.35	22.61	33.79	7.58	26.21	-3.86	97.90

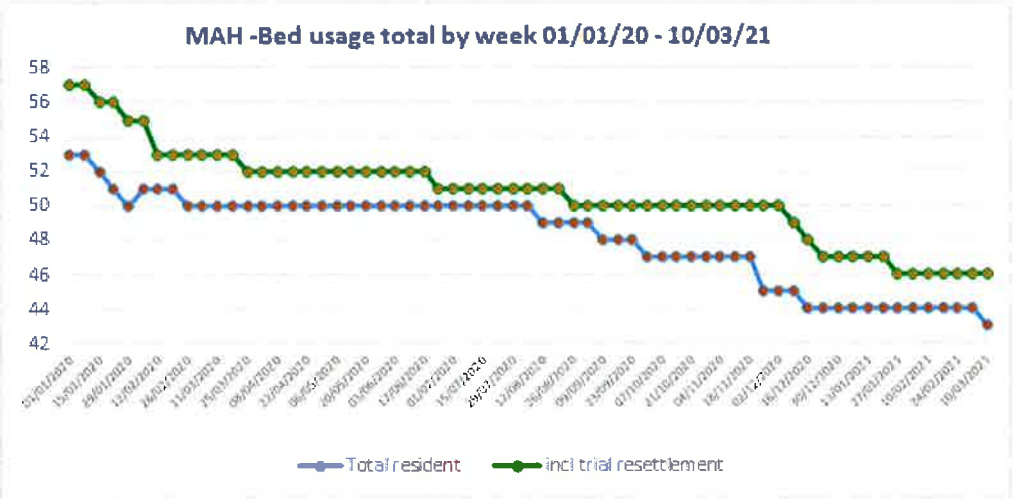
Date:	**Information w/e Wednesday 10/03/2021**
Lead:	**Gillian Traub - Interim Director**
Email:	**Gillian.Traub@belfasttrust.hscni.net**
Tel:	**02895048308**
Alternative contact:	**Tracy Kennedy - Co-Director**
Email:	**Tracy.Kennedy@belfasttrust.hscni.net**
Tel:	**02895048192**

Weekly Report Number - 104

1) Key Patient Activity Issues

1.1 MAH Inpatient Numbers

The number of patients in residence is now 43, with 1 patient having been discharged and 1 patient commencing resettlement. The number on trial resettlement is therefore 2 and one patient remains on extended home leave at the request of family.

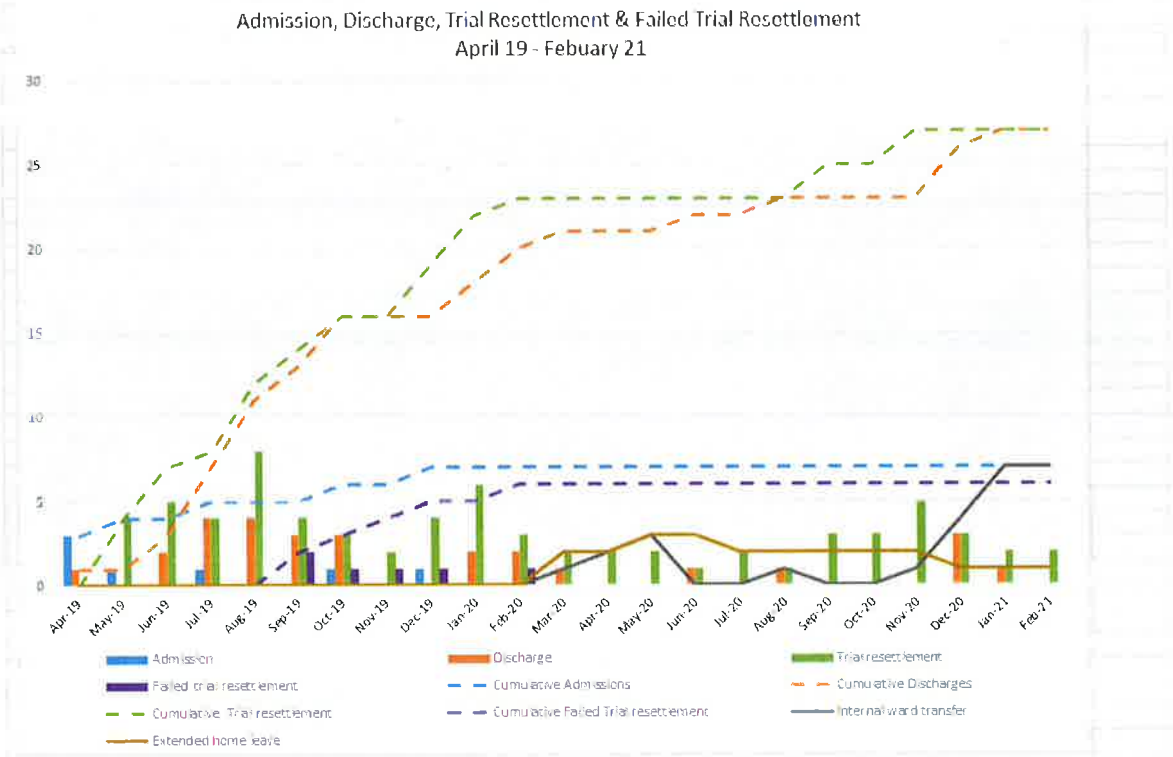


Patients in Muckamore Abbey Hospital by Trust of Residence are as follows : -

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	19	1
Belfast HSC Trust	15	1
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	0	0
Total	**43**	**2**

1.2 Monthly MAH Admissions, Trial Resettlements and Discharges

The graph below plots the monthly, and year to date, number of patients admitted, discharged, on trial resettlement or having returned from an unsuccessful trial resettlement.



Admission: admitted during month
Discharge: discharged during month
Trial resettlement: pts on TR on last day of month (not included if discharged/failed trial resettlement during the month)
Failed TR: Returned to MAH during the month
Cumulative Admissions: Number of actual patients
Cumulative Discharges: Number of actual patients
Cumulative Trial resettlements: Number of actual patients
Cumulative failed TR: Number of actual patients
Internal ward transfer: No of pts transferred within the month
Extended home leave: Pts on EHL on last day of the month

1.3 Failure Rate of Resettlement – 2020/21 updated

The failure rate of resettlement in the year 2019/20 was 23%. The table below shows the year to date position for 2020/2021 :

	2020/21			
	Successful Resettlement - patient discharged	**Failed Resettlement** - patient returned	**Ongoing Resettlement**	**Success Rate**
BHSCT	2	0	1	**100%**
NHSCT	2	0	1	**100%**
SEHSCT	1	0	0	**100%**
WHSCT	1	0	0	**100%**
Total	**6**	**0**	**2**	**100%**

(2) Safeguarding

2.1. Patient on Patient Adult Safeguarding Referrals – w/e 10 March 2021

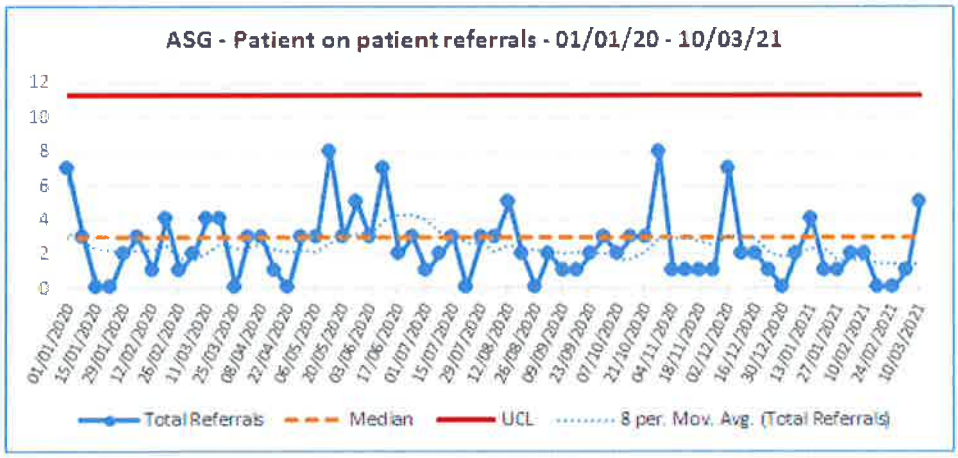
There were **5** patient on patient ASG referrals reported during the period.

10/03/2021								
Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
CF 2	Nurses Station	1	04/03/2021	12-4pm	+2 days	same day	ASGR(PP)	Physical
CF 2	Dining Room	1	04/03/2021	4-8pm	+1 day	+4 days	ASGR(PP)	Physical
CF 2	Nurses Station	1	05/03/2021	4-8pm	same day	+4 days	ASGR(PP)	Physical
Sixmile A	Dayroom	1	06/03/2021	4-8pm	same day	same day	ASGR(PP)	Emot/Psyc
CF 2	Nurses Station	1	08/03/2021	12-4pm	same day	+1 day	ASGR(PP)	Physical

Service Manager Comment

Three of the 4 incidents in Cranfield 2 involved the same patient against 3 other patients. This patient is unsettled at this time and is being reviewed regularly by the MDT Team.

Analysis for Patient on Patient ASG Referrals, Jan 2020 to date :

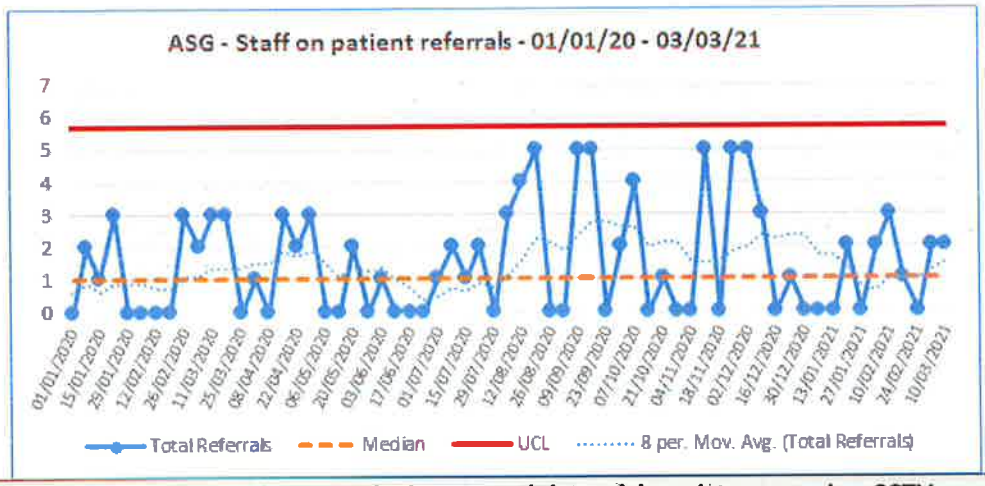


2.2 Staff on Patient Adult Safeguarding Referrals – w/e 10 March 2021

There were **2** staff on patient ASG referrals reported during the period.

10/03/2021								
Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
Erne	Ward	1	04/03/2021	4-8pm	same day	same day	ASGR(PP)	Physical
CF 2	Day Care	1	05/03/2021	Unknown	same day	same day	ASGR(PP)	Emot/Psyc

Trend Analysis for Staff on Patient ASG Referrals, January 2020 to date :



(3) Weekly governance review - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.

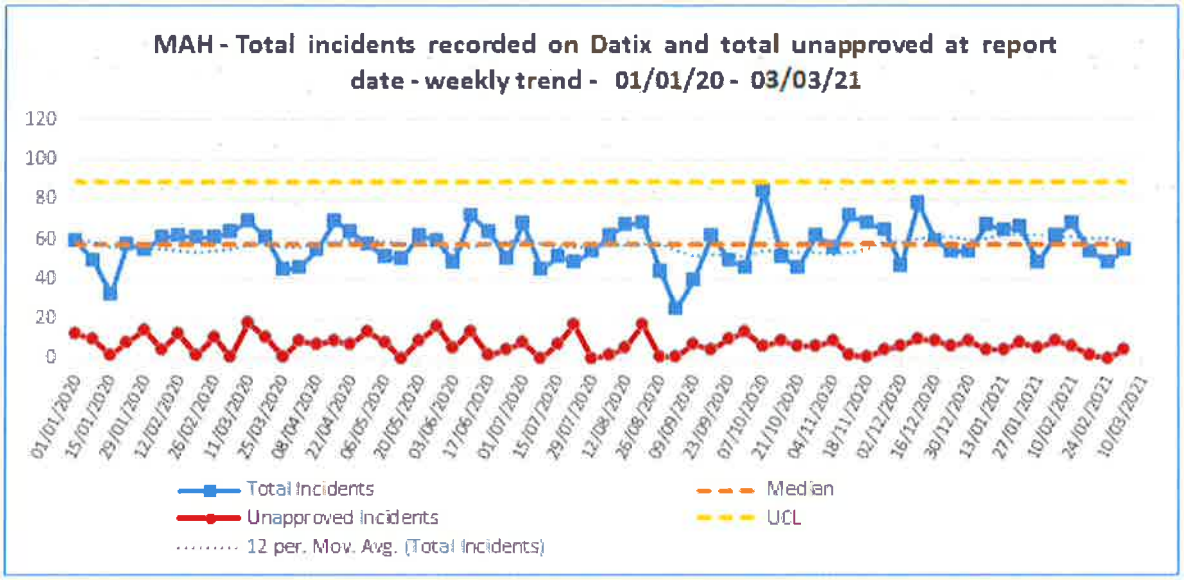
3.1 Incidents

Incident reporting relates to the period week ending 03 March 2021, as approved at 10 March 2021.

A total of **55** incidents were recorded, 1 of which was rejected and 4 across all wards/areas remain unapproved. This analysis covers the **50** approved incidents. The following table shows approval status by ward / location of incident:

Approval status 25/02/21 - 03/03/21 (app.10/03/2021)	Ardmore	CF 1	CF 2	Erne	Sixmile A	Sixmile T	Swimming Pool	Total
Unapproved, not viewed	0	0	1	3	0	0	0	4
Approved, investigation ongoing	0	0	1	2	1	0	0	4
Approved, investigation complete	5	13	8	5	13	2	0	46
Rejected	0	0	0	0	0	0	1	1
Total	5	13	10	10	14	2	1	55

The chart below shows incidents recorded on Datix from 1 January 2020 to date.



All 50 'approved' incidents can be further categorised by **those affected in the incident, by severity, by day of the week and by category/ type of incident.**

a) Those Affected

Those affected 25/02/21 - 03/03/21 (app.10/03/2021)	Organisational	Patient	Staff	Public/Visitors	Total
Actual self harm	0	2	0	0	2
Contact/Collision with Objects (not sharps) - Fixtures/fittings	0	1	0	0	1
Entrapment - In room	0	1	0	0	1
Administration to patient - Incorrect patient	0	1	0	0	1
Insufficient numbers of healthcare professionals	1	0	0	0	1
Other therapeutic incident	0	1	0	0	1
Physical	0	2	0	0	2
Physical contact	0	2	29	1	32
Physical threat (no contact)	0	0	6	0	6
Verbal Abuse	0	0	2	0	2
Slip/trip or fall - Walking	0	0	1	0	1
Total	1	10	38	1	50
	2%	20%	76%	2%	

Highlighted incident types with >3 incidents per category

Incidents are discussed at Ward level PIPA Meeting and weekly Live Governance chaired by the Clinical Director.

b) Severity

The classification of the approved incidents for the period are shown in the table below.

Incidents by Severity 25/02/21 - 03/03/21 (app.10/03/2021)	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Totals:	**31**	**19**	**0**	**0**	**0**	**50**
	62%	38%				

c) Incidents by Day by Location

	Ardmore	CF 1	CF 2	Erne	Sixmile A	Sixmile T	Total
Thursday	0	1	3	2	1	1	**8**
Friday	0	2	2	2	1	0	**7**
Saturday	0	3	0	1	2	0	**6**
Sunday	0	1	0	2	0	0	**3**
Monday	1	3	1	0	5	1	**11**
Tuesday	1	3	2	0	3	0	**9**
Wednesday	3	0	1	0	2	0	**6**
Total	**5**	**13**	**9**	**7**	**14**	**2**	**50**

Highlighted locations with >3 incidents in a day

d) Type / Location / Severity

Incidents by Severity 25/02/21 - 03/03/21 (app.10/03/2021)	Insignificant	Minor	Moderate	Major	Catastrophic	Total	% Incidents
Ardmore	**4**	**1**	**0**	**0**	**0**	**5**	10%
Verbal Abuse	1	0	0	0	0	1	
Physical contact	1	1	0	0	0	2	
Physical threat (no contact)	2	0	0	0	0	2	
Cranfield 1	**7**	**6**	**0**	**0**	**0**	**13**	26%
Actual self harm	1	1	0	0	0	2	
Insufficient numbers of healthcare professionals	1	0	0	0	0	1	
Physical contact	4	5	0	0	0	9	
Physical threat (no contact)	1	0	0	0	0	1	
Cranfield 2	**4**	**5**	**0**	**0**	**0**	**9**	18%
Physical contact	3	5	0	0	0	8	
Administration to Patient - Incorrect patient	1	0	0	0	0	1	
Erne	**4**	**3**	**0**	**0**	**0**	**7**	14%
Physical	1	1	0	0	0	2	
Entrapment - In room	1	0	0	0	0	1	
Slip/trip/fall - Walking	0	1	0	0	0	1	
Physical contact	1	1	0	0	0	2	
Other therapeutic incident	1	0	0	0	0	1	
Sixmile Assessment	**11**	**3**	**0**	**0**	**0**	**14**	28%
Physical contact	7	3	0	0	0	10	
Verbal Abuse	1	0	0	0	0	1	
Physical threat (no contact)	3	0	0	0	0	3	
Sixmile Treatment	**1**	**1**	**0**	**0**	**0**	**2**	4%
Contact/Collision with Objects (not sharps) - Fixtures/fittings	0	1	0	0	0	1	
Physical contact	1	0	0	0	0	1	
Totals:	**31**	**19**	**0**	**0**	**0**	**50**	
	62%	38%					

Erne Ward
Other Therapeutic Incident
27 February 2021
Staff A was allocated to work with Patient A who has been prescribed level 3 1:1 observations which are continuous observations during waking hours; staff:patient ratio of 1:1. Patient A was seen walking towards the office without Staff A. A member of staff raised concern that Patient A had been left unaccompanied. Staff A was reminded of the importance of remaining with Patient A at all times - Staff A is aware that he could have sought assistance instead of leaving Patient A alone. Adult Safeguarding referral made, NOK notified.

3.2 Medication Incidents

There was **1** medication incident reported in this period.

Cranfield 2
26 February 2021
At about 1000hrs Patient 1 took what was remaining of Patient 2`s yoghurt containing his medication and ate it. Staff managed to take it off Patient 1. Staff unsure as to what amount of medication Patient 1 ingested as a result of this. Staff retrieved the little amount of yoghurt remaining which was hardly a spoonful. This was brought to the attention of the Nurse in Charge immediately. Patient 1's clinical observations were obtained and NAD. Patient 1 was examined by a medical officer. Ward Consultant contacted. ASM updated and agreed protection plan. Staff Nurse who was supervising not to complete medications until medication update completed. Email sent to nurse bank and forwarded onto agency. Staff performance form completed and medication error form completed. Patient 1's NOK was updated and discussed at monthly meeting 9 March 2021.

Learning
Patient 2's medication must be supervised by a registered Staff Nurse at all times until these are consumed fully. Information highlighted to all Cranfield 2 staff members. Staff member to avail of a medication updated. Following this, Staff Member is to be supervised until deemed competent in administrating medications. Divisional Nurse working alongside ward management to determine any patterns or trends in medication error incident.

3.3. Use of Rapid Tranquilisation during Physical Intervention.

= **0** uses of rapid tranquilisation reported during the period w/e 10 March 2021.

3.4 Use of Prone Restraint

=**0** use of prone restraint reported during the period w/e. 10 March 2021.

3.5 Use of Supine Hold

= **3** uses of supine hold reported during the period w/e 10 March 2021.

Use of supine restraint during physical intervention 25/02/21 - 03/03/21 (based on all incidents - approved/not approved 04/03/2021)	Date	Patient	Total
Cranfield 2	05/03/2021	TJ	3
Total			**3**

3.6 Incidents of Physical Intervention (PI)

There were 39 incidents involving the use physical intervention w/e 10 March 2021, equating to 63% of all incidents.

Use of Physical Intervention 25/02/21 - 03/03/21 (based on all incidents - approved/not approved 04/03/2021)	YES - Holding only	YES - Disengagement only	YES - Disengagement and Holding	Total All Incidents	Total Use of PI	% PI of Total Incidents	% Use of PI by Loc
Ardmore	9	0	0	15	9	15%	23%
Cranfield 1	3	2	2	11	7	11%	18%
Cranfield 2	2	2	5	13	9	15%	23%
Cranfield ICU	1	0	0	1	1	2%	2%
Erne	1	0	0	8	1	2%	2%
Sixmile Assessment	12	0	0	13	12	19%	32%
Cosy Corner Restaurant	0	0	0	1	0		
Total	28	4	7	62	39	63%	100%
% Use of PI (of Total Incidents = 62)	45%	6%	12%			62 = Total Incidents	39 = Total Physical Interventions

Highlighted locations with >3 incidents of use of P.I. in a location

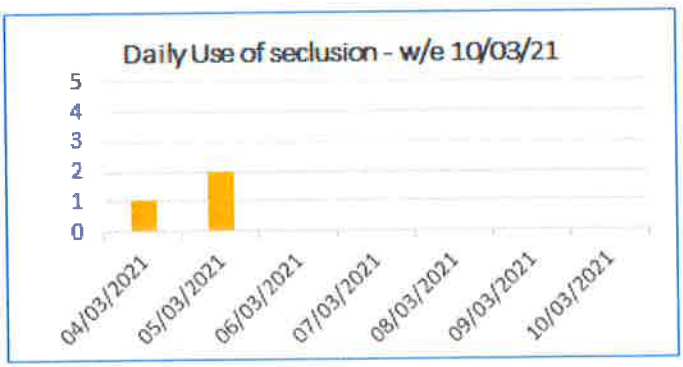
3.7 Seclusion and Voluntary Confinement

3.7.1 Seclusion

Seclusion was utilised on **3 occasions** during this period, in the management of **patient MB** in Sixmile Assessment and **patient TJ** in Cranfield 2:

- Shortest duration of seclusion – **40 minutes**
- Longest duration of seclusion – **5 hours 20 minutes**
- Earliest commencement of seclusion was **08:05am**
- Latest conclusion of seclusion was **02:20am**

Instances of Seclusion per Day of Week



Analysis by Patient of Seclusion

10/03/2021				
Patient ID	**Ward**	**Seclusion Area**	**Reason**	**No. of seclusions**
P77	CF 2	Patient's Bedroom	Aggression	1
P324	Sixmile A	Cranfield ICU Seclusion Room	Aggression	2

Number of Episodes

No episode ended later than **02:20am** and the earliest episode started at **08:05am**.

10/03/2021					
Time Seclusion Ended	7am - 12noon	12 noon - 5pm	5pm - 11 pm	11pm-7am	**Total**
No. of Seclusions	1	0	1	1	3

Length of Time of Seclusion

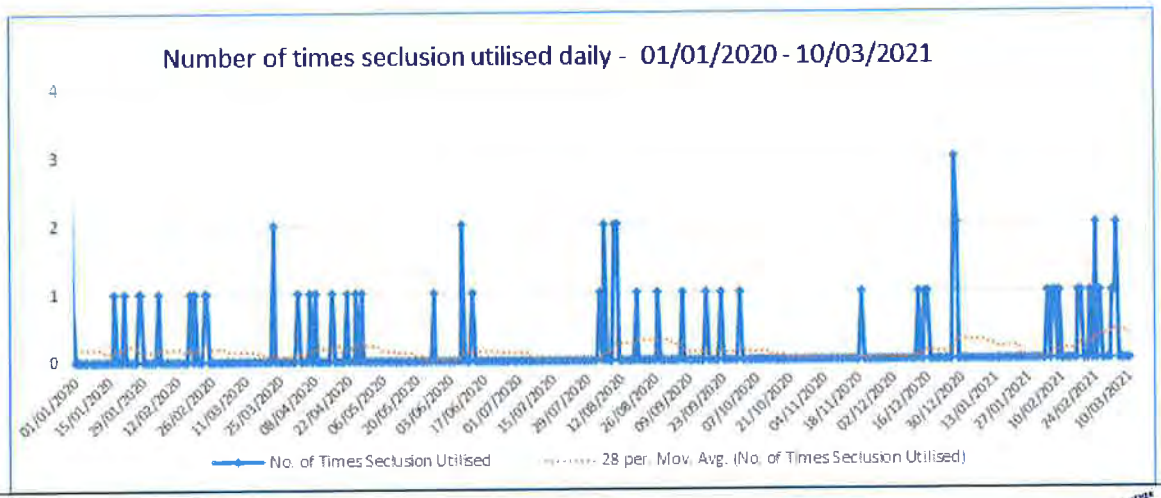
In terms of the length of time seclusion occurred, the table below details for each patient the length of time confinement lasted on each occasion by time band. The average time was **2 hours 17 minutes** for the period.

10/03/2021							
Pt. ID.	**<30mins**	**30 mins - 1 hr**	**1 - 2 Hrs**	**2 - 3 Hrs**	**3 - 4 Hrs**	**> 4 Hours**	**Total**
P77	0	0	0	0	0	1	1
P324	0	2	0	0	0	0	2
Total	0	2	0	0	0	1	3

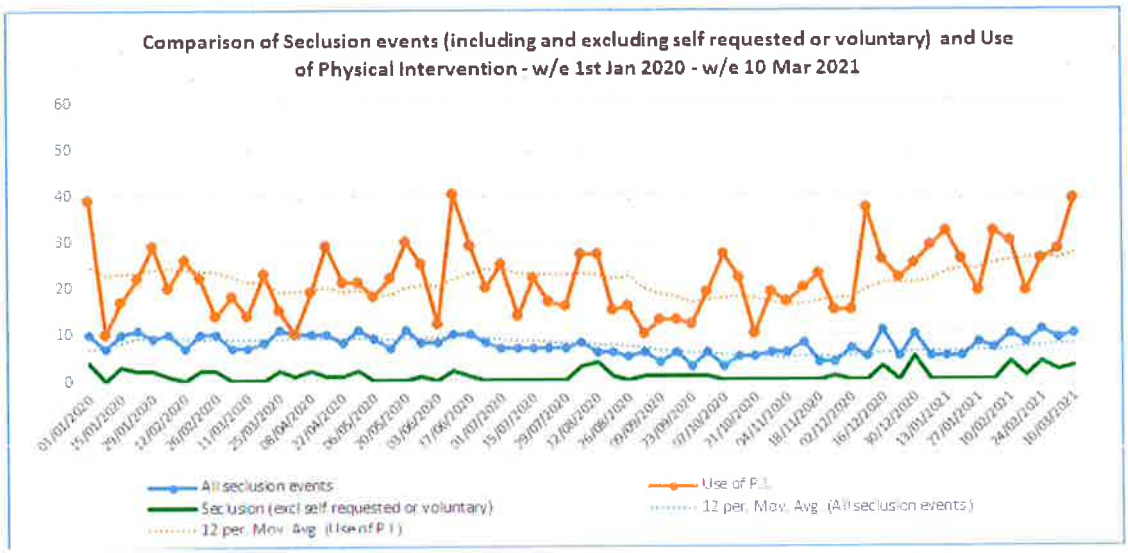
Observation Compliance

Seclusion Observation compliance - w/e 10/03/21				
Total seclusions	15 min obs	4 hr medical assess	1 hr medical assess	Issue
3	3 of 3	1 of 1	n/a	

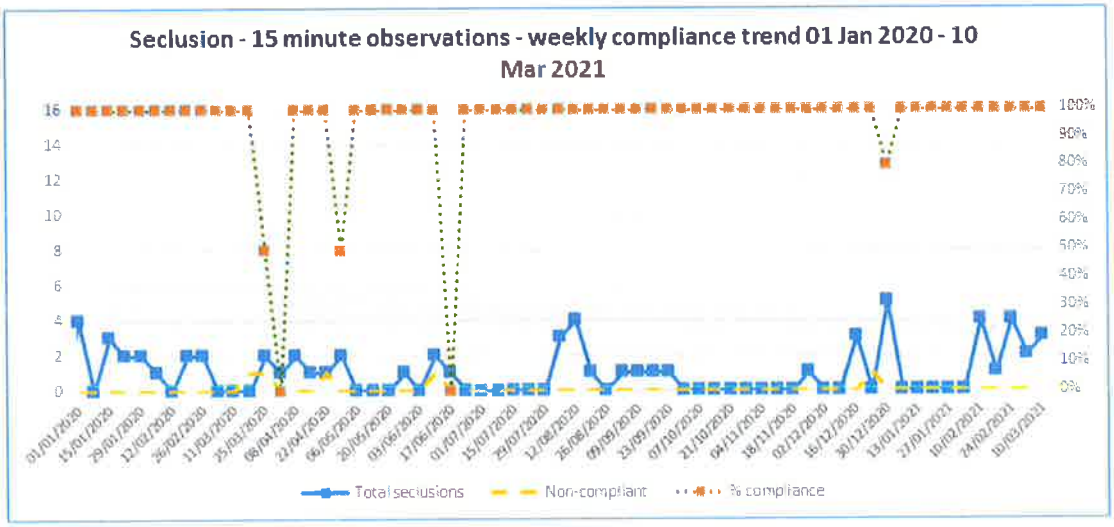
Daily Seclusion Trend (excludes voluntary confinement)



Comparison of Seclusion Events and Use of Physical Interventions

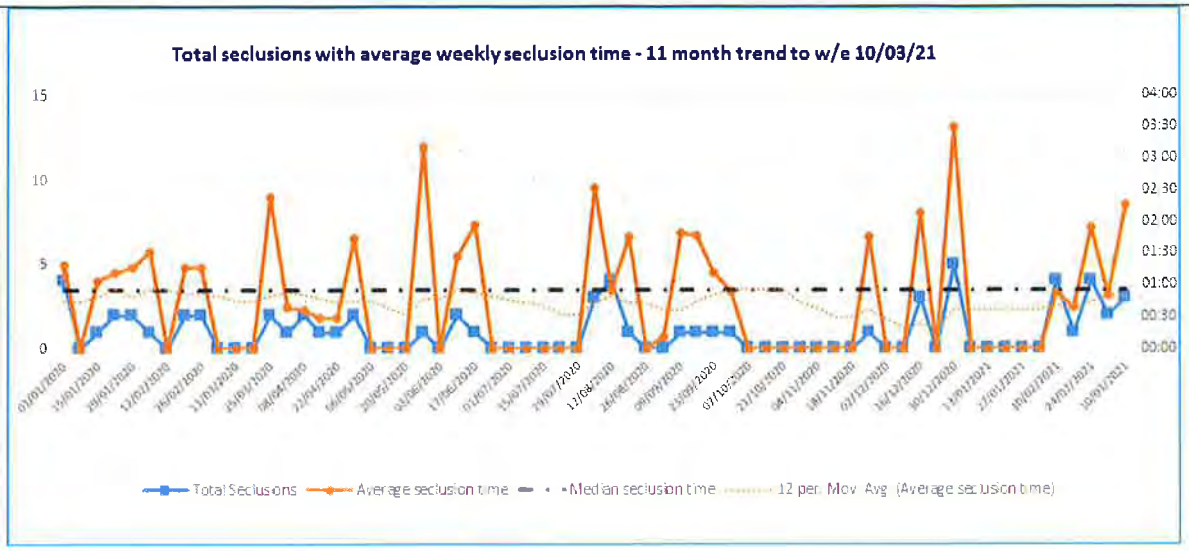


Seclusion Review Compliance



Seclusions with Average Weekly Seclusion Time

The graph below shows the trend of average weekly time in seclusion, per seclusion event :

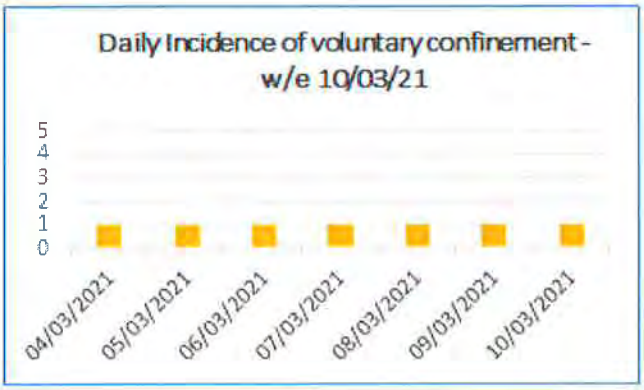


3.7.2 Voluntary Confinement

Voluntary Confinement was utilised on **7 occasions** in this period, in the management of **1 patient (MMcC)** in Sixmile Assessment:

- Shortest duration of voluntary confinement – **47 minutes**
- Longest duration of voluntary confinement – **2 hours 15 minutes**
- Earliest commencement of confinement was **09:45am**
- Latest conclusion of confinement was **12:32pm**

Instances of Voluntary Confinement per Day of Week



Analysis by Patient of Voluntary Confinement

10/03/2021				
Patient ID	**Ward**	**Confinement Area**	**Reason**	**No. of VC's**
P60	Sixmile A	Patients bedroom	Voluntary	7

Number of Episodes

No episode ended later than **12:32pm** and the earliest episode started at **09:45am**.

10/03/2021					
Time Vol Confinement Ended	7am - 12noon	12 noon - 5pm	5pm - 11 pm	11pm- 7am	**Total**
No. of VC's	3	4	0	0	7

Length of Time of Voluntary Confinement

In terms of the length of time voluntary confinement occurred, the table below details for each patient the length of time confinement lasted on each occasion by time band. The average time was **85 minutes** for the period.

10/03/2021							
Pt. ID.	**<30mins**	**30 mins - 1 hr**	**1 - 2 Hrs**	**2 - 3 Hrs**	**3 - 4 Hrs**	**>4 Hours**	**Total**
P60	0	1	5	1	0	0	7
Total	0	1	5	1	0	0	7

Observation Compliance

Voluntary confinement Observation compliance - w/e 10/03/2021				
Total Vol Confinement	15 min obs	4 hr medical assess	1 hr medical assess	Issue
7	7 of 7	n/a	n/a	

3.8 Complaints

There were no new complaints relating to Muckamore Abbey Hospital received during this period.

3.9. Risk Register Position

No change.

3.10. CCTV Viewing

(*References to Cx relate to camera numbers, e.g. C28)*

The QA Review Process was completed on 15 March 2021 for the viewing reports included below, and comments are included if applicable. There was one action from the previous week QA that needed to be brought forward to 8 March 2021. This investigation is ongoing in relation to a practice issue and will be reviewed again on 22 February 2021.

Erne 2 01/03/21 21:00-07:00	Four patients observed on the ward, 3 were up for a relatively short period of time and staff supported them with personal care and settling them back to their bedrooms (C3 6, 9 22:01 & C4 05:27). One patient remained on the ward all night and was monitored 1:1 by staff mainly in his dayspace (C13). Staff provided refreshments for the patient (C12 00:45, C13 04:29).

	Staff observed carrying out monitoring checks with patients throughout the shift. When patients were on the ward their personal needs were attended to promptly by staff.
Erne 1 **02/03/2021** **08.00 – 15.00**	A total of 5 patients observed during this time period. 1 patient on 1:1 observation staff visible in areas where patients were observed good engagement observed between staff and patients e.g. C42 patient engaging with patient in dayspace e.g. C30 12.45 nurse engaging with patient 1:1 basis Staff observed responding timely and appropriately to the needs of patient e.g. nurse gives patient his breakfast at dining table and sits with him e.g. two nurses assists patient put on his socks and shoes C30 12.45 e.g C37 10.18 nurse gives patient a patient a drink in dining room Nurse observed doing practical activity with patient C30 10.28 good engagement between staff and patient observed.
Cranfield 1 **02/03/21** **21:00-07:00**	Ward appeared busy and active throughout most of the night shift. 6 patients observed in early hours of shift in main dayspace, TV room and smoking room. Staff members observed engaging with patients in a positive manner, supporting patients with care needs and providing regular refreshments. Staff members were responsive to the needs of patients and provided prompt supervision and support when needed. 2 patients were occasionally upset (C25, 32, 34 21:38 & C28 23:47) and on each occasion received prompt care and assistance from staff members. One patient got up on quite a number of occasions and was promptly supervised and cared for by staff (C28 23:30). Staff visible on ward throughout shift and patients were checked on a regular basis. C32 22:41 – Patient appeared to hit out at staff member (camera view was hazy) and was assisted back into his bedroom by staff member who engaged low level arm holds. Staff group appeared to work very well as a team. They provided compassionate care to patients throughout this shift.
Erne 2 **03/03/2021** **07.00–09.00 V1** **09.00–15.00 V2**	**Viewer 1** 2 hours of shift observed. 3 patients observed – 1 patient spent most of the time in his room. 2nd patient supervised by staff as he moved from day space area 2 (C9) to day space 1 (C4) 3rd patient (C18) in room (back corridor C18) having drink/snack with staff members- all appeared to engaging well together. Good ratio of staff to patients. Patients general nursing care needs met, supervision provided and staff and patients engaging. **Viewer 2** Staff visible in areas on ward where patients were observed e.g. day space rooms, dining rooms, corridors, good engagement between staff and patients observed e.g. 09.04 C17 nurse interacting 1:1 basis with patient in corridor e.g. C18 13.51 nurse engaging with patients in sitting room. Staff observed to be responsive to patient needs. e.g. C4 10.56 nurse assists patient put on his coat c9 12.05 nurse observed assisting patient with eating his lunch. Ward Sister observed frequently on ward during this time period.
Moyola Daycare **04/03/21** **12:00-14:00**	4 patients present, engaged in artwork, a board game and baking. Each patient had staff working with them, encouraging patients to participate in the activities offered. Staff observed actively engaged with patients, verbally interacting with them in a positive and supportive manner.

Ardmore 1 **04/03/2021** **15.00 – 21.00**	Three patients observed during this time period. One lady in her room with ipad, another in separate room and last lady in day room. All patients were interacted well with – chatting, participating in the activity – viewed having a giggle and laugh which is always good to see. Really there was nothing beyond the routine expectation of what staff would be doing – good visibility and availability of staff throughout period of observation. Staff encouraging patients to eat and drink. Pleasant interactions of staff and patients.
Cranfield 2 **05/03/2021** **08.00 – 15.00**	Busy ward environment with plenty of movement of staff and patients observed. As always lots of activity and conversation around the nursing station. Staff participating well with patients – ensuring that they were accompanied in TV area – or other patient areas. One gentleman was restless and agitated. Staff member accompanied him around the ward – gently holding his hands. This appeared to diffuse the situation for a while – became restless again – different staff member accompanied patient but was out of view of camera's. De-escalation techniques did appear to work from what I could see. Ward Sister observed within ward chatting to patients and staff.
Sixmile Assessment **05/03/2021** **07.00 – 15.00**	C8 @07.49 staff remained observant of patients and engaged in conversation. However little evidence of therapeutic activities observed. Watching TV C10 @10.56. C10 @14.13 staff member keeping patient engaged in activity using cards and encouraging patient to participate. Staff talk and interact with warmth to the patients.
Sixmile Treatment **06/03/21** **21:00 – 07:00**	Ward appeared calm and quiet. Patients observed in main day space and garden area, chatting together and watching sport on TV. Patients observed in Life Skills room making refreshments. Staff members appeared active around the ward and appeared to verbally engage with patients. Staff members were visible in main ward area throughout the shift. Patients appeared to be checked on a regular basis. Several patients got up throughout night to have a smoke in the garden area under supervision of staff members. Good ratio of staff to patients.
Ardmore 2 **06/03/2021** **08.00 – 15.00**	Staff visible in patient public areas wards appeared quiet during this time period. Good engagement observed between staff and patients e.g. C26 09.50 nurse interacting on 1:1 basics with patient. Staff observed responding to patient needs e.g. C62 nurse brings meal to patient in wheelchair in appointment living room e.g. patient given drink by nurse in day space. C62 nurse observed doing activity with patient in apartment day space.
Sixmile Assessment **07/03/2021** **21.00 – 07.00**	Staff visible in day space, staff base and bedroom corridors. 3 patients observed during this period, 1 patient spent short time in day space went to bedroom at 21.30, the 2 remaining patients spent time watering t v, going down bedroom corridor and frequently going out to garden for cigarette. At 23.30 all patients appear to have gone to bed. Good engagement between staff and patients observed when patients awake. Staff observed responding to patients' needs. Staff give patient drink when in day space, 1 patient awake and on bedroom corridor at 02.29 from 02.30 – 04.15 patient frequently went between his bedroom and day space. Staff observed patient, interacted with patient on 1:1 and provided him with drink. Staff observed wearing masks at all times. Staff observed wiping down surfaces furniture and door handles. Staff observed regularly checking bedroom corridors and recording information on charts at staff base.

Cranfield 2 **07/03/21** **15:00-21:00**	Six patients observed. Good ratio of staff to patients. Quite a busy shift as patients moving about the ward. Patients appeared to enjoy talking to staff – particularly around the nurse's station area. Staff engaging with patients. 2 patients playing a board game for a brief period of time. Patients general and nursing care needs met. Patients requiring supervision with meals were provided for. 1 patient requiring constant supervision in apartment area – staff appeared responsive to his needs.
Erne 2 **07/03/21** **15:00-21:00**	Ward appeared generally quiet and calm. 4 patients observed in own living spaces; 3 of who received 1:1 supervision and monitoring. Patients appeared to listen to music and mostly remained in their own dayspace and surrounding corridors. One patient in dayspace, 4 appeared to be accompanied by a staff member off ward for a walk. Patients appeared to receive appropriate supervision and staff appeared responsive to their care needs. Good ratio of staff to patients.
Cranfield 1 **08/03/21** **07:00-15:00**	Busy active ward, particularly in the morning. Day care staff observed on ward working with one patient using verbal and non-verbal skills to engage patient in using jigsaws (C24 09:42). Patient in his bedroom required attention from staff, accompanied to TV room with head protection on. He was monitored by staff and was encouraged to engage in some artwork (C36 + 37 09:34 & C27 10:15). Both daycare and activity staff present on ward (C22 11:16). Staff member also engaged a patient by playing football in the garden (C57 10:28). At least 3 patients went out of the ward (possibly with daycare staff). Staff both alert and responsive to all patients' physical and emotional care needs. Staff observed giving hand and head massages to a number of patients (C21 10:15, C28 11:36). One patient was unsettled during the morning period and staff monitored and supported him, intervening when necessary to protect both the individual and other patients (C27 09:25). Staff provided regular refreshments/food, supported and assisted some patients at mealtimes (C22 12:11). One patient was unsettled during the morning period and required close monitoring from a number of staff, including the Charge Nurse at times. On one occasion the patient was in the TV room and went towards and subsequently started to struggle with a staff member. The wider staff team promptly responded and physically intervened to restrain the patient. Due to the camera angle there was no clear view of this. Staff appeared to use their verbal skills to calm the patient and after a relatively short period, were able to withdraw from the patient with the nurse in charge continuing to verbally interact with the patient in a calm manner. Staff withdrew from the room, patient was sitting on the floor and he removed/pushed down his lower clothing. Staff left the room closing the door. My impression was this was to allow the patient time and offer him some privacy. Throughout the shift, the staff team presented as working effectively together to provide empathetic care for the patients. There was good evidence of use of both verbal and non-verbal communication with the patients and an active interest in their welfare. The daycare and activity staff also had a positive input to the mood and wellbeing of the patients they engaged with.
Erne 1 **09/03/21** **07:00-15:00**	Ward appeared quiet and calm. 4 patients observed in own living spaces. Patients living in dayspace 1, 3 and Apt 1 received 1:1 supervision and monitoring. Patient in dayspace 2 spent periods sitting alone watching TV or in the garden area smoking. While basic care needs were met, there appeared to be intermittent verbal engagement between staff and patients. Staff members appeared to provide appropriate supervision of patients, food and refreshments were also provided. Good ratio of staff to patients.

Sixmile Treatment 09/03/21 15:00-21:00	Ward appeared busy and interactive. Patients observed in main dayspace, corridors and garden area, socially engaging with each other and staff members. Patients observed in Life Skills room making refreshments. Staff members appeared active around the ward and appeared to verbally engage with patients. Patients observed making hot drinks, watching TV and using iPhones. 2 patients appeared to return to ward from daycare with completed artwork, which was admired by staff and other patients. Staff members appeared responsive to the needs of patients and were observed interacting with patients on a 1:1 and group basis. Ward sister also engaged with patients frequently as did health care assistants, who were observed cooking alongside patients (C34 15:44) and making other refreshments. Interactions observed were positive and patients appeared to benefit from them and enjoy them. Good atmosphere on ward. Positive interactions observed between patients and staff members.
Daycare 10/03/2021 10.00 – 12.00	Good staff engagement between staff and patients, 2 patients doing activity at table with patient on wheelchair C27 11.05 staff observed interacting with patient at reception. Staff observing patients when in group rooms and supportive to patients who needed assistance. Very good staff ratio to patients.
Ardmore 1 10/03/21 21:00-07:00	Very quiet night shift. 3 patients observed, 2 of whom went to their bedrooms early on. Patient in room (C19) engaged in own activities, iPad and jigsaw. Staff member called in on this patient on a regular basis for a chat and a coffee (C19 22:00 & 21:14). Interactions between patients and staff members were positive. Staff members appeared responsive to care needs of patients. Staff were visible throughout ward during night shift. Patients appeared to be checked on a regular basis. Good ratio of staff to patients.

(4) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback

4.1. Safety Brief
Ongoing on a daily basis on each ward, using agreed template.

4.2 Weekly Live Governance meetings ongoing
Chaired by one of the senior management team involving all wards.

4.3 Monthly ward Clinical Improvement Groups
These have all recommenced and discussions have begun with the QI Manager in relation to datasets to support the groups.

4.4 Patient Experience Feedback
This work has recommenced with a number of lead professionals identified to deliver this project. This includes a questionnaire, which has been developed by the Divisional Social Worker which was circulated w/c 25 January 2021. We have received 19 responses to date and a further flyer has been circulated to encourage completion with an extended date for completion. Analysis is currently under way by the PPI team.

TILI group are supporting "A Safe and Happy" project, working with the Patient Council (which is a group of patients from across the various wards) to identify what makes them feel safe and happy on the Muckamore site and within their ward and how can we improve their experience.

The Service Manager has commenced a series of Service Manager and patient one-to-one meetings. This is a direct response from some patients' suggestions that this would be a beneficial exercise. The overarching theme of the individual discussions is entitled ***"How are we doing? What could we do better?"***

Work has commenced with the "Real Time Patient Feedback" team as to how best to capture the patient experience on the Muckamore site. The management team are reviewing the questions and will link this with TILI to create and easy read guide.

(5) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.

5.1. Staff Counsellor Sessions – 12 Sessions offered per week.
This service continues to offer support to staff.

5.2 Information from MAH Senior Nursing Team
The Senior Nursing Team continues to maintain a focus on workforce recruitment and retention. In addition the Senior nursing Team has been contributing to Resettlement discussions focussing on how to make the process even more patient focussed.

The detail below is provide to the DOH on a weekly basis

8 March 2021

Ward		Trial Leave	Total	Nursing Plan	BHSCT Staff	Agency	Other Backfill	Variance	% achieved against plan
CR1	9	0	9	37.15	10.06	12.05	11.21	-3.83	**89.70**
CR2	8	0	8	34.72	14.01	14.07	6.23	-0.41	**98.82**
Ardmore	6	1	7	31.17	19.07	7.76	5.02	0.68	**102.17**
Sixmile	12	1	13	34.16	9.55	21.3	3.22	-0.09	**99.74**
Erne	8	1	9	46.67	13.57	24.78	8.11	-0.21	**99.56**
Total	**43**	**3**	**46**	**183.87**	**66.26**	**79.96**	**33.79**	**-3.86**	**97.90**

(6) Emerging issues

Covid-19 Update (at time of report submission)

There are currently no outbreaks on site; and isolated Covid-19 related staff absence is continuing to be managed.

OPTIGENE/LAMP testing (saliva testing)

Routine weekly saliva testing of all staff on the MAH site has been agreed and commenced .This is being carried out in conjunction with Queens University.

Trade Unions

Trade Unions are highlighting concerns regarding the increasing number of physical assaults on staff and support to staff and discussion with the management team are ongoing. Discussions continue with Union representatives with a focus on staff engagement strategies. A Trust wide 'Violence Against Staff' working group has been established with associated action plan

A local working group has been established with activities commencing in Sixmile Ward - this is being supported by TILI and includes the Trust Equality Officer.

Review of PBS

The Service Manager has commenced a review of PBS in the hospital using the National Competencies Framework to assess how well embedded it is and how could this be improved.

Back to the Floor

The Service Manager has completed a shift in Cranfield One, working as a Healthcare Support Assistant - this is the fourth area in which a shift has been worked, with the exercise to be repeated across other ward areas. This has provided the Service Manager with an enhanced insight into staff induction, team working and how compassionate care is delivered. Staff have also taken the opportunity in a less formal environment to share their views on what's works well and what challenges they face on a day to day basis.

Medical Staffing

Medical Staffing on the Muckamore site has been reduced due to absence through sickness. In particular the Sixmile Ward is affected. As a result a review of staffing across the LD service is taking place and a contingency plan has been put in place with assistance from Adult Forensic Mental Health Services. Substantive medical cover will resume in Sixmile Ward week commencing 15 March 2021.

(7) Media and communications – FOIs, media enquiries etc.

There are no media enquiries outstanding.

1 FOI – partially outstanding. This was a 10 part FOI, including requests for minutes from a number of meetings and financial payments made by the Trust to an advocacy organisation. The requester has been asked for clarification regarding the minutes of meetings and the advocacy organisation has been advised of the detail in the response which may be provided. This is in line with ICO advice, re Section 43: 'Commercial Interests - a breakdown of sums paid would be exempt but a total for payments since 2016 would not. We are obliged to tell the organisation what has been requested and our planned response.'

One complaint received through family questionnaires - the ASM has been trying unsuccessfully to date to contact the complainant.

Three whistleblowing communications have been received – all via the RQIA , 2 through ASG duty desk and 1 other directly to management in relation to staff concerns regarding agency staff and workload.

(8) Financial Governance

No new issues to report.

(9) Next Steps/forward look – wider strategy update

Communication with Families
A range of activities continue

- Carer Involvement and PPI Lead for Learning Disability services (adults) – the advertisement will close on 18 March 2021.
- Muckamore Carer's Forum – these meetings continue.
- A Muckamore Carer Commitment Statement and a Carer's Agreement have been developed – these will set out how often family members want to be contacted, who they want to have as a key contact person, how they want to be communicated with, and what meetings they want to be invited to.
- Community Zoom Sessions – the purpose of these sessions was to reinvigorate the forum and reconnect with community families updating on Trust developments, and having Q&As. There were 6 sessions held, across a range of times and various days. 65 families, carers and services users took part in these sessions asking a range of questions covering issues such as Covid-19, restart of services, planning for the future and human rights approach. Initial feedback and response was generally positive and a few areas have been identified as next steps alongside the recommencement of the LD Community Forum. It was agreed that these zoom sessions will be rerun in a further 2-3 months.
- Three meetings have now taken place with representatives from Families Involved NI to develop Terms of Reference for a review of advocacy services. A review of advocacy services is a recommendation of the Leadership and Governance Review of Muckamore Abbey Hospital, 2012-2017. It is proposed to finalise the Terms of Reference by end March 2021.
- The Service Manager has also held a meeting with the Family Advocacy representatives as another means of improving communication between the Hospital and Carers.

(10) Other Issues requiring escalation for advice and senior decision making

None.

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.

MAHI - STM - 302 - 510
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.

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 LEGAL ADVICE PRIVILEGE [redacted]. 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 LEGAL ADVICE PRIVILEGE [redacted] In a departure from previous advice, DLS suggested LEGAL ADVICE PRIVILEGE [redacted]. The advice read as follows;

LEGAL ADVICE PRIVILEGE [redacted]

LEGAL ADVICE PRIVILEGE

[redacted]

LEGAL ADVICE PRIVILEGE

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** **377***	**3** **0**

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**

<table>
<tr><td>9.6.e</td><td>Number of Guardianships renewed during the reporting period (Article 23)</td><td>3</td></tr>
<tr><td>9.6.f</td><td>Number of Guardianships accepted by a nominated other person</td><td>0</td></tr>
<tr><td>9.6.g</td><td>Number of MHR hearings in respect of people in Guardianship
<table>
<tr><th>Requested by</th><th>Number MHRT requested</th><th>MHRT Hearings completed</th><th>Number of patients re-graded > 6weeks before hearing</th><th>Number of patients re-graded < 6 weeks before hearing</th><th>Number unexpectedly discharged by MRHT</th></tr>
<tr><td>Trust</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Patient</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Nearest Relative</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Other</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table></td><td></td></tr>
<tr><td>9.6.h</td><td>Total number of Discharges from Guardianship during the reporting period (Article 24)
<table>
<tr><td>Discharges as a result of an agreed multi-disciplinary care plan</td><td>1</td></tr>
<tr><td>Lapsed</td><td>1</td></tr>
<tr><td>Discharged by MHRT</td><td></td></tr>
<tr><td>Discharged by Nearest Relative</td><td></td></tr>
<tr><td>Total</td><td>2</td></tr>
</table></td><td></td></tr>
<tr><td></td><td>Comment on any trends or issues in respect of Guardianship</td><td></td></tr>
</table>

<table>
<tr><th colspan="3">Approved Social Worker (ASW) Register</th></tr>
<tr><td>9.7</td><td>Number of newly appointed Approved Social Workers during period</td><td>1</td></tr>
<tr><td>9.7.a</td><td>Number of Approved Social Workers removed during period</td><td>0</td></tr>
<tr><td>9.7.b</td><td>Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)</td><td>6</td></tr>
</table>

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.

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)*	

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	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
	Lack of access to Principal Practitioners for Family support and Safeguarding, Therapeutic LAC and lack of access to Family centres, contact services.		
	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
	xxviii. 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*	

Belfast Health and Social Care Trust

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BELFAST HEALTH & SOCIAL CARE TRUST

REGIONAL REPORTING TEMPLATE FOR DELEGATED STATUTORY FUNCTIONS

For Year end 31 March 2019

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) during the reporting period I April 2018-31 March 2019. 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 themes underpin the delivery of statutory services:

- Promoting and supporting the service user's engagement as fully as possible in the planning for and reviewing of arrangements for their care.
- Empowering service users to exercise as much autonomy as possible in their choices and decision-making about their life circumstances.
- Supporting parents/carers/and other key individuals in their caring roles through the provision of flexible, individualised supports and access to support networks.
- Working in partnership with voluntary, community, independent and statutory organisations to build resilience and capacity across communities to develop safe, inclusive, supportive localities.
- Provision of high quality, evidence informed services, which deliver positive outcomes for individuals, families and communities.
- Proportionate exercise of statutory authority to secure the safety and welfare of children and adults who are vulnerable to abuse/exploitation/ neglect/marginalisation.
- A continuous focus on improvement, quality and safety in the delivery of services.
- The recruitment, retention and development of a skilled and committed workforce through a culture of continuous learning and the pursuit of excellence.
- An ongoing focus on promoting the wellbeing of the workforce through their accessibility to bespoke supports and services and their engagement in and contribution to the development of corporate, Directorate and service planning processes.

The Scheme for Delegation provides the overarching assurance framework for the discharge of statutory social care functions. It outlines:

- The powers and duties delegated to the Trust.
- The principles and values underpinning 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 relation to the discharge of statutory functions.

The Scheme for Delegation requires the Trust to complete an annual report addressing how it has discharged those statutory functions pertaining to social care services delivery.

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 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 Divisional professional and line management structures to the Executive Director of Social Work and onto the Trust Board.

This Report has been prepared using the 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 Divisions by the Executive Director of Social Work.

SECTION 3: Individual 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 prescribed by the HSCB relating to statutory social care service delivery.

Appendices:

- BHSCT Assessed Year in Employment (Social Workers) Annual Overview Report ***(Data 8)***
- BHSCT Social Services Workforce Learning and Development Accountability Report ***(Data 11)***
- The Belfast Local Adult Safeguarding Panel ***(LASP)*** Report 2018/19
- Data Return 10 ***(Corporate parenting report)***
- Restriction of liberty report ***(ROL)*** 2018/19
- The Regional Emergency Social Work ***(RESW)*** Service Delegated Statutory Functions Report 2018/19

I would like to take this opportunity to recognise the role and contributions of Trust staff across all Directorates in the discharge of statutory functions, which is complex, challenging, highly skilled and rewarding work.

I would wish to express my appreciation, in particular, of the professionalism and dedication of the Trust's social care workforce in this regard.

Carol Diffin
Executive Director of Social Work
Director of Childrens Community Services/ Director
May 2019

2. Executive Summary

GENERAL

Executive Director of Social Work:
The Role of Executive Director of Social Work was undertaken by Mr John Growcott from 1st April 2018 – 31st August 2018 and by Mrs Carol Diffin from 1st September 2018.

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 returns provide detailed commentaries on the levels of compliance, areas of difficulty, achievements 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 a continuous drive for innovation 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 engaged in regular formal and informal contacts with NISCC.

As at 31 March 2019, the Trust had achieved full compliance with NISCC registration across all sectors of its social care staff.

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

The Trust's social care workforce is located within two Directorates, Adult Social and Primary Care and Childrens Community Services. During the reporting period, mirroring the situation in all of the Trust's operational Directorates, both Directorates have continued to embed their new collective leadership model.

Each of the operational Directorates have established Divisions mirroring the former service delivery units and have appointed/are in the process of appointing Senior Leadership Teams, which will have accountability for Divisional service delivery performance and governance arrangements. The new post of Divisional Social Worker has assumed the responsibilities of the Associate Directors of Social Work with enhanced responsibilities and accountabilities as a member of their Division Senior Leadership Team for the range of corporate governance and service delivery functions.

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

- The provision of operational management and 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

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

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

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 Services, 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 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:

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

The Trust has in place a Social Care Committee. The Committee Chair is Ms Anne O'Reilly, Non-Executive Director. The other two members of the Committee are also Non-Executive Directors Ms Miriam Karp and Dr Martin Bradley. 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 prior to their presentation to Trust Board.

The Social Care Steering Group (membership of which is made up of the Divisional Social Workers) 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 role and function of this group will be reviewed during 2019/2020 to take account of the new roles of the Divisional Social Workers.

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 Divisions/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.

With the establishment of the Divisional structures, the Terms of Reference of each of these committees will be reviewed with a focus on the strengthening of their respective governance functions.

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

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 in the context of the following issues: the demands, levels and complexity of need across all settings; enhanced public expectations and levels of scrutiny; the impact of the phased re-structuring of regional commissioning and reporting structures; the overarching financial and resources context; and ongoing difficulties with the regional recruitment pathway.

The Trust has prioritised:

- Safe, effective, compassionate and qualitative service delivery.
- The embedding of a culture and underpinning values, which promote excellence, innovation and continuous learning as, reflected in its investment in its workforce's knowledge and skills base.
- Partnerships with local communities and voluntary, private and statutory agencies.
- Community capacity building.
- Co-production, partnership and purposeful engagement with service users, carers and communities to improve service delivery.

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

DEPRIVATION OF LIBERTY:

Consistent with NISCC standards and RQIA advice, the Trust has worked in collaboration with the Directorate of Legal Services in attempts to resolve complex cases involving service users deemed to lack capacity to consent or object to decisions on their welfare, including considerations of Best Interests and deprivation of liberty safeguards. .

During the reporting period, a number of Services initiated proceedings to secure Declaratory Judgements.

REVISED REGIONAL ADULT SAFEGUARDING POLICY:

The implementation of the-above Regional Policy has significantly enhanced the scope and service delivery responsibilities of the Trust in relation to adult safeguarding. While the Trust is supportive of the thrust and aims of the Policy, the lack of the necessary resources to support implementation has been a major concern for the Trust. In particular, the Trust would highlight its view of the need for a significant investment in professional adult social work service delivery capacity in light of the prescribed responsibilities of Band 7 social work staff.

LARGE SCALE ADULT SAFEGUARDING INVESTIGATION

This has been a very challenging year in light of the high profile, large-scale adult safeguarding investigation in Muckamore Abbey Hospital, which has had a detrimental impact on our service users and carers and staff. A number of staff have been suspended and a number of staff are off on sick leave and staffing levels are reviewed daily. A police investigation is ongoing alongside a Trust investigation. An SAI was undertaken, chaired by an independent person, Margaret Flynn, the findings of which, alongside RQIA Inspection findings have provided the focus for work undertaken by the Trust in relation adult safeguarding, service user and carer involvement, and planning for delayed discharges.

ASW DAYTIME ROTA

The Mental Health Service Report provides a detailed commentary on the current challenges the Trust is encountering in the delivery of the ASW Daytime Rota.

These include:

- The diminution over a number of years of the complement of designated social work posts in the Mental Health Service Area.
- The demands on available social work capacity within the Service of the rise in adult safeguarding activity, particularly in relation to Band 7 staff.
- The pressing need to develop a robust workforce planning approach to social work requirements in Adult Services (including ASWs).
- The resourcing of and supports for staff engaged in the Regional ASW Training Programme.
- The changing role of the ASW under the Mental Capacity Act (2016) once partially implemented in Oct 2019

PLACEMENT CAPACITY IN CHILDRENS SERVICES

Pressures with regard to placement availability across residential and fostering services in the context of the volume and complexity of needs of the Trust's looked after children population. The Trust has had to reconfigure the use of one of its residential homes to provide care for 8-12 year olds who cannot be cared for within the fostering due to their complex and challenging profiles.

WORKFORCE

The challenges of recruiting and retaining a social work and social care workforce are highlighted in each service areas report particularly at band 5/6 and band 7 level. An urgent regional approach to workforce is required to address the high levels of vacancies, the high turnover of staff and high levels of sickness absence to try to stabilise and retain the workforce. At a Trust level there is a pressing need to develop a robust Trust-wide workforce planning approach to social work and social care to secure the necessary workforce volume, skills and knowledge base to meet service delivery demands across, frontline children's services, adult safeguarding, ASW functions and domiciliary provision.

The investment in the professionalisation of adult social care service delivery and the parallel development of the status and skills base of domiciliary and residential care staff are of particular significance in light of the strategic emphasis on care at home and the growing awareness of the importance of the social dimension to health and wellbeing.

There is a continuing need to address domiciliary care workforce recruitment and retention in light of the ongoing difficulties in providers' ability to deliver the necessary range of packages to meet assessed needs.

While improving relatively, the ongoing difficulties in delivering the Trust's Daytime ASW Rota re-inforce the risks associated with genericism in multi-

disciplinary service delivery models and the importance of strong uni-professional structures and workforce pathways.

Within children's services, there have been significant challenges over the past year with both recruiting and retaining experienced staff in fieldwork and residential settings. High levels of vacancies and high turnover of staff, with lack of available newly qualified staff have led to increased pressures on existing staff within the system, growing caseload sizes, and rising numbers of unallocated cases. Towards the end of the reporting period, the Trust was unable to provide a named allocated social worker to a number of looked after children. The challenges in relation to workforce was added to the Trusts Corporate Risk Register. It is hoped that this situation will improve during the first quarter of the next reporting period following a successful recruitment campaign.

DOMICILLARY CARE

The lack of capacity within Domiciliary Care is a significant concern for the Trust. Despite remedial measures out in place demand continues to outstrip capacity for this service. Care providers continue to report ongoing challenges to recruit and sustain the workforce.

ASSURANCE PROCESSES IN RELATION TO CARE HOMES

The publication of the Commissioner of Older People's 'Home Truths' Report has significantly challenged the Trust. The implementation of the actions from recommendations has led to an increased level of monitoring and review activity in relation to a number of Homes within the Trust's area, requiring significant focus and resources. The Trust continues to strengthen its assurance processes in relation to Care Homes, through the ongoing implementation of the Care Review and Support Team and Commissioned Services Governance team.

CO-PRODUCTION

Co-production is the template, which informs engagement with/of service users and carers in the development and delivery of safe, high quality and effective services. It embraces purposeful engagement, partnership, listening with respect and transparency.

COMMUNITY INFORMATION SYSTEM (PARIS)

Ongoing challenges have continued in relation to the implementation of the PARIS system within children's social care services and the optimising of PARIS functionality in Adult Services.

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 review arrangements in relation to assurance of discharge of statutory functions.

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 listed on the Trust's Principal Risks Register:

There is a risk that the Trust cannot quality assure and provide accurate reporting returns for social work and social care activity relating to the discharge of Statutory Functions.

This risk relates to the recommendation of an Internal Audit into the collation of information returns to the Commissioner in relation to the discharge of statutory functions.

The following provides an update on the Trust's actions to address the Audit recommendation:

The regional nature of PARIS implementation across children's social care services and the current volume of mandatory reporting requirements necessitate the regional standardisation of business and related data inputting processes.

The ongoing development of software and its subsequent testing had presented substantial logistical and resource demands and had resulted in a series of delays and re-scheduling of implementation.

The Childrens Services Directorate continued with its phased implementation of PARIS across its service base with only adoption and fostering services still to be migrated. This has been a significant challenge for staff at a time of increasing pressures arising from staff vacancies, and increasingly complex caseloads.

INFORMATION

Investment in the development of data management and analytics capacity and skills across social work and social care services continues to be a priority. The potential benefits of digitalisation within strong information governance structures to rationalise non-value bureaucracy, to facilitate transformational

working practices and to enhance outputs and outcomes for service users are substantial.

The implementation of PARIS across social care services has been a complex and challenging process. Significant difficulties in PARIS reporting functionality in Adult Services in particular have been significant. Implementation of the system in Childrens Services is progressing in the context of the implementation of the Signs of Safety model and further criticism of the efficacy of the UNOCINI Pathway model. Work is being led by the DOH in relation to reviewing the UNOCINI Framework and the Trust is participating in this review.

The Trust has secured a Trust-wide PARIS support-infrastructure to optimise the system's potential and to build information management capacity across both adults and children's services to meet Divisional performance, governance and improvement reporting and development requirements.

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.

- RQIA independent reviews and inspections of regulated facilities. RQIA and the Mental Health Review Tribunal's statutory duties to scrutinise the Trust's discharge of its statutory functions under the Mental Health (NI) Order 1986.
- External and internal performance management and accountability arrangements facilitate scrutiny of the Trust's performance in respect of the provision of statutory services.
- The Trust's Serious Adverse Incidents 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 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 (CMRs) 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 ongoing challenges to all Services during the reporting period. The position going forward remains unclear at this point. The volume and complexity of demand for services is unrelenting. The following are recurrent priorities across all service settings: workforce pressures particularly in relation to domiciliary care, Band 5/6 social workers, Band 7 capacity and ASW

provision; the need for significant investment in residential care models to meet specialist needs; investment in the development of governance structures to support Divisional organisational arrangements; and investment in digital systems, data management and analytics.

The impact on service users and carers of both the 'Home Truths' report and the investigation into adult safeguarding at Muckamore Abbey Hospital cannot be underestimated although significant learning has emerged from both for the Trust.

Despite these challenges, significant achievements have been noted across the services:

- The implementation of Signs of Safety in children's services is underway and presents an opportunity to embed strengths-based, evidence informed and outcomes focussed interventions with children in need and their families.
- The development of a specialist children's home for 8-12 year olds
- The continued growth of the GEM scheme providing better outcomes for looked after children in foster care
- Successful partnerships eg Belfast Area Outcomes group, Employability Scheme for Looked After Children, collaboration with PSNI and IFA for young people in residential care
- Development of a trauma informed approach in children's services with increased support for frontline staff and their managers
- The continued work with ARBD service users
- Engagement of service users and carers in the delivery of training, peer support and direction with regard to SDS
- Development of a Memorandum of Understanding between Day Services and RESWS to support ASWs
- Continued embedding of Think Family across Mental Health and Children's Services
- Belfast Recovery College recognised for its excellence of ethos and education
- Completion of its first Positive Action Employability Programme recruiting adults with learning disabilities into vacant permanent posts within Patient and Client Support Services
- Appointment of a Carer Consultant within Learning Disability Services
- The development of the role of Principal Social Worker within the Hospital social work service.
- The embedding of the CREST brining an additional level of assurance to people living in care homes
- Mobile technology project involving 3 community social work teams and hospital social work and Intermediate care teams
- Bedding down of a Quality Improvement Approach across the services

The Trust's Collective Leadership structures has continued to develop and when fully implemented will afford opportunities to strengthen the profile of community services, improve the management of internal and external interfaces and promote purposeful partnerships with and meaningful engagement of service users and carers.

The Trust is committed to the maintenance of vulnerable adults and children with complex health and social care needs and enhanced levels of risk to remain where possible in their own communities. This will require a sustained level of investment in community infrastructure and capacity. Strong partnerships with statutory, voluntary, community and private sector organisations and organisational structures, which embrace service user and care engagement, remain key to optimising available resources and outcomes.

Signature

Carol Diffin
Executive Director of Social Work/Director of Children's Community Services
May 2019

3. General Narrative

Programme of Care / Directorate:- Older People Services

3.1	**Named Officer responsible for professional Social Work**
	Ms Tracy Reid is the Divisional Social Worker for Older People's Services. The Divisional Social Worker has responsibility for operational and 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 Divisional Social Worker is responsible for: • The provision of operational management and 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 Divisional Social Worker 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**
	Assessed Year in Employment The service area has supported 18 staff through their AYE year during this reporting period. These staff have been supported to integrate theory to practice. The service area has been vigilant in their governance arrangements for newly qualified staff in terms of caseload monitoring and supervision arrangements, as well as carrying out quality assurance checks. There continues to be an ongoing Trust AYE peer support group which has been critical to the development of these new staff. **Supervision Arrangements** Supervisors are required to report monthly on instances where staff have not received supervision and identify actions in place to address this. The Principal Social Worker monitors exception returns and trends are analysed to identify areas of concern. An audit to assure the quality of supervision is scheduled for May 2019.

	Within this reporting period the service area has continually struggled with recruitment into key Band 7 middle management roles and this has impacted at times upon the service areas compliance with the timescales related to supervision. A number of Band 7 managers have completed the Regional Supervision 3 day training course. **Caseload weighting** The service area welcomes the proposed development of caseload weighting tools, as presented in March 2019 by the Department of Health. The service area is developing a Quality Improvement project in two Community Social Work Teams to test caseload weighting tools, as set out in the regional document. **Consolidation of Operational and Professional Structure** Within this reporting year the Trust has consolidated a Collective Leadership model of accountability. The Divisional Social Worker for Older People's Services provides professional and operational leadership for professional Social Work across Older People and Physical and Sensory Disability Services. Within Hospital and Community Social Work operational and professional responsibilities are merged in a single Social Work and professional line of accountability from the Social Worker to the Divisional Social Worker. During this reporting period a Band 7 Social Care Governance Lead has been developed in the service area. This is a new role and the post-holder works closely with the Principal Social Worker to strengthen governance arrangements and processes, and to identify learning and training opportunities across Older People's Community Social 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).**
	Social Work and Social Care Review As highlighted in previous reports, the service area has been undergoing significant change in recent years. This has included the standing down of Care Management and the transfer of the management of people in long term care to a discrete Care Review and Support Team (CREST). This team has made significant inroads in improving the lived experience of people in long term care. The impact of this team will be further discussed throughout this report. Historically, one of the key issues that has challenged the service area is ensuring that each person accessing the service has an initial professional assessment. This has been particularly challenging due to the high level of Social Care staff undertaking the keyworker role in Community Social Work. During this reporting period the service area has undertaken a significant piece of work, in introducing new referral criteria and a screening system for the prioritisation of referrals, which includes redirecting low level referrals to more appropriate pathways, such as the Connected Community Hubs. Since September 2018, all new referrals accepted to the Community Social Work service, receive a professional assessment and have a Social Worker allocated to them, as well as having access to professional review. This has required a significant change in the role of the Band 4 Social Care Co-ordinator. This grade of staff have moved away from completing initial screenings and undertaking independent case management to a monitoring and support role in which they are paired with a professional Social Worker.

	These new systems have resulted in a better understanding of the demands upon Community Social Work and have given sight to the unmet need within the service area. The service area has developed new allocation timeframes, in order to manage these demands and has had to establish waiting lists to prioritise and manage referrals. However, it is abundantly clear that cases known to Community Social Work are increasing in their complexity and require a statutory response. This is being acutely felt amongst Social Work staff as case loads are increasing and waiting lists for key areas such as Carers Assessments have steadily grown. Community Teams continue to have a high level of Social Care staff, approximately 50 % of staff in Community Social Work Teams do not hold a professional Social Work qualification. In order to develop a sustainable model of Social Work that is fit for purpose in the future, the service area is of the view, that they need to prioritise a review of the role and purpose of Social Care Co-ordinators in Community Social Work Teams. The longer term aim, will be to reduce the number of Social Care Co-ordinators and increase the number of Social Workers. This is necessary to ensure that the service area is able to meet its statutory obligations and deliver a high quality, safe and effective professional service. During this forthcoming report period, as Social Co-ordinators leave, they will be replaced by Social Workers but this will create a cost pressure. **Audits** The Service Area took part in a Trust Wide BSO Audit regarding Compliance with the Care Management Circular. The Trust received Limited Assurance and has developed an action plan to address the areas for improvement. As an outworking of this, the service area intends to review its care planning documentation, the information provided to service users, how consent is recorded and to better utilise Trust IT systems, so that the process of Care Management is better evidenced. The service area had already identified these as areas for improvement, through its own audit systems and a number of actions have commenced. The CREST team has undertaken an audit of family involvement in Care Reviews for people living in permanent long term care and who are known to them. The audit identified that 97% of families had been invited to the Care Review and 76% of families attended. This reflects significant improvement and addresses a long standing issue of concern for the service area, as previous audits have indicated very low attendance by families at reviews. The service area has also audited compliance with Staff Development Reviews. Moving from a low position of compliance, the service area has noted significant improvement, with further improvement anticipated as newly stabilised management structures bed down. The service area is currently undertaking an audit of compliance in relation to the management and review of one to one supervision for people with complex care needs.
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 Registration

The Service Area contributes to the Trust's assurance arrangements underpinning compliance with NISCC registration in respect of the social care workforce.

Regulation Quality and Improvement Authority
Overall the service area continues to achieve 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.

Enhancing Quality Assurance for Commissioned Services
The service area has strengthened its arrangements for assuring the quality of domiciliary care, through the implementation of a new Commissioning Services Governance Structure. This is led by an 8B Service Manager role who has oversight of the quality of commissioned care across the independent nursing home, residential home and domiciliary care sectors. Two service wide assurance groups with representation from safeguarding, CREST, commissioned services, complaints and community social work, continue to monitor complaints, patterns and trends in the Independent Care Home and Domiciliary Care Sectors.

Contracts with Independent Domiciliary and Care Home Providers
The service area has established systems that enables them to meet at least annually with all Independent Domiciliary Care and Care Home Providers to ensure that contractual obligations are met and to assure the Trust that the commissioned service is delivering quality, safe and compassionate care, as well as providing value for money.

Guardianship
The service area continues to support one person through the framework of Guardianship. The Trust has recently been challenged through the Mental Health Review Tribunal in relation to the use of Guardianship in this context. It was the outcome of the Tribunal that the Trust's use of Guardianship was appropriate.

Significant Court Judgements
The Trust has continued the Declaratory Order process in a small number of cases. During this reporting period:

- The service area has renewed one High Court Declaratory Order, relating to a person who did not wish to move from hospital to a care home. The initial Order required them to transition to the care home from hospital. The person remains in a care home and the Court remains satisfied that the Trust are meeting their statutory and Human Rights obligations. In another case the Trust sought and achieved a Declaratory Order regarding the unreasonable delayed discharge of a Trust resident in a Hospital outside of the Trust area. This also involved a significant piece of work in setting out the Trusts position regarding Continuing Health Care, which was to the satisfaction of Court.

- A Declaratory Order has been sought and achieved for a person who was subject to a significant family dispute regarding where they should reside. Staff worked closely with all family members and the hearing was not disputed. This will be due for renewal early next year.

-The Service Area has two cases pending. One involves the protection of an individual from harassment and interference by 3rd party. Another involving a capacity decision, as

current decision making, renders the person at high risk of death if not cared for in a suitable setting.

These cases highlight the complexity of issues that Social Work in Older People's services involves. These High Court processes have placed a significant pressure on our front line staff and the Service Area welcomes any clarity which the implementation of Capacity Legislation will bring to this area of consent and capacity.

Home Truths Report
The Service Area has been significantly challenged during this reporting period, in relation to the Commissioner of Older People's Home Truths Report into Care in Dunmurry Manor. We continue to be involved in processes associated with the report, including actions from recommendations made by the Commissioner, the ongoing independent review by CPEA Ltd, the adult safeguarding audit commissioned by the Department of Health and the ongoing PSNI investigation. In response to the report, the Service Area contacted families of all people residing in Care Homes by letter. The purpose of this was to reiterate the Trust's commitment to safe and high quality care and support, for people in Care Homes. They were also encouraged to raise any concerns in relation to the care of their relative, which they may have had. This resulted in a spike of reported concerns and the Trust increased its enhanced monitoring of some 12 homes during the late summer and autumn period. The impact of this on normal business cannot be over stated, in terms of the monitoring of the homes and the additional review activity required by keyworkers. The vast majority of these homes have been de-escalated during this time, but this has required significant focus and resources.

The Service Area continues to strengthen it assurance processes in relation to Care Homes, through the ongoing implementation of the Care Review and Support Team and Commissioned Services Governance Team.

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 areas/corporate governance arrangements.

Accidents and Incidents
These are monitored and reported on at the Service Area's governance meetings.

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, DAPO's, ABE trained interviewers and Approved Social Workers. The service area has developed a SDS reflective practice group to support the implementation of SDS. The CREST team undertake focused reflective practice sessions on a regular basis. The service area has also developed reflective practice fora for Social Workers within the first year of their service in Older People's Services.

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) Domiciliary Service Provision The Service Area continues to be challenged in the demand and supply of domiciliary care. The service area has continued to be significantly impacted by the lack of availability in domiciliary care, particularly in South and East Belfast. On the 31st March 2019 there were 645 unsecured care packages equating to 4023 hours. These ongoing supply issues are affecting the availability of sustainable and flexible Domiciliary Care to support people to live safely in their own homes and is delaying people in hospital. There is also reduced flow through intermediate care services such as reablement, community rehabilitation and bed based provision, due to the lack of available packages for those people exiting these services, who require long term support. This is resulting in multiple people having to await packages of care in a bed based facility. This creates significant risk and distress for service users, many of whom are in the last 1000	1)The Service Area intends to modernise the Statutory Homecare Service through the recruitment of additional home care staff and the introduction of a revised job description that may result in the newly recruited posts and some/all existing posts being re-banded. The aim of modernisation is to: • Increase the capacity of the Home Care service to deliver an additional 1500 hours per week • To reduce the current waiting list for domiciliary care • To free up transition services by providing domiciliary care at the point of exit from those services • To reduce spend in the use of transition bed-based services. • To reduce the number of joint packages currently in place. • To ensure the Trust home care service provides care to a wider and more complex base of home care clients and bed down a reablement focus for those service users	This is recorded as a principal risk on the Corporate Risk Register.

	days of their life, as well creating additional pressure on family carers.	with lower levels of need, to support flow through the homecare service In order to achieve this, the service area will require additional resource to re-band new and current Homecare staff from a Band 2 to Band 3. This will enable the Trust to compete with other Trusts and other service areas, in the recruitment of staff. 2) The service area in response to the high demand for Domiciliary Care, particularly in South and East Belfast, continues to provide a rapid response domiciliary care pilot to commission additional domiciliary hours from a number of providers at an enhanced rate. The objective is to improve hospital discharge and intermediate care flow, and to reduce unmet need. Additional localities were added in October 2018. This service has been targeted to support hospital discharges, but there have been challenges in maintaining flow through these pilot services. In reality, these pilots have not brought additional capacity to the domiciliary care sector, rather it has ensured that some independent sector provision has been reconfigured, and targeted alongside the Trust's RAPS service to support discharge from hospital.	

		3) The service area has continued to utilise interim care beds as a way of supporting hospital discharges. The service area has brought a small additional number of beds into its portfolio this year, with the current provision being 120 available beds, with a 94% utilisation at the end January 2019. 4) The service area has implemented twice weekly collective telephone conference calls to prioritise high risk cases and has developed an information system to capture daily activity/demand & flow. 5) Service users are being encouraged to avail of Self Directed Support in the form of Direct Payments in lieu of Dom Care service. 6) The Trust is fully engaged in regional work focusing on the remodelling of domiciliary care and is leading on a Concept Testing with the CLARE project, looking at earlier intervention. The service area has been successful in appointing an 8a Project Lead.	
	2) Instability of the Independent Domiciliary Care Sector The challenges in accessing new and timely Domiciliary Care from the Independent sector has been articulated.	The service area in recent months has been approached by Colin Care Domiciliary Provider and advised that they could no longer continue	This is recorded on the service area risk register.

	However, during this reporting period the service area has become increasingly concerned about the sustainability of current provision. The service area has been approached by a number of providers, in relation to unsustainability of service in specific areas of the city. Providers are citing challenges in recruiting staff, primarily due to being unable to compete with other service industries in relation to offering competitive rates of pay and attractive terms and conditions. On these occasions the service area has had to offer enhanced financial rates to maintain services in hard to recruit areas. The service area has done this with assurance that this enhancement is passed directly onto staff. **3) Instability in the Independent Care Home Sector** The service area has also noted fragility within the Independent Care Home Sector during this reporting period. The Trust has been approached by a small number of Care Home providers who are opting to change provision from General or EMI Nursing to Residential EMI. Providers are citing challenges in recruiting staff, primarily Nurses and being unable to compete with other services in relation to offering	to operate. The provider were unable to secure an alternative buyer. In the absence of an alternative option and to sustain provision, the Trust is having to TUPE the workforce into the Trust Homecare Service. The Trust is currently engaging with Colin Care staff, Trade Unions and HR to manage this transition. This is a very complex, costly and challenging process and the Trust is concerned that it may find itself in this position again, given the instability across the market. The service area in recent weeks been approached by Cedars Residential Care Home and advised that they could no longer continue to operate. They have registered their intention to close the Home by the end of June 19. The proprietor has advised that a reduction in referrals to this category of care and the regional rate has made the business model unsustainable. This is directly affecting 18 Belfast Trust residents and the service area is	This is recorded on the service area risk register.

	competitive rates of pay and attractive terms and conditions, as well as having to pay high agency rates. They are reporting decreased financial viability in their business models.	currently working to find suitable alternative care arrangements. Availability in this category of care is limited and reflects the changing model of Residential Care, with fewer people requiring this category of care.	
	4) **Challenges In Delivering Statutory EMI Residential Provision** The Trust has been undertaking a review of its current model of Residential EMI homes using an Appreciative Inquiry approach. Engagement has taken place with all key stakeholders and this review has now been concluded. A number of key outcomes and recommendations have been identified and these will be presented to the Director of Adult Social and Primary Care, with a view to consultation on the proposed future model.	A number of recommendations have been made from this review, including a proposal to close at least one home. The service area wishes to ensure that any resource arising from future modelling is redirected to improve the quality of the remaining EMI Residential Homes and to develop improved care and support for people living with dementia in the community. The review recommends the development of enhanced respite and enhanced dementia home care provision. The service area is exploring options to locate Dementia Specialists in the Trust Homecare service to support the development of high quality and responsive home care for people with dementia.	A risk assessment has been shared with RQIA and Executive team and is regularly reviewed.

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.**
	This reporting period has been very challenging for Older People's Social Work, in relation to the stability of the management and professional structure across the Community Social Work Service. This has been particularly felt at the Team Leader level, with 50% of teams having no permanent manager in place for over 18 months. The service area has struggled to recruit to this post, with staff perceiving equivalent Senior Practitioners grades and non-managerial posts more attractive. Despite multiple attempts to recruit Team Leaders both internally and externally, the service area has been unable to do so. These challenges have been further exacerbated, as the Service Manager Post for OPS Social Work was vacant for 75% of the last reporting period. The service area can advise that the Team Leader role has now been stood down and replaced with an 8a Locality Manager role. This combines operational team management with enhanced strategic and budgetary responsibilities. The service area is pleased to report that as of 1 April 2019, all posts within the management and professional structure, for Community Social Work have been recruited to. This is a significant achievement in securing the future of the Community Social Work and giving a platform to enable the service to establish and maintain performance standards, as well as innovating in response to increasing complexities. A recruitment day for Social Workers in June 2018 provided a significant waiting list, although HRPTS and Shared Services still present challenges in the management and timeliness of filling vacancies. We have worked to reduce the levels of agency cover and temporary contracts with a focus on permanent recruitment, where possible. There are no vacancy controls in place.
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 Home Charging** The Trust operates in accordance with the DHSSPS April 2018/19. Charging 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**
	This is reported in a separate DSF report for Hospital Social Work

3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	A Human Rights approach is central to Social Work practice in Older People's Services. The service area has implemented a Best Interest approach to supporting people without mental capacity when developing care plans. This issue is discussed further in Section 3.12. The service area works closely with independent advocacy services. During this reporting period, Social Workers have on a number of cases, accessed this support for service users. The service area has a Human Rights focused process in place for the management of one to one supervision in care settings, which considers any Deprivation of Liberty issues and ensures the least restrictive option is achieved. Human Rights training is available to staff on an on-going basis and is provided by the Social Work and Social Care Learning and Development Team. The Service Area is planning a Social Work Forum in June 2019 with a particular focus on Human Rights as it relates to people in Residential or Nursing Home settings. This is in response to recommendations made in the Home Truths report. Social Workers in the Palliative Care and Oncology Team are leading in the delivery of Human Rights at End of Life training. This will compliment our mandatory Human Rights training. We are continuing to work to ensure that all of our staff are articulate and competent in the integration of Human Rights to core and routine decision making.

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?
	Deprivation of Liberty Issues The service area continues to be concerned regarding the management and support of people, who lack the mental capacity to make their own decisions, particularly where that decision results in a deprivation of their liberty. We welcome the anticipated implementation of the Mental Capacity Act NI 2016 and the guidance that it will bring to this complex area. **Challenges in Domiciliary Care Provision and the impact on Article 8 rights.** As has been previously stated, the service area has very significant challenges in relation to the supply of domiciliary care. In able to maintain flow through the system the service area has had to increase its interim bed base. This has resulted in a significant number of people having to await their package of care in an	Staff continue to fully engage in use of the Best Interests Toolkit which has provided a useful guide to safe decision making in the absence of legislation. The service area has implemented a number of controls which has included: • No service user incurs a cost for a placement whilst awaiting their package of care • Social Workers work to identify interim beds that are closest to the persons home, where possible, so as to support a person's right to family life	The Service Area is considering the arrangements which will need to be in place regarding the implementation of the Mental Capacity Act. The Service Area is planning a Social Work Forum specifically to consider the Human Rights of people in Residential or Nursing Home settings in June 2019 The Trust continues to highlight the challenges in the supply of Domiciliary Care at a regional level. The Trust is fully committed to working with the HSCB in developing new models of sustainable Domiciliary Care

	intermediate facility, when it was their wish to be in their own home. The Trust are acutely aware of the engagement of rights when a person is unable to immediately return to their own home following a hospital admission. This can have a particular impact on family life and all the rights inherent in Article 8	• All people in these circumstances have Social Work and AHP support whilst awaiting their package of care The Trust has in place systems to monitor length of stays for those awaiting a package of care.	

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	CREST The CREST has become embedded during this reporting period and is bringing an additional level of assurance to people living in care homes. The team are building positive and effective working relationships with care home providers, residents and families. There is a Crest practitioner aligned to every home in Northern Ireland with a Belfast Trust resident. A clear escalation protocol has been developed and implemented to support homes of concern. The incidence of family involvement in care planning and review has significantly increased. Furthermore, CREST is achieving much improved compliance with annual reviews, as set out in the circular. The service area has engaged with the University of Kent to explore the utilisation of an Social Care Outcomes ASCOT model in care homes, which has not yet been developed in Northern Ireland. This validated tool has the potential to bring a fresh methodology to assuring the quality care experienced in care homes. CREST staff have recently attended a two day training programme facilitated by the University of Kent and are currently developing pilots, to test this model in the care home setting. **Opening of Cullingtree Meadow** The service area has welcomed its 5th Supported Housing facility, which opened in West Belfast in June 2018 in conjunction with Clanmill Housing. This is a significant investment in this part of the city and builds on an already successful model of supported housing, which has been implemented in other parts of the city. This new service is working to develop meaningful social integration and a dementia friendly community, to ensure tenants are connected to their local community. **QI project** Further to the Patient Client Council report in June 2018, which focused on Complaints in Care Homes, the service area led a Quality Improvement project with an aim to increase the confidence of residents and families to make complaints in care homes. Staff from the service area have worked in partnership with the Patient Client Council, a care home provider, residents and families to develop improved information and clearer processes to support the timely reporting of complaints. These have been developed in co-production with residents and families, and learning is to be shared across the care home sector. **Mobile Technology Project** 3 Community Social Work Teams along with Hospital Social Work and Intermediate Care staff have been included in the roll out of mobile devices to 225 staff. The aim of the project is to support staff to be more mobile across their working environment and to support improved assessment and recording. The service area has been

	working with developers, in the development of a Paris App to support improved connectivity. Staff have been very positive regarding the benefit of the devices and there is ongoing evaluation.
3.16	**SUMMARY**
	This reporting period has been a very challenging year for Older People's Social Work, particularly in sustaining service delivery during significant staffing and operational challenges. The service area continues to challenge itself, to strengthen the identity and impact of Social Work and Social Care and to identify improved and more innovative ways of working. Priorities for the Service Area in this forthcoming year will focus on - strengthening assurances in relation to the quality, safety and sustainability of independent sector care homes and domicilary care - to continue to embed and refine the newly developed CREST team, with a focus on identifying and implementing best practice - remodelling the Trust's Homecare service to maximise and increase capacity, and to unlock current blocks in flow through hospital and intermediate care - remodelling the Trust's EMI Residential provision in line with the recommendations set out in the EMI review - reviewing professional standards and strengthening governance arrangements for Community Social Work - reviewing the current skills mix in Community Social Work to enable the service to respond to statutory duties in a more timely way - creating new learning and development opportunities for staff and managers in Community Social Work - to develop a better understanding of the needs of carers and to develop better ways of identifying and supporting carers

Programme of Care / Directorate:- Hospital Social Work
3 Teams - Royal Victoria Hospital
2 Teams- Belfast City Hospital
1 Team - Northern Ireland Cancer Centre
1 Team - Musgrave Park Hospital
1 Team - Meadowlands Intermediate Care Wards
1 Team - Mater Hospital
1 Team - Weekend Hospital Social Work

3.1	**Named Officer responsible for professional Social Work**
	Ms Tracy Reid, Divisional Social Worker for Older People's Services. The Divisional Social Worker has responsibility for operational and 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 Divisional Social Worker is responsible for: • The provision of operational management and 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 Divisional Social Worker 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**
	AYE The service area has 6 AYE staff, during this reporting period. Assurance can be given that AYE social workers have a supervised caseload and receive the mandatory training and supports required, through day-to-day case management, direct supervision and the opportunity to be involved in the AYE peer support group. **Supervision arrangements**

	The service area continues to audit performance around professional supervision compliance and where appropriate develops action plans to address issues and provide assurances around meeting the requirements of the revised policy. 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. Within this reporting period, the service area has struggled to sustain a consistent Band 7 Senior Social Work group due to prolonged periods of sickness absence. This has meant that the service has operated with 22-44% of this middle management group for approximately half of the reporting period. This has impacted at times upon the service areas compliance with the timescales related to supervision. This has been acknowledged and recorded within the service area's risk register. **Consolidation of Professional Structure** Within this reporting year the Trust has consolidated a Collective Leadership model of accountability. The Divisional Social Worker for Older People's Services provides professional and operational leadership for professional Social Work across Older People and Physical and Sensory Disability Services. Within Hospital and Community Social Work operational and professional responsibilities are merged in a single Social Work and professional line of accountability from the Social Worker to the Divisional Social Worker. The post of Principal Social Worker for Hospital Social Work has been developed during this reporting period. This is a new role and it is envisaged that the post-holder will work closely with the Divisional Social Worker to oversee and implement governance arrangements and processes, and to identify learning and training opportunities within the hospital setting. The Principal Social worker will also work with their counterpart in the community setting to help identify interface issues and opportunities for Quality Improvement Projects, training and development. **Recruitment and retention of staff** This reporting period has been challenging in terms of the stability of Social Work staffing across Hospital Social Work. The service has been particularly reliant on Band 6 temporary and agency staff social workers across the acute hospital settings at Royal Victoria, Belfast City and Mater hospitals. Furthermore, there has been significant sickness absence within the Band 7 Senior Social Worker group, with the Assistant Service Manager and Principal Social Worker for Hospital Social Work providing day to day cover and support to the remaining Senior Social Workers and directly to Social Work staff. This has significantly impacted on the delivery of core management and assurance processes. This will be further discussed in 3.5.
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).**
	Review of Procedures The Trust is currently undertaking a review of the procedures and standards concerning the admission, care and treatment of children and young people on adult inpatient wards.

	Accidents and Incidents These are monitored and reported on at the Service Area's governance meetings and at local level through DATIX Analysis. **Processes for staff exiting service area** The service area has introduced a system by which all agency, temporary and permanent staff leaving employment with Hospital Social Work completes an exit interview with the Principal Social Worker. This reflective exercise provides an opportunity for the service area to explore positive working experiences and to identify learning opportunities from the staff member's time in post. This initiative has been well received by staff and is helpful in shaping service developments. **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 and Approved Social Workers. Unfortunately, due to the high level of sickness absence amongst Senior Social Workers, the service area has not been able to take forward planned Reflective Practice Fora. However, it intends to do so in this forthcoming year.
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 contributes to the Trust's assurance arrangements underpinning compliance with NISCC registration in respect of the social care workforce. **RQIA** A recent RQIA Review of Outpatients Services on hospital sites has highlighted the issue of awareness of Adult Safeguarding across multi-disciplinary teams in these departments. An action plan has been put in place to provide these departments with Safeguarding posters and information for display in waiting areas and awareness raising training for staff is currently being rolled out.

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
	Staff Recruitment And Retention Issues Within this reporting period, the service area has struggled to sustain a consistent Band 7 Senior Social Work team due to prolonged periods of sickness absence. This has meant that the service has operated with 22-44% of this middle management group for approximately half of the reporting period. Furthermore, there has been a high turnover of Social Work staff within Hospital Social Work and many staff report the challenges of working in this highly pressurised and relentless setting. During 75% of this reporting period the service was also without a Service Manager.	In relation to the management structure supporting Hospital Social Work, the service area is able to report some progress. The service area has now appointed a Social Work Service Manager who is supported by an Assistant Service Manager for Hospital Social Work and Principal Social Worker. Furthermore, a number of Senior Social Workers will be returning to post in the immediate future. However, there remains 2 Band 7 vacancies in the Royal Victoria Hospital site. The service area has attempted to recruit to both of these posts during the period, through HSC Recruit and Internal Trawls, but has been unable to do so. These posts are currently being advertised on HSC Recruit. The challenges in maintaining a stable management structure, significantly impacts upon the performance and delivery of the Social Work Teams. The service area is working, to fill all vacancies and temporarily filled posts at Band 6 level on a permanent basis. Some 11 Hospital Social Work posts are expected to filled over the forthcoming weeks.	This is recorded on the service area risk register

	Professional Standards Hospital Social Work operates within a highly contested setting, in which there are many continuous demands and scrutiny in relation to the meeting of hospital discharge targets and ongoing periods of hospital escalation. It is of concern for the service area, that the opportunity to review and develop professional standards can be deprioritised in this context. Due to pressures within this environment, for both practitioners and managers in terms of attendance at ward rounds, discharge meetings and continuous reporting in these matters, that there is limited opportunity for staff training and development, reflective practice opportunities, staff meetings and to update practices. The service area has particularly struggled to manage historical case file closures and freeing up time for staff to attend training opportunities.	The service area has appointed a Principal Social Worker for Hospital Social Work to take forward these issues. Whilst the post holder has been consumed in operational issues during this reporting period, they will be taking forward professional governance issues in the forthcoming period. This will include a review of training needs for Hospital Social Workers and will consider the development of a training programme for Senior Social Workers in a first line management role. They will undertake a review of professional standards for Social Work, including the implementation of new closure process for Social Work cases. Significant investment in training and revisiting of core assessment skills and professional standards is required.	No
	Maintaining Hospital Flow The pressures within hospitals to maintain flow during and beyond the winter period remain significant. Whilst the service area performs better in relation to complex discharge targets and through the weekend Hospital Social Work service, this remains challenging. The service area has	The service area, in response to the high demand for Domiciliary Care particularly in South and East Belfast, continues to provide a rapid response domiciliary care pilot to commission additional domiciliary hours from a number of providers at an enhanced rate. The objective was to improve hospital discharge	The implications of shortages in Domiciliary Care is recorded on the Principal Risk Register for the Trust.

	continued to be significantly impacted by the lack of availability of domiciliary care, particularly in South and East Belfast. During this reporting period a daily average of 600 people are awaiting a domiciliary care package across various settings, including their own home, intermediate care beds, reablement and hospital. This equates to 3500 - 4000 hours of unmet domiciliary care hours, with most people awaiting these hours in their own home or a community setting. These ongoing supply issues are affecting the availability of sustainable and flexible Domiciliary Care to support hospital discharges. There is also reduced flow through intermediate care services such as reablement, community rehabilitation and bed based provision, due to the lack of available packages for those people exiting these services, who require long term support. This has impacted upon the ability of the service area to provide primary pathways from the hospital setting. The out workings of this is a continued dependency on interim beds as an alternative to an appropriate pathway, with multiple people having to await packages of care in a bed based facility.	flow and reduce unmet need. Additional localities were added in October 2018. This service has been targeted to support hospital discharges, but there have been challenges in maintaining flow through these pilot services. In reality, these pilots have not brought additional capacity to the domiciliary care sector, rather it has ensured that some independent sector provision has been reconfigured, and targeted alongside the Trust's RAPS service to support discharge from hospital. The service area has continued to utilise interim care beds as a way of supporting hospital discharges. The service area has commissioned a small number of additional beds this year, with the current provision being 120 available beds, with a 94% utilisation at the end January 2019. The Division are currently undertaking a review into bed based rehabilitation services, particularly considering the role and purpose of Hospital Bed Based provision.	

	Meeting The Needs Of People With Complex Social Care Needs There are a small number of service users who are delayed unnecessarily in hospital due to the lack of availability of specialist pathways and provisions to support safe, timely and effective discharge. This is particularly evident in relation to people presenting with a delirium in the acute setting. Whilst these service users would benefit from a specialist recovery pathway, in a bed based setting or in their own home, this is not available to them. These service users are often declined admissions to care homes, as their behaviours can be perceived as too complex for general settings. However, they are excluded from current EMI provision as they do not have a dementia diagnosis. This has led to protracted and unnecessary delays in an unsuitable acute setting or an increase in the likelihood that that they will need to discharge with a one to one supervision provision. There are also challenges in assessing and managing the needs of people with dementia within the acute setting. This can lead to challenges in care planning for	The service area is currently implementing a delirium policy, which will require staff to proactively identify people with delirium to ensure improved recognition, diagnosis and management. 2 Delirium Lead Band 7 posts have been developed for the acute setting and their role will be to imbed this new policy through a Quality Improvement approach. The Trust is also part of the regional discussions with RQIA and the HSCB, who are considering current provisions for those people who require the support of EMI provision for a period of time, but who do not have a dementia diagnosis. The service area has also appointed 2 Band 8a Service Improvement Leads for Dementia. The aim of these posts is to lead key work streams to implement the outcomes from the regional audit on the needs of people with dementia in the acute setting. One of these Leads is to be based in the acute setting and will lead on key improvement projects in this setting. The Trust has also appointed a small team of Dementia Companions, who will work as part of the nursing team at ward level in the acute setting, to provide meaningful engagement and support to people with dementia.	No

	discharge, as these service users can at times present with distressed and complex behaviours at the ward level as they react to the environment around them. This can create a skewed view of their long term needs and this group of people are at high risk of discharging to institutional settings and/ or being identified as having needs that require one to one provision.	The service area is currently undertaking a review of Trust EMI provision and this is detailed further in the Older People's Service DSF report. The outcomes and recommendations from this review require further consultation, but does include recommendations to enhance respite and homecare provision, to support people with dementia in the community	

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.**

Recruitment and Retention

As previously detailed in section 3.5 - 3.7 there have been significant recruitment and absence issues in Hospital Social Work during this reporting period.

On 31St March 2019 there were no vacancy controls in place across the service area.

Social Care Workforce Review

As reported in previous years it has always been the intention of the service area to reform and modernise the role of the Hospital Social Workers across acute and specialist settings. The aim of the service area is to significantly change how the hospital social work service is planned, designed and delivered. The vision for the service area is to develop a more community facing and integrated model that will ensure continuity of care across interfaces and promote a recovery model to improve health outcomes and quality of life experiences for adults.

The establishment of Community Complex and Discharge Hubs within acute settings has made significant progress in the centralisation of information and coordination of community support services. These Hubs operate as a gateway to community pathways. Strongly interfacing with the community, the vision for the service is that people will be discharged from hospital within the standard timeframes, as soon as they are declared medically fit, through effective assessment and identification of an appropriate pathway, working to the principle of home first. Whilst the implementation of the Hubs has brought added benefit in relation to the centralisation of information and coordination of community support services, there continues to be a need for the further integration of Hospital Social Work into these community facing Hubs. To this end, work is currently being undertaken, to develop a more integrated model of service delivery, by bringing together the current Hospital Social Work service for unscheduled and acute care with the current Community Discharge and Support Hub, under an operational and professional collective leadership model. This further developed model will be renamed the Community Discharge and Social Work Hub and will provide a single point of referral for all Hospital Social Work and Intermediate Care pathways. It is intended that this next stage of implementation will commence on the Royal Victoria Hospital site, with a plan to implement it on other acute hospital sites. The aim of this improvement is to ensure that service user is triaged to the most appropriate professional and pathway for support and discharge planning at the earliest opportunity.

A key aspect of the vision for Hospital Social Work is to improve flow and the service user experience, through a hospital outreach model

	and community in reach for those people already known to community services. This will promote continuity of social care and enable older adults to move from hospital to home in a more timely and seemless manner. Time limited support with social workers reviewing and assessing service users in their own home utilising reablement, rehabilitation and making connections with community support networks would undoubtedly improve the experience of service users. Due to the pressures within the management structure for Hospital Social Work, the service area has not been able to progress this aspect of the model, to the extent that it would intend. However, this continues to be the vision for the service area and it anticipated that this should be progressed in the forthcoming year. **7 day working** The service area has also been working on the normalisation of a 7 day working model across Hospital Social Work. The service area currently provides a 7 day Social Work model across all acute sites in the Belfast as well as a Discharge Co-ordinator to the Ulster Hospital across 7 days. The current model for weekend provision is supported by a bank of Social Work staff, but the service area intends to deliver the weekend service as part of normal service provision working across 7 days. The service area is at an advanced stage in its move to 7 day working and is engaged in an HR change process with staff and trade unions.
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 Home Charging** The Trust operates in accordance with the DHSSPS April 2018/19. Charging 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**
	Role of Hospital Social Work Hospital Social Work in the Belfast Health and Social Care Trust uniquely operates across a broad range of acute and specialist hospitals. These include areas, such as the Regional Acquired Brain Injury Unit, Northern Ireland Cancer Centre, Older People's Services, Unscheduled and Acute Care, Regional Spinal Injury Unit, Cystic Fibrosis and HIV. In recent years, Hospital Social Work has been broadly understood in the context of maintaining flow, with a focus upon functional assessment of need to progress patient discharge. This has impacted upon the professional role of social work in hospital and shifted practice to being service led rather that service user led. The complexity of bureaucratic pathways and processes necessary to maintain flow information and coding has consumed professional time. This has resulted in a significant change in the Social Work role.

The service area is currently working to develop a better understanding of what type of Social Work service and intervention is required, specific to the setting in which it operates. The model of Social Work required to support the necessary and timely discharges through unscheduled care is different to the model of social work required to support a young adult receiving intensive chemotherapy for an acute leukaemia or a person with a new life changing and traumatic brain injury. Each of these settings are equally challenging but require different levels of Social Work assessment and skills. In some areas, due to the short term and episodic nature of admissions, the social work assessment has been replaced by a social work screening or short term intervention. This is appropriate given that it is recognised that professional social work assessment is, where possible, best completed in a community setting. However, in other areas of Hospital Social Work complex assessment and intensive social and family support in the Hospital setting is required.

Hospital Social Work in contrast to the Community Social Work setting is predominantly made up of professional Social Workers with a limited skills mix. This model is no longer sustainable or appropriate in the hospital setting. The service area intends to introduce a skills mix into some areas of the Hospital Social Work service, in this forthcoming year. The service area is confident that the introduction of a Social Work Assistant role, working alongside a Social Worker in acute settings has the potential to improve flow and maximise current resources. This will lead to a reduction in professional Social Work resource being, directed to low level and non-complex work.

Adult Safeguarding
Processes and staff resources are in place to provide a response to Adult Safeguarding referrals across the hospital sites in Belfast Health and Social Care Trust. Designated Adult Protection Officers and Investigating Officers are available on each of the hospital sites and cover arrangements are in place, if required. Hospital Social Workers work closely with BHSCT Adult Protection Gateway Team to screen and manage referrals. Hospital Social Work also support residents from other Trust areas coming into regional hospital facilities for care and treatment. When Adult Safeguarding issues arise, staff work with Gateway Teams from other Trusts to ensure referrals are made to the appropriate area and immediate protection plans are agreed.

Social Work staff in safeguarding roles provide a sensitive and professional response in the management of safeguarding referrals taking cognisance of issues such as physical and psychological vulnerability, illness, trauma and mental capacity. These can often affect a service users ability to engage in the investigatory process and protection planning. Staff have been challenged at times by colleagues when Adult Safeguarding issues have impacted upon discharge planning. However, staff continue to advocate for service users in these circumstances

	Monthly returns are provided to the Adult Protection Gateway Team (BHSCT) by way of collection and monitoring of referrals for BHSCT referrals. The service area has initiated a new reporting process for 2019/20 to capture the number of referrals to other Trust Adult Protection Teams, as the extent of this work has been hidden. A recent RQIA Review report into Outpatients Services on the hospital sites highlighted the issue of awareness of Adult Safeguarding. An action plan has been put in place to provide these departments with Safeguarding posters and information for display in waiting areas and to develop training for staff. **Carers Support** The service area is concerned that due to operational challenges, there has been a loss of focus on the needs of Carers, particularly in the acute setting. Whilst the service area had previously completed a Quality Improvement project in relation to this, these improvements have not been sustained. There is a need to engage with carers to understand, how best to identify and support them and this has been identified an area for improvement during this forthcoming year.
3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	A Human Rights approach is central to Hospital Social Work practice. The service area has implemented a Best Interest approach to supporting people without Mental Capacity when developing discharge plans from Hospital. This issue is discussed further in Section 3.12. The service area works closely with independent advocacy services. During this reporting period, Social Workers have on a number of cases, accessed this support for service users in hospital settings. The service area has a Human Rights focused process in place to analyse requests for one to one supervision on discharge from hospital, which considers any Deprivation of Liberty and ensures the least restrictive option is achieved. Human Rights training is available to staff on an on-going basis and is provided by the Social Work and Social Care Learning and Development Team.

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?
	DEPRIVATION OF LIBERTY ISSUES The service area continues to be concerned in relation to the Human Rights issues specific to the adults who lack mental capacity and who are Deprived of their Liberty. The service area has highlighted previously their concerns about the absence of a legal framework or regional guidance to support staff in managing these complex issues	The Service Area has implemented a "Best Interest Toolkit for Social Workers" and has delivered training on this human rights-based approach. This is an interim measure in the absence of the full implementation of Mental Capacity legislation. The service area has completed in house training with Senior Practitioners and Team Leaders across Hospital and Community settings to disseminate learning from Declaratory Judgement cases focusing on Deprivation of Liberty Issues.	Regional guidance is required in the absence of statutory safeguards and the service area welcomes the phased implementation of the new Mental Capacity legislation from October 2019, which will provide a framework within which Deprivation Of Liberty issues can be managed.
	IMPACT OF DOMICILIARY CARE CRISIS As has been previously stated, the service area has very significant challenges in relation to the supply of domiciliary care. In able to maintain flow through the system the service area has had to increase its interim bed base. This has resulted in a significant number of people having to	The service area has implemented a number of controls which has included: • No service user incurs a cost for a placement whilst awaiting their package of care	The Trust continues to highlight the challenges in the supply of Domiciliary Care at a regional level. The Trust is fully committed to working with the HSCB in developing new models of sustainable Domiciliary Care

	await their package of care in an intermediate facility, when it was their wish to be in their own home.	• Social Workers work to identify interim beds that are closest to the persons home, where possible • All people in these circumstances have Social Work and AHP support whilst awaiting their package of care The Trust has in place systems to monitor length of stays for those awaiting a package of care.	

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	The development of the role of Principal Social Worker for Hospital demonstrates the service area's commitment to delivering a safe, high quality and continuously improving Hospital Social Work service. The purpose of this role is to improve the governance arrangements and professional development supports for Hospital Social Work. The challenge for the service area is to ensure that this new role is not consumed by operational challenges.
3.16	**SUMMARY**
	This reporting period has been a very challenging year for Hospital Social Work, particularly in sustaining service delivery during significant staffing and operational challenges. Hospital Social Work continues to challenge itself, to identify improved and more integrated ways of working across the range of hospital settings. However, Hospital Social Work is acutely aware of the need to balance operational and system demands, with a need for a relentless focus on quality and professional standards. Priorities for the Service Area in this forthcoming year will focus on - strengthening the Community Discharge and Social Work Hubs, to improve integration and performance across the hospital and community settings - reviewing professional standards and strengthening governance arrangements - introducing a change in the skills mix in Hospital Social Work to maximise current resources - creating new learning and development opportunities for staff and managers in Hospital Social Work - to develop a better understanding of the needs of carers in this setting and to develop better ways of identifying and supporting carers

Programme of Care / Directorate:- Physical and Sensory Disability Services

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

Ms Tracy Reid is the Divisional Social Worker for Adult Community and Older People's Services. Ms Bernie Kelly is the Service Manager and Social Work Lead for the Physical and Sensory Disability Service Area (PSD). They are 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 Divisional Social Worker is responsible for:

- The provision of operational management and 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

The Social Work Lead is responsible for:

- Professional leadership of the social work and social care workforce within the Service.
- The establishment of structures within the Service 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's Interim and Annual Statutory Functions Reports.
- The promotion and profiling of the role of the social work and social care workforce in contributing to the Trust's strategic objectives and key service delivery priorities.
- The promotion and profiling of the discrete knowledge and skills base of the social care workforce within the Service.
- Ensuring that arrangements are in place within the Service to facilitate the social care workforce's learning and development opportunities.
- Ensuring that arrangements are in place within the Service 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 line management

	and professional structures to the Executive Director of Social Work and onto the Trust Board. As of June 2017, all of the first line manager posts within the Service have a designated Social Work status.
3.2	**Supervision arrangements for social workers**
	Assessed Year in Employment The Service Area currently has two social workers currently undergoing their Assessed Year in Employment (AYE). These social workers work within the Physical Health and Disability and Sensory Support Teams. These staff have restricted caseloads and increased supervision arrangements in place. They receive additional input from an AYE support group led by the training team **Supervision** All staff have access to regular supervision and there is generally high compliance with the Trust's supervision policy for adult services. 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. The eleven 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. In addition to staff having access to formal and informal supervision, they also complete their Staff Development Reviews on a yearly basis and have access to peer support groups. Staff also attend Investigating Officers, Designated Adult Protection Officers and Achieving Best Evidence practice development and support fora. All of these initiatives enable and promote reflective learning, facilitate opportunities to address practice and service delivery challenges and to enhance the professional development of staff. **Caseload Weighting Arrangements** At present no formal caseload weighting tool is being used within the Service Area, as having participated in a pilot previously it was felt this did not enhance service delivery or provide additional support to staff with caseload management. The Team Leader overview of quantity and complexity of caseloads remains the core mechanism for addressing equity of workloads. Currently the service area utilises supervision as a method to provide a regular, focused opportunities to review the supervisee's caseload and to determine allocation of work. This is held under review and a caseload weighting tool may be employed in future.
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 Procedure which details referral screening and allocation processes and related professional responsibilities. The Sensory Support Service continues to adhere to the Regional Sensory Services guidelines and procedures. Team Leaders and Senior Practitioners are responsible for ensuring adherence to the procedures. Day care within the service area adheres to the Trust's procedures for day care services which address the processes required to ensure compliance with RQIA standards. **Audits, Reviews and Evaluations** **Social Work**

The social work teams continue to provide comprehensive assessments of need using the NISAT tool. There is a strong focus on preventative work, to reduce hospital admissions, improve quality of life and reduce social isolation.

During this reporting period one of the social work teams took part in the piloting of a Department of Health Social Well-being Tool. This was an initial test of a tool co-produced with service users to assist conversations between service users and social workers in relation to the person's social wellbeing. Whilst the tool was effective and led to meaningful conversations, the feedback from social workers was that these conversations are already being facilitated through the existing tools of NISAT, ASCOT and SDS support planning.

Adult safeguarding continues to be a significant area of work for the social workers and this client group presents with many complexities, as detailed in the Adult Safeguarding report.

The service area promotes a peer support model within individual teams, managers groups and social work forums. These groups are invaluable in terms of communicating and discussing lessons learned from research and considering implications for practice.

Commissioned Services

The service area has a dedicated team which commissions services for those with complex needs with the aim of linking identified needs of service users and carers to service delivery. The team works closely with Domiciliary providers, Residential care, Nursing care and Supported Living providers with the key function being the monitoring and review of care packages/ placements.

Links are maintained with the Trust Governance team and Care Review and Support team (CReST) in respect of quality indicators and performance management of Independent providers. In light of recent challenges the service area has ensured that comprehensive reviews of all residential and nursing home placements have been carried out.

Across the Trust there are difficulties in securing care packages and the issues pertaining to this are referenced in Section 3.5 of this report. The team continues to scrutinise assessments and work alongside colleagues across community and hospital settings to agree appropriate discharge pathways and service delivery. The team participates in the Trust twice weekly Priority call with managers from across Adult Social & Primary Care and hospitals to agree those service users that are in urgent need of service delivery. Those prioritised are referred into the Trust Care Bureau to seek urgent packages of care and establish patient flow from hospital. There are significant challenges in respect of domiciliary care provision and these are detailed in sections 3.5/3.6 and 3.7. The service area has been involved in Trust meetings with key stakeholders, including providers to reflect on the challenges both now and into the future, to consider short term and long term remedial measures.

There has been significant increase in the number of patients that are needing complex nursing care needs at home and the team participates in the regional group meeting with BSO to assist with planning for how these complex care needs can be met longer term in the community.

Within the last few months staff have worked closely with Speech & Language Therapy staff to identify service users with Speech & Language Therapy assessments that required translation due to implementation of International Dysphagia Diet Standardisation Initiative (IDDSI). Staff completed case finding and undertook the translation for service users.

Staff meet with the Trust Finance team on a regular basis to review debts owed and recover monies due for Care home placements. This includes cases with complex financial circumstances and working through these with service users, their families and representatives to ensure that correct charges are applied. The team also ensure that appropriate measures are in place to prevent debt accruing, protecting service users and referring to the Office of Care and Protection when required.

Community Brain Injury Team
The Community Brain Injury Team (CBIT) offers community based rehabilitation and support aimed at promoting independence, wellbeing, and maximising participation in family life and community life after brain injury.

The team has a range of professionals including Social Work, Physiotherapy, Occupational Therapy, Speech & Language Therapy and Clinical Neuro-Psychology.

The Community Brain Injury team continues to work closely with other professionals within the Trust; various statutory, voluntary and community organisations in order to progress the 23 recommendations made by the RQIA Review of Brain Injury Services in NI (2015). The team continues to work with the Acquired Brain Injury Alliance (ABIA) a Belfast Trust forum configured following the 2015 review and is looking at improving service provision to acquired brain injured service users and their families.

The Community Brain Injury team has worked collaboratively with Headway and Reconnect on behalf of ABIA in reviewing and updating information for people with ABI, families and carers. This piece of work had been commissioned by the HSCB and the outcomes were launched during Brain Injury Awareness week in May 2018. This launch coincided with a successful public engagement event run by the Community Brain Injury team during Brain Injury Awareness week which brought together carers, advocacy, statutory and independent sector groups.

The Community Brain Injury team collaborated with various partners and service users following the re-tendering of HSCB contracts for training of persons post-brain injury, assisting service users to transition to the organisation successful in the tender process and also identifying alternative, appropriate supports when needed.

During this reporting period, the CBIT again breached the 13 week maximum waiting time from referral to assessment and treatment on three occasions, and the HSCB have been advised accordingly. Breaches have occurred due to workload pressures, ongoing recruitment difficulties and long-term staff sick leave within CBIT. In August 2018 a new Clinical Lead (Consultant Clinical Psychologist in Neuro-psychology) took up post. There have been substantive staffing challenges in the team due to staff taking up new appointments. Sick leave and maternity have presented additional challenges. Refilling vacancies has been challenging due to a dearth of appropriately trained and experienced staff being available across the region. The Community Brain Injury team is seeking to proactively manage this by engaging staff on a rotational basis with

aligned services. The availability and function of rehabilitation assistants is currently being explored.

Reviews of the core business of the Community Brain Injury team, as well as internal processes have been ongoing in order to provide a timely response to referrals and ensure effectiveness of service provision. Within the team there is an increased focus on ensuring the service provided is as responsive, efficient and person-centred as possible, with feedback from our service users proactively built into team processes.

The tendering process for a HSCB funded Community Link Service has been progressed, with the intention this should be operational by mid-2019. This service will be delivered by the third sector and embedded within the CBIT. The Community Link Service will work in partnership with community, voluntary, statutory, and independent sector organisations to provide access to a wide range of community based services and opportunities in the areas of education, training, volunteering, employment, social, leisure, recreation and culture in order to meet identified needs of people with ABI. The Community Link Service will be supported by CBIT colleagues in order to help address the cognitive, emotional, and behavioural issues of service users who have become, or at risk of, social isolation. When operational it is intended that the Community Link Service will implement the Bridges Self Management Approach to rehabilitation focussing on the social aspects in order to improve individuals' health and wellbeing.

Providing care for adults with extremely challenging behaviour or with complex needs continues to be a major issue for the Trust. The Trust continues to make slow progress in sourcing appropriate placements and accommodation for service users with complex neuro-disability needs (including alcohol-related brain damage and acquired brain injury). This is mainly due to lack of suitably experienced services within the independent and third sector. Between April 2017 and March 2018 CBIT staff have worked in partnership with Glebe Nursing Home who have re-configured to a residential unit for service users with ABI. To date there have been a number of very successful placements therein. From discussions with operational and management staff within Glebe a recurring issue relates to the elicitation and involvement of outside services, particularly adult mental health in the day-to-day management of service users.

Interface issues between Community Brain Injury team and Adult Mental Health services remain a concern. The risk of mental health issues, in persons with a brain injury are substantial. However, there have been a number of incidents where the accessing of appropriate mental health support in a timely way has been lacking. From experiences with Glebe (where Belfast Trust service users are hosted in a service outside of Belfast, i.e. Northern Trust area) it would appear that the scenario of persons with a history of a brain injury struggling to access support via mental health services is not specific to Belfast Trust. The Community Brain Injury team continue to meet on a monthly basis with a Consultant Neuropsychiatrist to ensure a combined approach to management of current psychiatric and behavioural considerations within CBIT caseloads. However, this provision, on its own, is not sufficient to meet the substantial mental health needs of the population CBIT serve. Collaborative, co-working arrangements between CBIT, Adult Mental Health and neuropsychiatry might make some progress towards enhancing this service provision, but professional training and understanding of brain injury and its implications for service involvement is central to this.

Alcohol Related Brain Damage

Alcohol related brain damage (ARBD) describes cognitive impairment directly related to chronic alcohol consumption. This group of service users frequently fall through the net conferring huge costs to healthcare services. Service users with ARBD are often placed in care homes totally unsuited to their recovery. With figures forecast to increase, there is an urgent need to address the lack of suitable care options regionally.

It has been proven that with the right treatment, service users with ARBD can recover and transform their lives. Services in the UK with similar drinking populations to NI have shown impressive outcomes such as a reduction in hospital admissions for people with ARBD by 85%, highlighting the impact of providing treatment. ARBD is a reversible condition and up to 75% of patients can make partial or complete recovery given personalised treatment and care.

Due to significant numbers of ARBD service users within Physical & Sensory Disability, the service area is working with others internally and externally to address this unmet need. Working in collaboration with Leonard Cheshire and an independent provider, plans are well established to re-configure an Older Peoples Home into a residential rehabilitation unit for ARBD service users. It is anticipated that this unit, based in South Belfast, will be sub-regional i.e. targeting appropriate service users from Belfast and South Eastern Trusts and will be operational in Spring 2020.

Day Opportunities

Following the transfer of seven Older Peoples day centres into Physical & Sensory Disability in 2016, and due to the Trust's commitment to Quality Improvement (QI), a number of quality improvement initiatives were established. One such initiative was to realign and standardise the referral process of these services to ensure quality and governance are at the centre of day opportunities.

With this in mind the day centres personnel developed a more appropriate referral pathway. This included a Day Opportunities Admission panel. A key feature of this work was piloting the utilization of Pre-placement Comprehensive Occupational Therapy Assessments. The process has been extant for one year and a review for performance and assurance will take place in the next reporting period.

As part of the Regional Quality Improvement in Social Work Programme, two day centre managers began a Co-production QI initiative to review and standardise Day Care Initial Assessment Document for all service area day centres. The new document was developed with the help of the mentors and facilitators on the Regional QI Social Work Programme. The new document will be rolled out in all centres later in the year.

A review of Older People's day centres has been completed during the reporting period using an Appreciative Inquiry (AI) approach, engaging service users and staff in the process. The review has been very well received and the service area is currently working on implementing identified outcomes. RQIA Inspection reports are also generally positive with few recommendations for improvement.

A Service User Council has been established with service users from each centre which meets on a quarterly basis. These meetings give service users an opportunity to be involved in planning, evaluating day care services and developing best practice across the day opportunities framework. These meetings empower and enable service users to voice their opinions and ensure that their knowledge and expertise is taken into consideration. The meetings have been very successful and the impact has been validated by service user feedback across all centres.

The two Community Access staff continue working in partnership with service users, their carers and family members towards the goals of social inclusion, community integration and active participation based on the principles of equality, consent, dignity and respect.

They engage with the individual to identify strengths, qualities, interests and goals for the future and develop a one page profile and person centred plan. Community Access promotes social wellbeing, reduces social isolation and promotes independence. An audit and review of intervention confirmed an evidence base to date that has been extremely positive and preventative in outcomes.

Sensory Support
During the past year the Regional Sensory Implementation Group (RSIG) has continued to implement the actions set out within the Physical and Sensory Disability Strategy.

As reported last year, following the public consultation on the provision of Communication Support Services for people who are profoundly deaf and hard of hearing, there was overwhelming agreement of the recommendation for a Regional Communication Support Service (RCSS) supplied by BSO. The Health & Social Care Board approved the implementation of this in May 2017 and the Service Area continues to be represented on the RCSS Steering Group. The focus of this work is to develop and deliver a Regional Communication Support service that includes robust governance and accountability arrangements. It is anticipated that this work will continue throughout the next reporting period as this is a complex piece of work that involves many stakeholders and has implications for the profoundly deaf and hard of hearing community.

The Sensory Support team continue to implement the actions and recommendations of the Deafblind Needs Analysis Review. Training continues to be provided across the Trust and also to external agencies, such as nursing homes, to raise awareness of dual sensory loss. The two staff members who obtained the Diploma in Deafblind Studies hold a specialist role within the team in completing deafblind assessments. They also continue to provide support and education to colleagues in the assessment and delivery of effective care planning for deafblind service users. In addition, a regional sub group has been set up to develop services for deafblind people regionally and this group meets on a bi-monthly basis.

With regards to specialist training, the service area is pleased to report that developments continue; one staff member completed a course in sight loss and dementia and this has already proved to be of benefit to service users. Regional training days have been arranged funded by the HSCB and these have provided invaluable training to staff. A comprehensive training plan has been developed by a regional sub-group and this is awaiting ratification. The service area continues to provide a tinnitus support group for service users, in partnership with the British Tinnitus Association. The service area has also worked in partnership with Action on Hearing Loss to deliver tinnitus management programmes, awareness raising events, and one to one supports to service users. One staff member who is a trained Lip-reading teacher continues to deliver lip reading courses for hard of hearing service users throughout the year. The service area has noted that demand for this provision remains low and one trained staff member is an adequate resource at present.

The service area is currently involved in ongoing work to develop a regional equipment framework in order to ensure compliance with procurement legislation. This work is expected to continue during the next reporting period and representatives from the

service area are meeting regularly with other Trusts, HSCB and BSO to ensure equitable and accessible provision of sensory equipment.

The Trust participated in the Developing Eyecare partnership and a sub group was set up within this to review and update the certification of visual impairment process in NI. As part of this co-production between the Trust and Service Users they processed a certification ID card which will be distributed regionally to people certified with a sight loss. This was launched on 15th April 2019.

Self-Directed Support
Phase 1 of the implementation of Self- Directed Support (SDS) ended on 31st March 2019, and Phase 2 (2019 – 2023) will commence on 1st April 2019. The Strategic Development Priorities for Phase 2 over the next 4 years include the following:

- Managed Budgets - Develop and Implement Procurement Framework to support Option 1, Direct Payments, and Option 2 Managed Budgets
- Provider Engagement
- Resource Allocation System –HSCB to research best model for SDS in Northern Ireland
- SDS Measuring Outcomes – ASCOT and Outcome Star
- SDS Activity Toolkit – develop information systems to capture this data across Trusts

As recurrent funding for Self-Directed Support has been agreed by the Department of Health, the Belfast Trust has appointed the SDS Trust Implementation Officer on a permanent basis.

With regard to structures in the Trust for the implementation of Self-Directed Support, the Trust SDS Steering Group continues to be chaired by the Director of Adult Social and Primary Care and meets quarterly. The SDS Implementation Group continues to be chaired by the Service Manager for Physical & Sensory Disability Services and meets bi-monthly. There is representation from all service areas, service users, carers, contracts, training team, information management, and the voluntary sector.

There is also a SDS Service User and Carer Advisory Group, chaired by a carer, and supported by the SDS Trust Project Manager. One of the service user representatives in this group completed the Safer Quality Belfast Quality Improvement Programme in June 2018, being the first ever service user to do so. His project was *'To support Social Workers to increase the completion of Support Planning'.* His quality improvement project has been presented at a number of Quality Improvement events in Belfast Trust.

The Trust has adopted a co-production model with regard to the training on SDS, with engagement of service users and carers. Their lived experience and contribution has been positively evaluated, following feedback from staff at the training. A quarterly reflective practice group for SDS was established to embed the SDS approach into social work practice. However, due to low uptake, the SDS Project Manager and SDS Practice Development Lead from the Learning and Development team have offered to attend team/staff meetings to address any practice or implementation issues. A SDS training calendar is in place until March 2020.

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

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

Adult Social Care Outcomes Tool
The Department of Health advised in January 2015 that the Adult Social Care Outcomes Toolkit (ASCOT) would be the tool adopted by all Trusts moving forward to monitor qualitative data, as it could be readily integrated into service user review processes. The ASCOT data constitutes a key component of the Department's reporting against Programme for Government commitments and is referenced in the Departmental Business Plan for 2017/18.

All Trusts were advised by HSCB that full implementation of ASCOT must be in place by 1st April 2018. Physical & Sensory Disability Services commenced ASCOT Implementation on 8th January 2018, with all other Adult Service Areas commencing on 1st April 2018.

A SharePoint site has been established by BSO for collation of ASCOT data from Belfast Trust. HSCB view this information quarterly.

Carers
The Service Manager in Physical & Sensory Disability has operational lead for Carer Support Services. Work on the Trust Carers Strategy, 'Caring Together in Belfast 2017-2020', is ongoing. The Belfast HSC Trust continues its commitment to implementation of the key priorities as agreed with carers and a summary of activity is reported below:

Reaching Carers and Developing Carer Support Pathways

Carer information packs have been reviewed in year and 8,000 packs have been reprinted for distribution. In response to Carers requests for a central point of contact, a central email account has been set up. Carer Service infrastructure has been reviewed, with recommendations to increase allocation of resources to assist with telephone support, information and advice for carers. The Trust Carer Coordinators continue to provide input with teams to maintain the profile of carers within service areas.

The Trust launched a Framework for Staff with caring responsibilities during 18/19. Its aim is to promote awareness with staff and managers to ensure that staff carers are supported to manage their caring role alongside their employment. They are also made aware of wider carer supports available within the Trust.

A number of new initiatives have commenced during 18/19 2019 including:

- A new partnership with Community Pharmacy; seeking to identify carers, not known to services, and refer them for support.
- Trust Carer Coordinators have developed a Belfast Trust Carer Workers Network to strengthen links with and improve communication between the Trust and organisations in the voluntary and community sectors.

The Trust continues to ***Support Carer Health and Wellbeing*** by offering a range of services including: information sessions, group activities, relaxation days, evening events and ongoing provision of carer therapies, grants and direct payments. A significant number of carers continue to be supported through the provision of day care opportunities, domiciliary support and residential short breaks.

Carer Coordinators are currently undertaking an evaluation of the Trust Carer complementary therapy service to determine the value of this service and how it may be improved.

Communicating With & Involving Carers

The Physical & Sensory Disability Service continues to deliver the Cathos model to profile the role and needs of carers for people with physical and sensory disabilities. This aims to keep the views of carers central to service planning and development; during this reporting period there was a range of successful activities arranged. Each team continues to have a staff member with a designated responsibility to progress carer engagement and ensure effective communication with and on behalf of carers.

The Trust Carer Coordinators have an integral, advisory role within service areas. In addition, they provide carer awareness training as part of the induction programme for new staff and carer assessment and support planning training to staff carrying out carer assessments in order to ensure best practice and outcomes for carers.

Generic Reviews, Audits and Evaluations
Service user engagement via specific working groups or fora continue to be utilised and are viewed 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 payment and adult safeguarding activity. These figures are monitored and analysed by the Service Area to identify any emerging issues or trends. As previously noted, this data has been improved upon since the implementation of the Business Support Team.

The Service Area continues to monitor issues related to safety and quality themes emerging from adverse incidents, Departmental queries, complaints and compliments via quarterly Service Governance Meetings which are chaired by the Service Manager and supported by the Governance Lead for the Service. 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 fora. The Governance meeting also has processes in place to review and manage the Service Risk Register for Older People, Physical & Sensory Disability. The Service Area has participated in one Serious Adverse Incident in this reporting period and the draft report has been issued. This was a complex case with three Service Areas involved and while there has been

	some generic learning, there has been no specific recommendations for the Service Area. **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 individual provider. The service area participates 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 service user satisfaction and outcomes are achieved. **Contracts with Independent Domiciliary Care Organisations** The service area meets with all commissioned providers at least annually to ensure value for money through a qualitative and quantitative scrutiny process. As previously noted, during this reporting period the service area has also actively participated in Trust meetings with domiciliary care providers to determine how best to meet the increasing demands on this service, especially with limited capacity from providers. This is referenced in section 3.5 of the report as an area of concern. **Contracts with Independent Residential/Nursing/Supported Living Organisations** The service area continues its negotiations, along with Contracts personnel, independent nursing and supported living providers regarding re-configuration/extending provision to include service users with Alcohol Related Brain Damage (ARBD) and brain injury/complex needs. Please refer to section 3.5 for further details of work progression. **Reflective Practice Groups** The service area has continued to promote a peer support model within individual teams, service management 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 continues to be 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. **RQIA** Day Care services continue to be compliant with the RQIA standards and are subject to ongoing inspection and monitoring. Any recommendations or requirements are acted on as priority actions. The service area also ensures effective communication and engagement with RQIA when concerns are raised regarding nursing, residential, supported living placements, domiciliary care provision or adult safeguarding concerns.

Community Emergency Response Team

The Service Manager in Physical & Sensory Disability is the Co-ordinator of the Trust Community Emergency Response Team (CERT) which is activated during a declared major incident in the community.

The Trust responded to three critical incidents which required a multi-agency response during the reporting period. Additionally, relevant Trust staff attended three multi-agency training exercises; one organised internally on cyber security and two multi-agency exercises on responses to cruise ships incidents and EU exit arrangements.

Members of the CERT team continue to participate in the work of the multi-agency Belfast Emergency Preparedness Group, co-ordinated by Belfast City Council, and the Trust's Emergency Preparedness, Planning and Implementation Group, chaired by the Deputy Chief Executive. This helps to ensure effective preparedness and response to incidents along with relevant partners internally and externally.

Vulnerable Persons Resettlement Scheme

The Vulnerable Persons Resettlement Scheme (VPRS) was introduced in 2014 by the UK Government with the aim of providing a safe and legal route for certain categories of the most vulnerable Syrian refugees to travel to the UK.

The service area actively participates in the Trust's Syrian Refugee Planning Group, which comprises of representatives from all relevant service areas within the Trust. The group meets on a regular basis to plan for the arrival of each group of Syrian refugees. Information is provided in advance which enables staff to prepare for the needs of the refugees arriving.

The service area has recently assisted in welcoming Group 20 to Northern Ireland. The scheme has assisted in resettling nearly 2000 vulnerable individuals and families in various locations throughout Northern Ireland and the scheme is due to continue until 2020.

The service area assists in identifying adults with physical or sensory disabilities prior to their arrival in Northern Ireland; this allows for the planning of services, equipment and housing needs for these individuals. Service area staff attend the two Welcome centres following the arrival of the Syrian refugees and complete a further assessment of needs and risk, and identify any immediate needs the individuals may have. As not all of the Syrian refugees remain in the Belfast Trust area therefore staff liaise with other similar teams throughout Northern Ireland. This allows the receiving Trust to be prepared for any needs the individuals may have.

During this reporting period service area staff have been involved in supporting a particularly complex Syrian family with physical, sensory and child care needs, requiring considerable input across service areas and agencies. The Trust has been commended on their work with this family by DOH.

In November 2018, a member of the service area was invited to attend the IOM/HO Mobility Workshop in London; the purpose of this was to allow staff from the VPRS's throughout the UK to meet and discuss the issues or difficulties in meeting the needs of individual refugees with physical disabilities, mainly the lack of appropriate housing. Trust staff gave a presentation to their colleagues from throughout the UK and met with the medical staff from the five refugee camps. This allowed staff the opportunity to communicate the information required in the assessments received prior to the refugees

	arriving in the UK and NI. The workshop enabled staff to understand some of the difficulties faced by the medical staff completing the assessments in the refugee camps and to gain a better understanding of the cultural differences. **PSNI** Following the implementation of the regional Adult Safeguarding Policy, the service area has noted a decline in the engagement of the Joint Protocol arrangements with the Public Protection Unit to safeguard Vulnerable Adults. This is due to Trusts and PSNI interpreting the policy differently. This is reported in detail in the Adult Safeguarding report. As referenced above, the service area also partners and engages effectively with the PSNI in the Belfast Emergency Preparedness Group. **MARAC and PPANI** The service area continues to participate as appropriate in local MARAC and PPANI Panels. **LASP** The service area is represented on the Belfast LASP Group. **Office of Care and Protection** The service area continues to engage with the Office of Care and Protection in relation to supporting service users manage their financial affairs. **Judicial Reviews and Significant Court Judgements** The service area has not had any Judicial Reviews or significant court judgements in this reporting period but takes 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.	**Lack of Capacity within Private Providers** As previously reported there continues to be significant concern with the lack of capacity across the independent provider sector. The reasons and concerns regarding instability in the domiciliary care sector have been well documented. Providers are frequently unable to secure new packages resulting in delays in service provision which has had a severe detrimental impact on service users and carers. Regrettably the situation remains largely unchanged as domiciliary care providers continue to have limited capacity to meet the demand. Providers report that they are unable to sustain their workforce due to low pay and poor recognition for the role they undertake. There is notably more challenges to meet the need in specific areas of Belfast. Service users in these areas can wait	The service area continues to put in place remedial measures. Risk assessments are completed for all cases where the providers are unable to implement care packages. Further to this family engagement is sought for assistance with personal care tasks and the service user is offered Self Directed Support via Direct Payments. Nursing or residential placement if appropriate are also offered, however these placements are also limited as they struggle to meet demand too. The service area actively participates in twice weekly priority calls to identify those most at risk and in need. Currently these service users tend to be patients who have palliative care needs and wish to return home to their families. The Trust has commenced pilots with a small number of providers for those areas where there is significant challenges however this has tended to focus on hospital discharges. There	Issues pertaining to the lack of providers are on the service area Risk Register and categorised as High.

	lengthy periods before a service can be secured. Care providers report that service users within this service area place additional pressure because their complex care needs require additional times and the verbal and physical aggression of service users with cognitive challenges place additional strain on care staff to provide a sustainable service. Lack of appropriate domiciliary care provision is not only impacting on service users and families, but it is also has a direct negative impact on hospital discharges, service delivery and meeting performance targets as there is limited flow within the system.	is also a concern that this will not be a sustainable long term solution. On-going and timely review of cases remains to ensure assessed needs are being prioritised. .	
2.	**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 is pleased to report that the nursing home unit for acquired brain injury continues to provide much needed accommodation for this client group. The facility has employed additional staff and provided specialist training to enable them meet the needs of this complex group. Feedback from stakeholders about the performance of the unit is positive and indeed additional beds within the	Issues pertaining to the lack of appropriate accommodation for service users are on the service area Risk Register and are categorised as Low.

	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 manage these service users. This can result in additional spend to procure one-to-one supervision to reduce risks to service users. 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. The situation is exacerbated if capacity assessments are required. Finding medical personnel who will undertake them and the £500 average charging fee continues to remain challenging for the service area. Whilst there have been positive developments in securing accommodation, the service area would note that the charges for these units are over double the regional rate and this has significant concern from a budgetary perspective and the detrimental impact on People First monies for other parts of the service area.	unit are being reconfigured for this client group. Our service users are receiving a high standard of care and there is an increased understanding of their complexities. There have been challenges at times due to the inability to access psychiatric/mental health support at times of crisis. Following on from last year's report the service area continues to work in partnership with a voluntary organisation who, in partnership with a housing association, have secured a building in South Belfast which is currently being reconfigured into a residential rehabilitation unit for people with ARBD. It is envisaged that this unit will open in Spring 2020.	

3.	**Self-Directed Support (SDS)** The Departmental indicator 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'.* There are currently 2223 service users and carers in receipt of SDS within the Trust, who have a 7 criteria Support Plan in place. The service area is pleased to report that PSD hold 1094 of these cases which represents over 49.2% of the total figure. All service areas are now engaged in the implementation of SDS and are working under the SDS framework in respect of all new referrals and reviews.	The Trust has both a SDS Steering Group as well as 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. The Trust has exceeded the Direct Payment target by 4.5% in 2018/2019. In addition, engagement with provider organisations is ongoing to ensure that the full range of options under SDS are available. The HSCB are currently refining the specification for Managed Budgets. The Learning and Development Service report that staff continue to attend training from all service areas to support implementation of SDS. To date, 1855 staff throughout the Trust have been trained at various levels of SDS. The SDS Project Manager and the Practice Development Officer for SDS have reviewed and updated the content of SDS training based on staff feedback and evaluation. This has been in partnership with the service users and	There is a separate risk register for Self-Directed Support, as requested by HSCB.

		carers who co-produce the training. Their lived experience and contribution has been positively received by staff.	
	SDS Activity returns to HSCB As previously reported, CIS does not support SDS implementation or the collection of data for the mandatory SDS Activity return to HSCB.	A manual data collection process was implemented by the SDS Project Manager in March 2017. This has been rolled out across all service areas, and training provided to team managers with regard to the completion of the data return documentation. In Autumn 2018 the HSCB Information department and the three Trusts that use CIS, commenced a project to examine how CIS could manage the data collection required for HSCB Activity returns. This work is on-going across the region.	
4.	**Acquired Brain Injury** There continues to be difficulties for the Community Brain Injury team (CBIT) in providing home-based support packages for service users with prolonged disorders of consciousness (PDOC). These service users are potentially vulnerable, have very intensive and specialist requirements and present as challenging, particularly for non-family carers. There are often practical difficulties including the recruitment and retention of suitably trained staff.	All previous actions continue which is to ensure home care arrangements are subject to risk assessment and are adequately supported by social work and care management staff.	This is not on the Risk Register at present but the service area is monitoring the concern.

	Due to limited bed capacity in RABIU some service users are being discharged from acute hospital settings to CBIT which do not have the staffing resource, skills or facilities to manage their complex needs. These service users are potentially very vulnerable and require high levels of support.		
5.	**Recruitment and Retaining a Sustainable Workforce** The service area continues to experience staff vacancies due to staff retirements, maternity and sick leave. Experience to date has demonstrated that recruiting and sustaining a stable workforce with the requisite skills and knowledge base is a significant challenge. BSO recruitment processes contribute to significant delays in replacing posts. These delays give rise to significant increased pressures on staff in relation to the management of existing caseloads and 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 staff morale.	Remedial measures for managing this issue remain the same as previously reported-the scrutiny process requires confirmation of the ongoing need for a post and details of the implications for the discharge of statutory functions if a post is not filled. 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 the supervision process. The service area has had to recruit an increasing number of agency social work staff to ensure the safe discharge of statutory functions.	Issues pertaining to recruitment are on the service area Risk Register and is categorised as High.

6.	**Adult Safeguarding** Issues pertaining to adult safeguarding are referenced in the separate Adult Safeguarding report.	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 Low.

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 Issues pertaining to workforce have been highlighted as a concern in section 3.5. There are robust vacancy control systems within the Trust. All vacancies are scrutinised to ensure the post is still required. 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. There are currently three social work vacancies within the Physical Health & Disability Teams. In addition to retirements and promotions, the service area also has temporary vacancies due to sickness and maternity leave. This compounded with an increased demand on services and recruitment delays has meant that the service area has had to increase the number of agency staff to ensure the safe discharge of statutory functions. There are currently three agency social workers recruited to the Physical Health & Disability Teams. CBIT experienced difficulty in this reporting period with ongoing difficulties recruiting and retaining AHPs and are working with the Head of AHPs to consider rotational posts and other measures to meet the gap. **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 DOH March 2017 Charging for the 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**
	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 Disabilities. It is recognised by staff within the Service Area that people with disabilities 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 based culture within the Service. The service area participates in the Trust's Disability Steering Group which aims to improve accessibility and services for people with disabilities. The service area continues to promote, uphold and foster individual and community human rights. It undertakes a human rights based approach in its work with service users, their families and carers. Human Rights are integral to social work values and practice. All Trust policies are screened and proofed to ensure compliance with Equality and Human Rights considerations. All staff are supported to attend mandatory and additional equality training. Staff adhere to procedural requirements which inform the documentation of human rights based considerations in decision making regarding service delivery: ➢ 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 regards to Adult Safeguarding, there continues to be an ongoing challenge in balancing the service user's right to a private life and promoting his/her individual choice to make their own decisions which may place them at risk of abuse. 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 of being victims of human trafficking. This has adversely impacted on the relationship between social workers and service users on those occasions when they have refused any further service provision from the Trust which has no legal basis to impose such interventions.	With regards to the Joint Protocol arrangements for reporting to the PSNI, the service area has noted in the Adult Safeguarding Report the current concerns with the interpretation of this policy. Staff continue to access training on Human Rights and Adult Safeguarding including Joint Protocol arrangements. Staff have one to one supervision and access to peer support to reflect on their practice and decision making. Staff complete risk assessments and protection plans which have prompts for staff to record human rights considerations in partnership with the service user.	All ongoing
	Deprivation of Liberty This is an ongoing and significant challenge for staff within the service area	Staff attend mandatory training on Human Rights and have one to one supervision	All ongoing

	when they are required to balance the statutory duty to promote the safeguarding of vulnerable service users while affirming the importance of their right to self-determination and the exercise of informed choice. 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 they are required to demonstrate that they have balanced the individual's human rights with the need to protect them or the wider public from potential harm.	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.	
	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 significant challenges for staff. In these circumstances staff are required to balance	Staff complete risk assessments 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 ongoing

	the risk of harm associated with the individual's non-compliance with an individual's right to self-determination in the delivery of services.	Staff also attend mandatory training on Human Rights and have access to one to one supervision and peer support which facilitate reflective discussion and learning on complex practice decision-making.	
	Acquired Brain Injury Longer term service users with ABI who are managed at home and have very intensive and specialist care requirements can present particular challenges in relation to engagement with non-family carers and social work staff. There are often practical difficulties including recruitment and retention of suitably trained staff to manage their complex needs. The role of consulting with family and friends in providing information to help determine the best interests of a service user who lacks capacity is not always easy for staff.	Staff complete risk assessments and prioritise and manage their responsibilities and the relationships and communication between all involved. Best interests are not restricted solely to medical considerations. Evaluation of best interests is a holistic exercise, and best addressed through a team-based approach.	All ongoing

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	Despite the challenges that Health and Social Care have experienced in this reporting period the service area has delivered key achievements and improvements in promoting the independence and lives of people with physical and sensory disabilities. Senior managers and staff promote the rights of people with disabilities through regional working groups and the Trust's Disability Steering Group. Members of the service area attended a celebratory event in Stormont during this reporting period to acknowledge the worked progressed through the Physical & Sensory Disability Strategy which has now ceased. Great efforts are being made to extend provision and care pathways for those with very complex physical and mental health needs which straddle a number of Service Areas. A recent report from the Royal College of Psychiatrists commends the service area for their work with ARBD service users despite the acknowledged gaps in service provision for this cohort. The service area has lead operational responsibility for the Carers agenda in the Trust and has made significant efforts to promote awareness of carers needs and improve services to carers throughout the Trust in community and acute settings. The service area has taken the lead in the development of the new Carers Strategy. This has been co-produced with carers and reflects and re-affirms a commitment to significant engagement and involvement of carers in the design of services for carers. The service area also has lead operational responsibility for the roll-out of Self-Directed Support in the Trust. The service area has consistently led on the personalisation agenda and is promoting a culture of personalisation in other relevant Service Areas to ensure that the Trust will meet the challenging targets with regard to SDS. One of the strengths of the Trust approach has been the engagement of service users and carers who are providing training, peer support and direction with regard to SDS. The Sensory Support team was a finalist in the regional 2018 Social Work Awards under the Adult Team category in recognition for the DVD they produced in co-production with service users. Following the review of Physical and Sensory Disability Day Care, the service area has reviewed day care for Older People using an Appreciative Inquiry Approach and is following up on recommendations. Improving services is a key objective for the service area. Staff are encouraged to consider new innovative ways to improve practice and this is facilitated via peer support groups and staff development workshops. Several senior managers have successfully completed a range of quality improvement courses and embed this training into their operational practice. Building capacity within the workforce together with recognising and rewarding work is ongoing and many staff in the service area are

	undertaking post qualifying social work training and other specialist training. This ensures that we are abreast of updated knowledge, skills and research so that we can deliver services which meets the needs of people with physical and sensory disabilities. The Trust has been working towards Investors in People re-accreditation in March 2019 and await the outcome. The service area is engaging all staff in the IIP leading, supporting and improving agenda. The Service Area continues to ensure communication with service users and carers via established newsletters: ➢ Newsletter for Carers ➢ Newsletter for the Mourne Project ➢ Newsletter for People with Sensory Loss ➢ Newsletter for Community Access These newsletters include information on services, new developments and articles from service users and providers associated with the service area. It enables the service area to communicate better with service users and promote partnership working. In addition, the service area continues to recognise the significance and importance of engaging with our service user groups, particularly when modernising and developing services.
3.16	**SUMMARY**
	The service area welcomes the principles and strategic direction of the Bengoa, Delivering Together and Power to People reports. It recognises the significant challenges in progressing the strategic direction outlined in these documents. In particular, meeting the demands and complexity of service user needs and expectations at a time of constrained resources remains a challenge. The lack of capacity within domiciliary care is a significant concern for the service area. Despite remedial measures being put in place demand continues to outweigh capacity for this service. Care providers report ongoing challenges to recruit and sustain this workforce. It is recognised that this workforce is crucial to enable the aforementioned strategic themes to be met, but also to ensure safe and timely discharge and flow from hospital to community settings. This is compounded by the shortage of specialist facilities to meet complex needs. Despite the challenges, the service area continues to improve care pathways for ARBD service users and those with acquired brain injury needs. There are improvements currently underway within the Community Brain Injury Team which the service area anticipates these will impact positively on service delivery in the next reporting period. The Sensory Support Service continues to utilise funding to improve specialist training for staff and work collaboratively with other Trusts and stakeholders to create better outcomes for service users.

	Within day care we continue to extend the range of day opportunities in consultation with service users, carers and relevant staff. A review of day centres for older people and significant improvement agenda throughout all day centres is being progressed. The service area is leading on the promotion of self-directed support, ASCOT, carers, and community emergency planning and response within the Trust. Delays in recruitment continue to adversely impact on staff caseloads and staff morale. The service area workforce remains highly motivated, resilient and committed to continuous service improvement with a focus on delivering person centred, qualitative and innovative services.

Programme of Care / Directorate:- Mental Health Services

3.1	**Named Officer responsible for professional Social Work**
	During the reporting period, Ms Mary O'Brien discharged the role of Divisional Social Worker. The Mental Health Service has assumed shadow Divisional status within the Adult Social and Primary Care Directorate and the collective leadership model has been implemented. The post holder has had responsibility for professional issues pertaining to the Social Work and social care workforce within the Mental health Services. She has been accountable to the Executive Director of Social Work for the assurance of arrangements underpinning the discharge of statutory functions related to the delivery of social care services within the Service. The Divisional Social Worker is responsible for: • The provision of professional leadership of the social care workforce within the service. • The establishment of structures within the service to provide assurance to the Executive Director on the discharge of statutory functions. • As a member of the Directorate's senior management group, the provision of specialist advice on professional issues pertaining to the social care workforce and social care service delivery. • The collation and assurance of the Service's 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 were in place within the Service to identify and provide access to training and post-qualifying accredited learning and development opportunities. • Ensuring that arrangements were in place to provide assurance with regard to workforce compliance with NISCC registration and regulatory 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's line management and professional structures to the Executive Director of Social Work and onto the Trust Board. The Divisional Social Worker has assured the Mental Health Service's Annual Statutory Functions 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**
	The Service is compliant with the DHSSPS Circular 02/2015, which details the responsibilities of employing organisations in relation to AYE Social Work staff.

	In total, there were thirteen Social Workers in the Service completing AYE during the reporting period, three of which have completed AYE, two have left the service and eight are still completing AYE at the time of reporting. Line managers are asked to fully consider the needs of AYE staff in regard to caseload protection arrangements by their professional supervisors. Any concerns regarding the caseload weighting or the capacity of the AYE staff member to manage work allocated is addressed directly with the line managers by professional supervisors. There have been significant pressures during the reporting period within community mental health teams due to the ongoing challenges of nursing vacancies and sick leave. As a result, it has not always possible for caseloads to remain protected. This is kept under regular review by the line manager and professional supervisor. Adherence to professional supervision arrangements underpinned by the Trust Adult Services Social Work Supervision Policy has been assured despite an increase in agency and temporary Social Work staff recruited to backfill into nursing vacancies to ensure service delivery is maintained. This has been a challenge due to ten agency and four temporary Social Work staff being recruited within the reporting period. Professional Social Work supervision is provided to all Service Social Workers on at least a three monthly basis and runs in tandem with operational supervision arrangements. There are a limited number of Band 7 Social Work Team Leaders in the Service, seven currently with one vacancy soon to be filled and, consequently, a high proportion of Social Work staff are line managed by non-Social Work operational managers across the thirty seven community based mental health services (excluding six inpatient wards). Currently there are seven permanent Social Work trained Team Leaders in post, with a further one acting Social Work trained Team Leader. Two additional Clinical Services Managerial posts have been developed to support community mental health teams which have been taken up by Social Work trained managers. This has significantly bolstered support to Social Work staff within primary and recovery teams since October 2018 and has further supported professional supervision of nine Social Work staff and helped to support Social Work professional development particularly in regard to delegated statutory functions such as Adult Safeguarding, Mental Health Review Tribunals (MHRT) and Guardianship. The Service's Professional Social Work Governance Team consists of an acting Principal Social Worker (PSW), two acting Social Work Development Leads (Band 7) and one Senior Social Work/DAPO practitioner (only 1.5 of these two posts is currently permanently funded). There is also a Social Work Lead in CAMHS who provides professional supervision to eight of the thirty six Social Work staff within CAMHs the remainder of staff receive professional supervision through their Team Leader or a senior professional lead within their service. In total, thirteen professional Social Work trained staff are providing professional supervision across all adult mental health services (41 in total following the addition of the Lifeline service) to 81 Social Work staff. There is a total of 117 Social Work staff in the programme at this time. The Acting PSW provides professional Social Work supervision to fifteen staff, nine Band 7 Senior Practitioners, three 8a managers and three Team Leaders. The PSW is also practice assessor to one ASW Programme candidates and in addition delivers ASW supervision to five staff. The Service currently achieves compliance with the requirements of the Trust's Adult Services Professional Social Work Supervision Policy in regard to provision on a three

monthly basis. However this is in most cases offered more frequently as a means to support developing Social work staff.

Performance Review
The Trust's Staff Development Review (SDR) Framework has been well established with updating of KSF Social Work outlines. This has been adopted and undertaken with all Social Work staff throughout the service with compliance audited through the Divisional Social Work lead and Human Resources (HR). The Trust compliance contributed to the Investors in People awards with compliance at 60% approximately. The SDR process is completed in partnership by operational managers and professional supervisors annually to ensure that the Social Work and social care staff are afforded a holistic, personalised review of their personal and professional development, highlighting good performance and areas for future development and learning. This also takes cognisance of the Professional in Practice framework and mandatory training requirements. Clear objectives for the year enable the staff member to focus on key goals underpinned by evidence-informed, recovery-focused and person centred practice.

Arrangements for provision of professional supervision to Social Workers in the Mental Health Service are as follows:

AYE
There are currently eight Band 5 AYE agency staff in post. They receive one-to-one supervision on a two-weekly basis in conjunction with a Band 7 professional social work supervisor to ensure work is meeting agency and professional standards and to ensure NISCC gateway requirements are met. The supervisor audits and reviews work in terms of agency and professional standards that will demonstrate personal and professional development. Feedback and recommendations are given to provide advice and guidance on improving the quality standards and analysis of information linked to critical decision making. Where issues are identified in regard to the staff members practice, the supervisor will review with the team leader and devise a supervision support plan to meet the staff member's needs and that of the service.

Temporary Social Work Staff
A further four Band 5/6 Social Work staff have been recruited on temporary contracts (back fill for nursing vacancies) and ten agency staff took up posts in the last year. A bespoke induction programme is being developed for primary care and recovery teams which will further support recently updated corporate induction which now runs on a monthly basis to ensure staff have access at the beginning of their employment. The programme will include the Trust's strategic context, child protection and adult safeguarding policy and procedure, statutory functions such as guardianship, carers assessments and MHRTs; MARAC; role of the Social Worker in a multidisciplinary team; Think Family ethos of working; recovery-orientated practice; person-centred planning; training in key therapeutic interventions and accredited post-qualifying development.

The challenge of providing professional Social Work supervision has been improved due to recruitment of two Social Work trained Clinical Services Managers and five Social Work trained team leaders with one further temporary Social Work trained team leader across the service area and a soon to be filled team leader inpatient post. There are currently eleven Band 7 Senior Practitioners within the community mental health teams, with six of these providing professional supervision to other community teams without Social Work Team Leaders.

Work will continue to support and further develop the Social Work profile, representation of Social Work within multidisciplinary teams and the diverse contribution of Social Work to mental health Services.

The Supervision Support Group for the fifteen Senior Social Work practitioner/managers who are providing professional supervision is undertaken quarterly with the acting PSW assuming chairing responsibilities. Focus has been on the development of new team leaders in regard to statutory functions, standard setting, reflective supervision and service development initiatives supported by the balanced scorecard goals such as service user feedback, the reduction of waiting times, improving governance systems, embedding adult safeguarding processes and building a more resilient workforce through reflective practice.

Quarterly Mental Health Social Work Forum
The Social Work Forum has grown in size in the past year due to the introduction of agency and temporary Social Work staff. This has been an opportunity to further enhance learning and development in regard to agency and professionals standards. Each forum has a different focus such as relaunching the use of a social history based on a 'Think Family' perspective, drawing on the strengths of the think family Social Work Assessment Pilot in 2017-2018. The forum has also delivered training by the Social Work development lead on Declaratory Orders exploring good practice and introducing a template for the completion of applications to court, developed by the Social Work development lead which was commended by DLS.

In addition, the service has experienced an increased need to consider the use of Guardianship (with three currently pending transfers into guardianship and one further considered case) in addition to seven current guardianship cases considered for renewal annually. This has illustrated the need for further training to be provided to Social Work staff and work by the acting PSW to develop a template and operational guide to inform staff and ensure consistency across the service area. The Forums continue to embed the unique contribution that Social Work brings to the experience of mental health service users, carers and the public.

Approved Social Workers
There are currently twenty five active ASW's on the day-time rota with 2 additional ASW's pending ratification by QUB and six ASW candidates in training (due pending successful completion to be able to participate on the rota from February 2020). This includes one fulltime ASW to support the demands on the rota and the limited number of ASW's available to participate on the daily rota sixteen slots per month are provided by this member of staff. There is also one agency ASW who provides approximately 5 slots per month.

Approved Social Work Forum
The acting PSW has developed a bespoke ASW Forum which takes place on a bi-monthly basis. It provides a mechanism for the development of ASW practice skills, shared learning, dissemination of policy and legislation, and practice development.

The PSW or an experienced ASW/DAPO provides bespoke 1-1 professional ASW supervision on an eight-weekly basis. Each ASW has face to face supervision at bi-monthly intervals.

	ASW Supports in practice ➢ ASW manager co-ordinating the rota daily ➢ Yearly ASW audit – pending appointment of ASW trainer. ➢ ASW risk assessment review arranged currently due to limited ASW cohort due to recent staff leaving posts and to continue focus on ASW recruitment and retention. ➢ Buddying system being considered ➢ NHSCT model of operation being explored but is not currently operational due to lack of sufficient numbers to operate this model. ➢ Service user feedback being implemented following MHO assessment – QI initiative been planned currently. ➢ Regional ASW forum to share learning and develop practices e.g. documentation, information leaflets. ➢ Current audit of GP availability and impact on service. ➢ Representation on the regional bed management protocol meetings, ➢ DATIX recording of all prolonged assessments or impact on service delivery which has an impact on risk management. ➢ 8a on call out of hours practical support offered by the 8a service rota as and when required. ➢ The regional ASW working group has reviewed the information that is given to the service user and the nearest relative at the point of assessment under the Mental Health Order and this will be utilised on completion by all Trusts to ensure consistency across the service area. The Acting PSW has also reviewed the information provided by the medical records department to the service user and nearest relative at each stage of the detention process. ➢ ASW Training 3 Year refresher training ➢ Bespoke training matrix for ASW staff being developed. See sections 3.3, 3.5-3.7 for further updates on ASW practice
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).**
	Mental Health Service Adult Safeguarding Audit An audit of adult safeguarding processes was undertaken across mental health teams including inpatients, in March 2019. While there were some areas for improvement, the audit illustrated that in 87% of cases, adult safeguarding referrals were appropriately made and detailed, with line manager decision making and in 97% of cases there was a protection plan fully completed or an appropriate alternative response. Completion of significant interview ASP3 was completed in 97% of cases where this was required and ASP4 risk assessment completed in 38% of appropriate cases. The use of ASP4 has been limited and may have influenced the outcomes. This has been addressed through support groups, an aid memoire developed for community teams and bespoke refresher training to be provided this year for mental health teams. The main areas for improvement identified were in regard to confirmation of the capacity of service users on the referral ; details of the alleged incidents including dates/times etc, updating CRA tools; care plans and Paris recording with adult safeguarding investigations/referrals; completion of detailed line manager decision – making; specific actions taken in alternative responses should be detailed more clearly; timescale for completion of adult safeguarding investigation linked to team pressures and capacity; detail included in documentation at times could be improved; evidence of copy of the protection plan being given to service users and being signed by them was unclear; clarity on the

outcomes and future actions, e.g. in GP letters ; more consideration of the completion of ASP7 where appropriate and completion of service users comments including wishes and understanding of plan agreed.

While there is work to be completed in regard to further embedding the regional policy and procedures (2015; 2016), the audit indicated compliance with the majority of processes necessary. Further work will be completed with the implementation of adult safeguarding onto Paris and use of the APP forms which will be undertaken in the months to come. This will also facilitate the implementation of a single integrated gateway for adult safeguarding across the directorate with consistency of documentation and systems being developed across each programme of care.

See LASP report for further detail.

Supervision File Audits
Team Leaders are required to audit two case files during supervision sessions. While Operations Managers retain responsibility for assuring this process, professional supervisors also audit work completed by supervisees to give assurance regarding competence and meeting agency and professional standards. This includes at least two pieces of work at each supervision session, with feedback provided by the professional supervisor. Where concerns in relation to performance/professional competencies emerge, the professional supervisor, in consultation with the team leader and supervisee, is responsible for identifying the necessary actions/supports/timescales to progress requisite improvements.

Audit of ASW requests from GP's for Mental Health Order Assessments
There has been a noticeable trend in requests for assessment under the MHO by GP's to be made in the afternoon or where joint assessments are delayed due to lack of GP availability resulting in assessments increasingly occurring after hours. This has had a significant impact on the delay in assessments taking place which may potentially increase the risks to the service user and others and also reduces the ability of keyworkers to be able to support the GP and ASW during assessments if delays are lengthy and significantly after working hours. Additionally this has had a significant and negative impact on current ASW's whose working hours can span up fifteen hours due to commencing the assessment and conveyance process later, resulting in protracted after hours working. This has an impact on the working arrangements of the ASW, impacts on family life and also on the ASW's substantive post the following day. This has impacted on recruitment and maintaining the current ASW team on the rota.

An audit of ASW requests by GP's was undertaken by the acting PSW from September to December 2018 to quantify the frequency of requests made by GP's later in the daytime impacting significantly on the assessments taking place out of hours. The audit indicated that 15% of all requests for MHO assessment were delayed due to GP availability and 25% of all assessments requested after 3.30pm by GP's which will require ASW's on the day time rota to work after hours. Outcomes identified will be replicated at a regional ASW audit facilitated through the regional ASW forum and will be considered where there are local and regional implications for service delivery.

The Service has continued to explore options to address recruitment and retention pressures in respect of the ASW Daytime Rota with some success although underlying workforce challenges remain significant. This has been further highlighted by workforce

planning in regard to the Mental Capacity Act which suggests that ASW recruitment will need to be a priority. See below and section 9 for further discussion.

Workforce Review

The Service has been reviewing on an ongoing basis, the Social Work workforce and the needs of the service area in regard to the discharge of statutory functions and also in regard to future planning. This has been influenced by the departmental review of recruitment of Social Workers across the region and development of pathways to maintain Social Workers within the HSC workforce. At the recent Social Work Workforce Workshop 14th March which illustrated the key areas where recruitment and career development may be impeded, innovative ways to recruit and maintain staff within the workforce were considered. Consideration was also given to the working environment and job satisfaction in an effort to retain experienced staff.

A further factor is the impact of the roles and responsibilities identified with the forthcoming Mental Capacity Act, which has recently been recommended by the department to be partially implemented by October 2019 in regard to consideration of cases where there may be deprivation of liberty. The acting PSW recently arranged a regional workshop with ASW's and leads from across the five Trusts to consider the Mental Capacity Act draft Code of Practice and implications for ASW's currently trained and their current posts. In summary, the issues of concern in regard to the draft code have been summarised in section 3.8

Further work will be undertaken at the forthcoming Mental Capacity Act workshop in May 2019 to consider the social care workforce requirements which will need a focus on the issue of normative staffing levels to ensure capacity to discharge current and anticipated designated statutory Social Work responsibilities conferred in the Capacity legislation. This will have particular importance if the Act is partially implemented this year.

Recruitment and Retention

The previous year has seen continued difficulty in recruitment of nursing staff into community teams. While this has impacted on teams in regard to professional skill mix this has been an opportunity to increase the Social Work compliment as temporary Social Work posts have backfilled generic vacancies to meet service need with mainly band 5 AYE staff. This has increased the need for increased professional Social Work supervision and increased frequency of supervision for AYE staff.

The recruitment and retention of Band 7 Team Leaders has been a challenge but has improved with the recruitment of five permanent Team Leaders, one acting Team Leader and two clinical service managers all of which are Social Work trained and therefore provide Social Work professional supervision and developmental guidance to Social Workers in community teams. Social Work trained team leaders also have additional responsibilities relative to their non-Social Work peers as they also undertake DAPO and ASW roles. This has been an issue regionally and has impacted on team leader responsibilities. Increased operational demands arising out of the ASW and DAPO roles for team leaders is not sustainable. This is being supported currently by the recruitment of two Senior Social Work practitioners to support the community mental health teams, currently six teams which will be integrated into 4 teams to cover north, south, east and west Belfast. These roles will support team leaders in statutory functions.

Assessment Centres
The Service's Assessment Centre model was developed in 2018 as an innovative approach to service delivery to meet the increasing demands for mental health assessment following GP referral. The service is currently providing 60 slots per week for mental health assessment and 10 slots per week for psychiatric assessment across Belfast with an attendance rate of 70% and a reduction in waiting times. Assessments are provided in a multi-disciplinary model and are based in two Belfast sites, in north and east Belfast. The model is an evidence-based approach, which aims to address waiting list pressures.

The two Assessment Centres have workforce complements comprised of two Band 6 Social Workers, two Band 7 Senior Social Work practitioners (only one currently recruited), four psychiatric nurses, and two co-ordinators located at two sites- Woodstock Lodge and Old See House. The two senior practitioners have responsibility for providing professional supervision to the Band 6 Social Work staff, DAPO role and Think Family considerations.

Think Child, Think Parent, Think Family Strategy
The Think Family Social Work Assessment (TFSWA) pilot commenced in January 2017 to March 2018. The model seeks to deliver improved services and supports to families in which a parent has mental health difficulties with the aim of reducing the potentially negative impact of parental/carer mental illness on children through holistic assessment of the individual family members within a collaborative, inclusive, multi-professional and multi-agency assessment tool and enhanced 'family support plans' underpinned by 'The Family Model' (Falkov 2012).

The outcomes of the regional pilot (of which the Trust completed over half of all assessments) were significant and illustrated key themes from feedback from service users and carers;

- 83% advised they had better understanding of the impact of their illness on child and family.
- (92%) of respondents, also perceived that the family conversation had improved relationships with children and other family members
- In (92%) adults indicated satisfaction with family focused practice.
- In (62%) of adults, the family conversation had helped increase understanding of cultural and community influences.
- MDT feedback was very positive in promoting family conversations and understanding between family members regarding mental illness.

The outcomes of the pilot have been far reaching and have fuelled the development of several other projects as follows,

1. A Think Family symposium held 17th May 2018 hosted by Queens University Belfast and the Health and Social Care Board which focused on international examples of family focused practice of which the TFSWA pilot was featured as an example of practice and as part of an international study. The acting PSW presented on the regional outcomes of the TFSWA pilot and in regard to use of 'The Family Model' (Falkov 2012) within the Trust. This is further supported by the Champions model and by the four champions who have been trained in use of 'The Family Model by Dr Adrian Falkov.

	2. The PSW has also written a submission to the Journal 'Advances in mental health' which is being considered for submission in the special edition journal 2019 in regard to Family Focused Practice. The article is based on the findings of the regional TFSWA pilot and the benefits for family focused practice. 3. The Acting PSW will be attending an international conference in OSLO conference 'it takes a village' in May 2019 to present the findings of the TFSWA regional pilot based on the findings of the research. This is an opportunity for the Trust to demonstrate their commitment to the 'Think Family' ethos, how this has been embedded into practice and how this model can demonstrate significantly positive outcomes for families without significant resource implications. 4. The Family Model (TFM) e- learning – so that TFM can be accessible to all staff working with families, in conjunction with the HSCB, filming of TFM based on real sessions undertaken with champion staff who were involved in the pilot will take place on the 7th May 2019. One of the champions from the Trust will be a participant in the filming based on real case studies. This will then be used as educational material and accessible through the leadership platform to enable training of staff in use of the model at beginners, intermediate and advanced levels. Again the Trust is fully participant in this exciting venture and in evidence informed practice. 5. A Think Family audit being undertaken by QUB on behalf of HSBC of team files in mental health and addictions services is in the process of being completed in the Trust. This is part of a regional audit of how the 'Think Family' approach has been embedded into practice in regard to family focused approaches to working with families. The outcomes will be shared regionally.
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 interfaces with a number of other statutory agencies in relation to the discharge of its statutory functions responsibilities. These include: **NISCC** The Service continues to remain compliant with NISCC's registration requirements pertaining to the social care workforce, and work actively to ensure the Trust and its workforce meet NISCC requirements for Standards of Practice and Conduct. **RQIA** The Service Area continues to comply with required reporting of all notifiable incidents in accordance with regulations, also working in partnership with RQIA to address concerns and/or seek clarification on statutory functions where required. The Service complies with recommendations emerging from RQIA inspections of regulated services. A recent inspection of inpatient wards within the Trust indicated good adherence to the Adult Safeguarding Operational Procedures (2016) by inpatient staff and in regard to procedure being followed during DAPO co-ordination of investigations.

	The Director of Social Work updates RQIA in relation to the appointment of ASW's within the Trust, guardianship applications, transfers and renewals, application to the MHRT as well as automatic application for MHRT as required. **Declaratory Orders** Consistent with NISCC standards and RQIA advice, the Trust has worked in collaboration with Directorate of Legal Services in attempts to resolve complex cases involving service users deemed to lack capacity to consent or object to decisions on their welfare, including considerations of Best Interests and deprivation of liberty safeguards. In the last review period, the Trust has sought and withdrawn one Declaratory Order application, with a further two applications currently pending. **PHA** The Community and Partnerships Service regularly interfaces with a range of statutory agencies in the delivery of services. The Drug Outreach Team is a PHA-funded service providing an outreach function targeting 'hard-to-reach' injecting drug users, with the aim of encouraging harm reduction approaches to drug misuse and facilitating engagement with Tier 3 services to provide Oral Substitution Therapy. The service has continued to focus on the needs of this vulnerable and at risk service user group with particular focus on adult safeguarding with an increase in referrals in regard to service users at risk of sexual violence in the context of drug misuse. This will be kept under review with a view to considering how interface agencies can best meet the needs of service users, particularly close working relationships with community policing. Further transformational funding has contributed the inclusion of health care services in the development of a Homeless Hub at Townsend street nearby the Welcome Centre. It is envisaged that this will be a multi-disciplinary resource with a 'one stop' access to a range of support advice and physical care services for the homeless community with the aim of enabling those who are most vulnerable to achieve health and stability in improving their quality of life. Currently premises have been secured and a band 6 nursing post with a view to a Band 7 senior Social Work Practitioner post. **Other Statutory Services** The Service is committed to partnership working with all statutory agencies, which have responsibilities interfacing with those of the Service. 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.)

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
	➢ **<u>Approved Social Work</u>** **Recruitment and Retention** There is a continued challenge in recruiting and maintaining ASW's on the daytime rota. While numbers have increased due to the Trusts commitment to training six ASW's per year, there has been a loss of six ASW's during the reporting period due to planned retirement (1); the demands of the role (3); and due to promotion and staff moving post (2). Recruitment of ASW candidates has also proved challenging due to the impact of lengthy and unpredictable working hours as a result of limited resources (GP, ambulance, police and beds). The Service is taking forward the development of data collation, management and analysis on PARIS as part of a Directorate-wide focus on substantially enhancing its information infrastructure and reporting capacity. This will aid current and future workforce planning regarding the ASW service.	Development of a full time ASW who completes sixteen slots per month and an agency ASW staff member provides five slots per month on the rota which has substantially enhanced the ability to cover the daily rota and provide assurance of the Trusts ability to deliver statutory functions. There are currently twenty five ASWs maintaining the Trust's Daytime Rota with two additional ASW's pending ratification by QUB and six ASW candidates in training (due pending successful completion to be able to participate on the rota from February 2020).	The Daytime ASW Rota is reviewed yearly under the risk assessment framework within the Trust Governance department. This is being reviewed currently as there have been six ASW's who have left the day time rota in the last year due to various reasons which has impacted significantly on the SW cohort. This may necessitate the ASW service being again added to the Trust risk register following removal last year due to improvements in service provision.

	Two further ASW's will be leaving the rota in the next few months due to commencing new posts. There are three ASWs on the Rota per working day and, as required, there is a need to increase this number when more than three assessments are taking place simultaneously. **Mental Capacity Act** The Draft code of Practice for the Mental Capacity Act identifies key statutory roles for ASW which entail a significant extension to the current roles under the Mental Health Order. Therefore profiling of future ASW numbers in this context is a priority with the need for representation across all key programmes of care given the brevity and scope of the Act.	For the third year the Trust has funded six ASW candidates per year to enhance the current ASW cohort. Three candidates successfully completed the Programme in the reporting period, with two pending ratification and one to resubmit in September. The Trust will continue to fund six places per year. The Trust has continued to engage in the regional consultation processes linked to the development of Regulations, guidance and policy related to the implementation of the Mental capacity legislation. The Trust in partnership with the Norther Trust recently convened a regional ASW group to consider the draft code of practice and regulations to provide feedback to the department. This will also inform the forthcoming Mental Capacity Act workforce planning on the 2nd May. The potential breadth and scale of the legislation across all services, the substantial logistical and organisational challenges in respect of workforce training delivery, service delivery processes and governance structures will be reviewed following this consultation.	

	Acute admission beds There remains ongoing challenges for ASW staff due professional, logistical and organisational demands of the role. Working alone/autonomously, co-ordinating increasingly complex situations further exacerbated by limited GP, police and ambulance availability, and at times there continues to be limited bed availability. The regional bed protocol can add to delays in waiting for a consultant to consultant agreement on out of area admissions which are increasingly common due to limited bed availability. During delays the ASW has to support acutely unwell service users, at times where there can be risks to staff and others while also supporting often concerned and frustrated family members.	Following significant difficulties in securing inpatient admissions in the last reporting period, a new model has been developed by the Trust on all admissions to adult psychiatry wards called PIPA (Purposeful Inpatient Admission). The model is based on the Toyota production business model and aims to chart the patients admission from day one with the aim of planning discharge by reviewing all patients daily and reporting on outstanding actions at the 'report out' this is consolidated with a Formulation meeting within three days of admission. This has improved the admission process with a reduction in bed occupancy resulting in more bed availability and resulting reduction in prolonged assessments for ASW staff and patients. The Acting PSW attends the regional bed management group to participate in action planning regarding bed management regionally. Following a temporary suspension of the Trust established Multi-Agency Working Group due to changes to senior management, this group has recently reformed. This includes representation from PSNI, NIAS, GPs/ Primary Care, Acute	

		Hospital Services and Mental Health Services, to provide a forum to promote collaborative interagency practice under the Mental Health Order.	
	Length of time to complete ASW Assessment The time scale for completed assessments remains similar to last year, approximately 7 hours on average. Key delays in assessment and conveyance remain the same in regard to GP limited availability to react to assessments when requested, reduced prioritisation when ambulance requested, police use of interagency protocol (2017) has continued to impact on police assessment of the need to assist in assessments and bed availability. The latter has been further impacted on a reduction in admission to Muckamore Abbey Hospital thus requiring the admission of service users with learning disabilities who require admission to adult psychiatric beds. In addition, the recent audit of GP requests for Mental Health Order assessment indicated that 15% of all assessments were delayed due to reduced GP availability to attend an assessment when	A recent regional bed pathway for learning disability patients has been developed while this is welcome it has not improved delays. As part of cross-Divisional efforts improvements in interface working, the acting PSW will deliver training on the role of the ASW within MHO assessments to Emergency Department staff. This has been delayed in provision due to a lack of mental health trainer. This will be provided by a social work consultant in conjunction with medical staff The Service is taking forward the development of data collation, management and analysis on PARIS as part of a Directorate-wide focus on substantially enhancing its information infrastructure and reporting capacity. The Regional ASW forum will continue to review patterns in MHO activity and	

	requested and 25% of all assessment requested after 3.30pm resulting in ASW's working after hours. **Conveyance to Hospital** The Regional Interagency Protocol on the Operation of Place of Safety and Conveyance to hospital under the Mental Health Order (1986) (2017) provides the current operational framework for PSNI attendances at ASW-managed admissions for assessment. **Demands on ASW workforce** The cumulative impact of these demands on the ASW workforce give rise to significant reduced role satisfaction and challenges in recruitment and maintaining staff on the rota. Engagement with staff members, staff side and professional representatives, the Service is seeking to further services and supports to ASW staff in this complex and challenging role.	practices to ensure that service delivery is meets the needs of service users and carers with assessment of the impact on staff and service provision. The Department has requested a review of the Protocol in light of the issues associated with PSNI capacity and attendance referenced above **ASW Provisions**; ➢ **Memorandum of Understanding between RESWS and BHSCT:** Due to the increase in prolonged assessments under the MHO due to issues aforementioned, the agreement enables day time and RESWS ASW's to hand over assessment to each other where timescales for assessment are extended beyond reasonable working hours. This has been in place since May 2018 which has been successful where there is availability in each service.	

		➢ **ASW Supervision:** each ASW has face to face supervision at bi-monthly intervals, ASW forums run bi-monthly, multiagency interface meeting being reconvened, service user and ASW feedback on service development and supports being implemented. ➢ **ASW Supports:** ASW manager co-ordinating the rota daily ➢ Yearly ASW audit – pending the recruitment of the co-ordinator ➢ ASW risk assessment ongoing review. ➢ Buddying system being considered ➢ NHSCT model of operation being explored but is not currently operational due to lack of sufficient numbers to operate this model. ➢ Service user feedback being implemented following MHO assessment – QI initiative been planned currently ➢ Regional ASW forum to share learning and develop practices eg documentation, information leaflets. ➢ Current audit of GP availability and impact on service. ➢ Representation on the regional bed management protocol meetings,	

		➢ DATIX recording of all prolonged assessments or impact on service delivery which has an impact on risk management. ➢ 8a on call out of hours rota support offered if and when required for practical issues. ➢ ASW Training: three year refresher training, training sessions at ASW forum, ASW supervision, bespoke training matrix for ASW staff being developed	
	ADULT SAFEGUARDING The referral numbers for 2018/2019 were 825. This is an increase of 20% from levels recorded during the preceding year. Completed investigations during the reporting period were 41. This is also an increase of 10% on the previous year's figures. Protection Plans 417, an increase of 15%. Joint Protocol 10, a decrease of 50%. ABE interviews 3, a decrease of 70% The Adult Safeguarding Policy has identified the Designated Adult Protection Officer (DAPO) role as a Band 7 senior practitioner or a Social Work Manager. There have been continued demands upon	➢ Bespoke mental health adult safeguarding training developed and provided to new staff. ➢ Refresher training to existing staff with focus on completion of documentation and recording skills. ➢ IO/DAPO support groups ➢ Aid memoire developed to aid completion of safeguarding documentation by MH ASG team ➢ Meeting with staff side and divisional social work and nurse leads to improve understanding of the IO/DAPO/ line manager roles	

	a limited pool of Band 7 Social Work staff within the Service arising out of limited number of designated Social Worker and Senior Social Work practitioners within teams to take on the role. There has also been an increase in adult safeguarding activity and their related ASW and operational management duties are unsustainable. At present there are 14 DAPOs delivering the role into forty one services, with the most substantial remit carried by the Adult Safeguarding Team providing DAPO support to twenty-three services. For the nine ASW trained DAPO staff the role also includes; ➢ The provision of advice and guidance to staff (all professions) and outside agencies on safeguarding issues. ➢ Liaison with the PSNI regarding whether investigations should be single agency or joint protocol managed.	➢ Development of single integrated referral gateway across the directorate ➢ Implementation of APP forms onto Paris across the service area to improve governance arrangements and to aid data collation. ➢ It has been agreed that an *a lead for ASG is required, a job description will be developed and it is hoped that the post can be advertised in the next number of months.	

	➢ The provision of Social Work professional supervision to Social Work staff who have a non-Social Work operational manager. ➢ Practising as ASWs on the Daytime Rota ➢ Practice Assessors for ASW Programme. ➢ MARAC lead role and collation of adult safeguarding data returns. There continues to be challenges in the embedding of adult safeguarding awareness and practice knowledge, particularly in those services in which there is no current Social Work, these are as follows; ➢ Refusal of band 6 nurses to undertake IO training. ➢ Completion of documentation to Trust standards in regard to appropriate content ➢ Understanding of the role of the IO ➢ Further embedding understanding of alternative responses ➢ Further development of line manager decision making ➢ Completion of documentation within timescale due to prolonged reduced team capacity.		

	➢ Workforce planning also needs to be cognisant of parallel responsibilities for Band 7 social work staff in the context of adult safeguarding duties, ASW role and Team Leader functions.		

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.**
	Vacancies Currently there are six Band 6 temporary social work vacancies due to secondments, two permanent Social work vacancies, and two permanent team leader vacancies with the permanent PSW post to be recruited imminently. All these posts are currently in a recruitment process but there are delays evident in the recruitment processing systems outside of Trust control. Vacancies can create instability within teams, and with a significant number of expressions of interest currently, the focus within community teams is to fill positions permanently. The challenge of recruiting into Social Work positions both locally and regionally was explored at the Social Work Strategy: Workforce Workshop on the14th March 2019. The focus was on processes used in recruitment systems, competition between Trusts in recruiting from the same pool of applicant, difficulty in retaining staff in positons due to the high number of temporary posts and number of Social Workers who prefer the flexibility of agency working which can result in a high staff turnover and impact on service consistency and stability. The OSS Workforce Data based on 2018-2019 OSS statistics was explored in workgroups focused on Succession Planning, Agency and AYE Working and scoping the structural issues that need to be addressed to increase regional consistency for the future workforce. The OSS will analyse current trends and implementation issues to make recommendations that will shape the future workforce and action Social Work Strategy outcomes. The issues of limited protected posts/normative staffing for Social Work was also highlighted in the context of the Mental Capacity Act implementation. **Social Work and Team Leader Recruitment and Retention** Fortunately the service has supported Social Workers to take up team leader positions in five community mental health teams (including drug outreach team) which has bolstered the Social Work development and prioritising of delegated statutory functions within teams. This was supported by negotiations with staff side representatives in the previous reporting year in securing two of the Service Team Leader posts to be designated Social Work posts. This will provide much needed professional supervision and DAPO capacity. This was further supported by the recruitment of two temporary Clinical Services Managers who are both Social Workers to support the team leader role, Social Work delegated statutory functions and service development. It has been acknowledged that the team leader role for Social Work trained managers is challenging as in addition to the Team Leader responsibilities,(incorporating line management and professional supervision), they are required to undertake the DAPO role and also participate on the ASW Daytime Rota. This is a regional issue, profiled as a workforce priority in the regional Workforce Social Work Strategy.

	The Service management structure of community mental health has been redesigned during the reporting period to provide further support to primary and recovery teams. The structure of those teams providing front line assessment and interventions to service users within the service area is being reviewed to provide a model of care that targets need effectively, is responsive and timely, recovery and service user focused and accessible to service users and carers. A focus of the review process will consider the skill mix within teams and further consideration to the need to protect posts to ensure current and future service needs in regard to delegated statutory functions can be met for example in regard to MHRT provision, IO and DAPO roles, professional supervision and developing ASW candidates. There is a pressing need to establish a robust workforce planning approach to ensure sufficient Social Work capacity to discharge bespoke statutory functions and to contribute to a range of core skills and knowledge essential to the delivery of safe, qualitative, evidence based, co-produced services. **MHRT Social Circumstances report requests** The last reporting period has seen an increase in requests for tribunals to be heard within the assessment period (6 within the reporting period). This has been a trend in recent years. In the context of the volume of service delivery demands, this can be a pressure on involved Social Work staff to complete the necessary report in adequate detail within the specified time-scale. Good practice guidance requires the report is lodged with the Mental Health Review Tribunal (MHRT) two weeks prior to the Tribunal hearing, which is not feasible within the 14 day assessment timescale. **Approved Social Worker Service Provision** The Service has outlined the major workforce challenges, which are impacting on the delivery of the ASW Daytime Rota and its ongoing efforts to address recruitment and retention of ASW staff in the short and longer-term. Please see 3.2, 3.3, 3.5-3.7 above. **Mental Capacity Act (2016)** The draft Code of Practice for the Mental Capacity Act issued in December 2018 details significant roles for Approved Social Workers. These roles include: 1. Making a short–term detention authorisation; 2. Consultation where a nominated person objects to a short-term detention authorisation; 3. Membership of Trust panels that will authorise; a. Treatment with serious consequences where the nominated person objects; b. Detention amounting to a deprivation of liberty; c. Attendance requirements; d. Community residence requirements

	As previously discussed, the Acting PSW had arranged in partnership with the NHSCT, a regional ASW workshop on the 16th April 2019 to enable ASW's across the five Trusts to explore and review the draft code of practice and regulations in consideration of the impact on their current role as ASW and also in consideration of the future requirements of the role with extended responsibilities. Key themes emerged which inform a regional Mental Capacity Act Workshop being held by the Department on the 2nd May 2019; 1. Emergency interventions: completion of statement of incapacity, request for emergency assessment for intervention and process, guidance on the process of disregarding Safeguards in an emergency. 2. Short-term detention authorisations: Sequence of short term detention process, completion of Capacity assessment and best interests, where assessment will take place, definitions for example POH, POSH and 'the meaning of liable (to be detained)' in different contexts, definitions of Prevention of harm and type. 3. Legal Power to convey, use of Warrants, process of application and documentation and in what circumstances can these be used. 4. ASW report completion and governance arrangements. 5. Trust Authorisation Panels: planning in regard to operationalisation, extent of the ASW role on the panel, responsibility for making applications to be clarified. 6. Review Tribunals: process for applying to a tribunal roles and responsibilities for practitioners, legal supports. 7. Need for dual training of ASW's on both pieces of legislation. 8. Training timescales and resource implications given current challenges to ASW recruitment and retention of staff.
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 & Nursing Homes Charging – The Trust operates in accordance with the DHSSPS April 2015 Charge for Residential Accommodation Guide (CRAG) to determine charges. Updated guidance has been circulated to staff. Home Help Service – The Trust operates in accordance with the Model Scheme for the Provision of a Home Help Service The Trust does not currently require service users to contribute for assessed domically services.
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**
	Currently the Hospital Social Work team is made up of five Social Workers and one discharge co-ordinator. At the time of reporting there has been one long term permanent vacancy of the discharge co-ordinator (soon to be filled) and one Social Work post vacancy. The service is provided at each of the

	current hospital sites, the Mater (three wards) and Knockbracken Healthcare Park (Avoca, Rathlin, Clare and NRU) however the new acute inpatient centre at City hospital site is due to open on the 20th June 2019 where all wards will be relocated to one site. This will provide significant benefits for service users and carers with accessibility to major transport routes and will also remove the need for service users to be transferred between sites should they require psychiatric intensive care. The facilities are of a high standard providing service users with individual rooms, surrounded by gardens to aid their recovery with family contact room for each ward and various therapeutic activities on site. Social Work has advocated for the role within the multi-disciplinary context particularly within the PIPA framework. Social Work is a core function of the hospital MDT with specific roles in relation to all new patient admissions to the service. Key Social Work interventions are; ➢ Formulating a social history with the service user and their carers, ➢ Developing service user's treatment and care plans ➢ Co-ordinate links with other statutory agencies e.g. children's services, probation, physical disability services, care management, and also community services. ➢ Wellness Recovery Action Planning (WRAP) ➢ Carer and young carer assessments ➢ Think Family ethos (participation in the completion of the TFSWA pilot in the last reporting year) ➢ Adult safeguarding referral and investigation – completion of the IO and DAPO roles by the hospital Social Work team. ➢ Delegated statutory functions in regard to MHRT completion, guardianship and liaison with children's services. ➢ Family and carer liaison and consultation ➢ Discharge and contingency planning to include care management referral and accommodation planning ➢ Psychosocial interventions and use of models to underpin relational working with service users and carers to promote a recovery based person centred approach to care and self- determination. ➢ Trauma informed practice for example signs of safety and Adverse Childhood experiences. ➢ For those service users already known to a community Social Worker, hospital Social Work staff will liaise with community services to manage service delivery continuity across the discharge pathway. Currently the acting PSW is contributing to the inpatient review of role of Social Work within the MDT along with other professional leads to consolidate key interventions within the hospital environment and to agree outcomes based measures. This will ensure that outcomes for service users continue to be tracked and there is a benchmark to demonstrate the unique contribution that Social Work makes to the acute inpatient experience.
3.11	**Provide a summary of actions undertaken to adopt a Human Rights based approach in your work with service users and carers.**
	The principles and ethos of a Human Rights approach is of central importance to all aspects of Social Work and Social Care interventions. It is the

	foundation upon which we base all aspects of care, support, advice and professional practice. In ensuring that a Human rights based approach remains pivotal in all aspects of care and governance arrangements, it is necessary to review and ensure adherence to both Trust roles and responsibilities in terms of person centred, recovery focused interventions based on a partnership approach in meeting the needs and rights of Service Users, carers and families in ensuring timely, appropriate and effective access to service provision. Consolidation of a human rights approach is integrated into all aspects of Social Work practice in several ways; **Discharge of statutory functions** **Mental Health Order Assessments** The use of statutory powers under the Mental Health Order is mandated only in those circumstances in which, following rigorous application of the Mental Health Order, there is a significant risk of harm to the individual or others thus necessitating compulsory powers to be used which are proportionate and lawful. Such assessments take place where there is no alternative options available that can safely provide the level of care required for the Service User and the least restrictive option has be explored. In such complex situations, it remains necessary for the ASW to remain cognisant of their roles and responsibilities in working in partnership with the Service User. It is necessary to be transparent where this is possible and to uphold the dignity and respectful treatment of Service Users in all situations where this is not contrary to the safety of the Service User and others. Monitoring of ASW practice is undertaken in professional supervision and professional responsibilities and good practice standards are reiterated at the ASW forums that take place bi-monthly which have a human rights focus. In addition, ASWs are required to undertake refresher training every three years and to undertake at least 2 assessments per year to maintain their ASW registration. ASW reports are also reviewed at professional supervision to ensure that professional and Trust governance standards are met alongside ensuring that any interference with the Service Users Human Rights have been clearly explained and evidenced in regard to proportionate and lawful practice. The Service User and nearest relative have the right to appeal a compulsory admission to hospital via the mental health review tribunal which ensures that the Service Users human rights are enforced particularly in regard to Article 5, article 6 and article 8 of the Human Rights Act (1998). Consideration of Guardianship also follows this ethos. **Declaratory Orders** Consistent with NISCC standards and RQIA advice, the Trust has worked in collaboration with Directorate of Legal Services in attempts to resolve complex cases involving service users deemed to lack capacity to consent or object to decisions on their welfare, including considerations of Best Interests and deprivation of liberty safeguards. In the last review period, the Trust has

	sought and withdrawn one Declaratory Order application, with a further two applications currently pending. **Deprivation of Liberty** Human Rights considerations are central to professional decision-making. Documentation co-produced with Service Users in regard to the Regional Mental Health Care Pathway illustrates partnership and joint ownership of equality and ethically based assessment and service provision. Reports linked to the discharge of statutory functions involving restrictions of personal liberty must be explicitly justified and evidenced in terms of practice and regulated. Any Deprivation of Liberty must be explained, recorded, reviewed and shared with the Service User, All statutory agencies such as RQIA, and reviews undertaken by the MDT with family members must explicitly explain and address those situations where a deprivation of liberty is of absolute need to maintain the safety of the Service User and/or others. Specific training is provided in relation to the 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, MHRT and referrals to the Office of Care and Protection. Training for all Social Workers on preparation for and presentation at a MHRT including a focus on the Human Rights Act (1998) was provided in training at the Social Work Forum on the 7th June 2017. This is also addressed through mandatory training within the Trust and mandatory 3 yearly ASW renewal training.

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 balanced consideration of the criteria for assessment, representation to the mental health review tribunal, application for and renewal of guardianship and undertaking the ASW role in the Supervision and Treatment Orders to be fully interpreted with reference to the Human Rights Act (1998). Adherence to both pieces legislation needs to ensure that actions taken are lawful, necessary and proportionate. This is also applied to increasing applications made to the court in respect of Declaratory Orders where deprivation of liberty requires court directed interventions. There are implications for the balancing of rights with the proposed partial implementation of the Mental Capacity Act recommended by the Department by October 2019. Current legislation does	➢ Provision of training session in respect of guardianship and Declaratory Order application at social work forums within the reporting period and last year in regard to MHRT training. Also the provision of training on disability discrimination Act. ➢ Mandatory training matrix is being updated for all mental health services in conjunction with the acting PSW which will highlight all corporate workforce training including human rights training. ➢ Champions Model continues to grow. Each quarterly meeting (four per quarter) has encouraged ongoing attendance by champions across the service area adopting a think family ethos of inclusion, family recovery, advocacy and a rights based approach to holistic intervention with families. ➢ Ongoing emphasis on learning from practice experience and sharing of knowledge through attendance at ASW forums (bi-monthly) and Social Work forums (quarterly) to enhance decision-	Ongoing work as detailed

	not make provision for current consideration of deprivation of liberty, hence the new legislation is welcome. However, there are significant resource, financial, operational and training implications for the Act to be implemented and further guidance is required to action this regionally. Balancing of service user Article 2, 3, Article 5, 6 and 8 rights, and statutory duty to safeguard adults at risk of harm and in need of protection. Consent to make a referral and to share information during investigations require a partnership approach based on transparency and openness in enabling service users to understand the duty of the Trust in reporting crime. This can be a difficult process where the service user does not wish to make a complaint. While IO's are guided by the Adult safeguarding policy and Procedures (2016), further work is being undertaken in conjunction with the training team to enhance IO/DAPO/line manager decision making with regard to thresholds and criteria for considering situations where consent is overruled in the interests of public safety.	making, risk analysis and interpretation into recovery based action planning with service user participation, human rights focus based on dignity, respect and advocacy for service users and carers to fully participate in decisions regarding their lives in this complex area. ➢ Provision of quarterly DAPO and IO support groups to share learning and to disseminate practice developments in regard to further embedding a rights based approach to adult safeguarding investigation. ➢ Bespoke mental health DAPO and IO refresher training is being developed with a focus on decision making skills and recording of investigation documentation. ➢ Ongoing training with regard to MARAC and PPANI processes. ➢ Mandatory corporate data protection training. ➢ Use of Best Interests toolkit developed by the Trust training provided at the social work forum. ➢ Continued consideration for the need for applications to High Court in those cases where significant deprivation of liberty is identified pending Mental	

		Capacity Act Legislation. Ongoing consultation with legal services. ➢ Regional ASW meeting undertaken to consider the implications of the Mental Capacity Act for the ASW role. This will contribute to the feedback provided to the Mental Capacity Act Reference Group and workforce planning workshop. ➢ Engagement with and participation of carers/extended family in all circumstances where a deprivation of liberty is identified. ➢ Engagement of independent patient and carers advocacy. ➢ Adherence to Adult Safeguarding Policy and Procedures. ➢ Engagement with the service user to establish their wishes. If lacking capacity, use of Best Interests framework to facilitate multi-disciplinary decision-making.	

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	➢ **Recruitment of Senior Social Work practitioners and Social Work managers** – to support the delivery of statutory functions in community teams, there have been 5 Social Work trained team leaders appointed, two Social Work trained Clinical services managers and six Senior Social Work practitioners being trained per year across the directorate in adult services with the ASW training. ➢ **Memorandum of Understanding** – close working relationships with ASW managers within RESWS and the day time rota has developed this agreement which serves to support ASW in both services where there are prolonged delays in conveyance of a service user who requires assessment under the mental Health Order. This agreement has fostered closer working relationships between both services and ensures a seamless service for service users and carers while supporting ASW's to undertake a role that can oftentimes lead to excessively long working hours impacting on substantive post. ➢ **Regional audit of GP response times** and ASW requests will serve to inform the development of services particularly in regard to the forth coming Mental Capacity Act. ➢ **Adult Safeguarding Audit -** A recent service adult safeguarding audit indicated 87% compliance with the regional operational policy with recommendations in regard to completion of adult safeguarding referrals and 97% adherence in completion of protection plans. In addition, there has been increased use of alternative response in regard to safeguarding actions which indicates an improvement in understanding of thresholds. Areas of improvement continue to be focused on recording detail, accuracy of information, line manager decision-making being completed clearly and in detail and updating of recording systems with safeguarding outcomes. This will be further supported through bespoke refresher training to be provided to IO's and DAPO's and line managers in regard to the recording on adult safeguarding documentation and will further support quality assured standards with the implementation of safeguarding recording onto Paris. ➢ The Service continues to promote and embed the Think Family ethos. This is through a variety of methods such as continued use of The Family Model (Falkov 2012)l and forthcoming pilot to further adopt use of the model within children services (by the Social Work development lead), adopting principles of Think Family in the social history template, presentation at the Think Family Symposium and conference in Oslo 'It Takes a Village' whereby the acting PSW will present the regional pilot and case study from the pilot at the conference to highlight the outcomes of

	this successful piece of research. The acting PSW has also submitted an article based on the regional pilot to the 'Advances in Mental Health' Journal for consideration for submission. The Champions Model continues to expand with seventy seven champions across children and mental health services and more recently learning disability services and in embedding Think Family practice across both Services. **The Recovery College Awards** ➢ **2018/19 Belfast Recovery College** awarded a CPD 2018 accreditation mark (UK wide) in recognition of its excellence of ethos and education, which gives CPD, points to courses. The College is first in N. Ireland to achieve this and the second Recovery College in the UK to achieve this mark. ➢ **2019/20 All Ireland Aontas Star Award Winners 2019 – Large Organisations –** Adult Learning Initiatives that Support Health and Wellbeing for making an outstanding contribution to adult learning in this field. We are the first Recovery College North and South to receive this Award. ➢ **2019/20 CPD Provider of Training Excellence Award 30.4.2019** The Award is a Quality Award as a Centre of Training Excellence from the CPD Standards Office (UK based). CPD means Continuing Professional Development. Accreditation is given to Colleges of learning UK wide from this Awarding Body. This accredits the full Recovery College. Student one to one feedback, tutors, paperwork, qualitative and quantitative date are assessed. If successful, we are the first Recovery College UK wide, North and South to receive this quality kite-mark of education excellence. ➢ The Recovery College now has 1707 students and has grown from strength to strength as demonstrated by the awards above. ➢ **Homeless Hub** - Further transformational funding has contributed to the inclusion of health care services in the development of a Homeless Hub at Townsend Street nearby the Welcome Centre. It is envisaged that this will be a multi-disciplinary resource with a 'one stop' access to a range of support advice and physical care services for those individuals who are homeless with the aim of enabling those who are most vulnerable to achieve health and stability in improving their quality of life. Currently premises have been secured and a band 6 CPN post with a view to a Band 7 Senior Social Work Practitioner post.
3.16	**SUMMARY**
	There are several areas that remain as a priority in terms of service targets;

	➢ Recruitment and retention of ASWs for the daytime rota and operational pressures associated with interfaces that impede completion of assessment, for example, bed availability and the frequency of dependency on out of area beds. ➢ Continue to support increased recruitment and retention of band 7 Social Workers into the roles of SSWP and team leaders across the mental health service to increase Social Work representation in multidisciplinary teams. ➢ Continued need for support of teams on processing adult safeguarding referrals due to the lack of DAPOs in situ and need to further strengthen the investigating officer role within teams. ➢ Creative exploration of options to improve Social Work workforce planning and improving capacity within the Service particularly in relation to ASW recruitment and retention particularly in relation to the requirements indicated by the Mental Capacity Act and ongoing consideration of the duality of ASW and DAPO roles within community mental health teams. ➢ Strengthened workforce-planning structures and expertise to support a stable workforce, with sufficient capacity to meet service delivery demands across all service settings- an immediate focus on ASW and adult safeguarding. ➢ Progress of the assessment centre in conjunction with current planning for reintegration of community mental health teams in the forthcoming year to improve service delivery based on the right time in the right place and right person ethos. ➢ An increase in designated Social Work staffing levels in the Mental Health Service to improve skills mix and to prepare for future demands in meeting delegated statutory functions. ➢ Planning for the transfer of inpatient services to the new acute inpatient centre at the city Hospital site which will provide accessible, central, consistent care to inpatients on the one site.

Programme of Care / Directorate:- Learning Disability Services

3.1	**Named Officer responsible for professional Social Work**
	In the reporting year, Ms H425 has discharged the role as Associate Director of Social Work and then as Divisional SW in Learning Disability. The Divisional Social Worker has responsibility for professional issues pertaining to the social work and social care workforce within the Service. 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. The Divisional Social Worker is responsible for: ➢ The professional leadership of the Division's social work and social care workforce. ➢ The assurance of arrangements for the discharge of statutory functions relating to the delivery of statutory social care services by the Divisional workforce as detailed in the Regional Scheme of Delegation. ➢ The provision of expert advice to the Divisional Leadership Team on matters pertaining to the social work and social care workforce and the discharge of statutory social care functions. ➢ The establishment within the Division of arrangements to ensure an unbroken line of accountability for the discharge of statutory functions by the social work and social care workforce through the Divisional Social Worker to the Executive Director of Social Work. ➢ The establishment of arrangements and ongoing responsibility for the completion of the Divisional Interim and Annual Statutory Functions Reports. ➢ The establishment of arrangements to facilitate the completion of other reporting requirements (both internal and external) relating to the discharge of statutory functions. ➢ The establishment and assurance of Divisional arrangements to ensure the social work and social care workforce's compliance
3.2	**Supervision arrangements for social workers**
	The service area had 6 agency AYE staff during the reporting period. One of these staff successfully completed their Assessed Year in practice within the service area. They all received a robust induction including orientation to the service area, opportunity to shadow staff, mandatory training and familiarisation with relevant policies/ procedures. In compliance with the Regional Guidance for Registrants and their Employers, NISCC July 2010 the AYE staff received professional supervision on a fortnightly basis. They have a protected caseload, which is regularly reviewed at supervision. Professional SW supervision to AYE staff ensured their training and development needs were identified and addressed. It also provided regular opportunity for staff to reflect on their practice in a safe and supportive environment. Constructive feedback forms part of each supervision session following regular audit of records against agency standards and procedures and from direct observation. AYE staff have also availed of attendance at the AYE peer support group and the SW forum within the service area. All AYE staff also have a self-development review (SDR) completed to identify how they are contributing to the corporate objectives of the Trust.

	The Service continues to work within 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. Supervisory staff have also completed the Trust's professional supervision course. Within the service area the 4 Community Learning Disability teams are managed by Band 7 Team Leaders from a SW background. This ensures that all Band 6 staff within these teams receive professional SW supervision from their line manager. All SW staff therefore within these teams and the Hospital SW team are supervised on a 4-6 weekly basis as per the Trust policy. The Team Leader also audits service user files on a regular basis and provides feedback to staff at supervision. All Team Leaders who are qualified SW are in turn provided with SW professional supervision by the 8A Operations manager on a 6-8 weekly basis. The 8A Social Work Operations Manager audits supervision files on a 3 monthly basis. In addition to 1:1 supervision, all SW staff attend the Service Area SW Forum which meets every quarter. This is an excellent opportunity for SW staff to meet with other SW staff across the service area. This forum has provided the opportunity for learning to take place through visiting speakers and or training sessions being incorporated into it. It also provides a valuable space for SW staff to reflect on practice. A number of SW staff within the service area act as Approved Social Workers (ASW). All ASW staff now receive 1:1 professional supervision from an ASW manager (band 7 and above). This supervision takes place 4-6 weekly. Given the pressures placed on the ASW staff to participate of the ASW daytime rota and the complexity of the work associated with the discharge of statutory functions the service area now has also established a service area ASW practice forum, which meets quarterly. The Service area ASW Practice Forum allows newly qualified ASWs and more experienced practitioners to share practice learning in a safe and supportive environment. This Forum also provides opportunity for shared learning, to reflect on practice, to network with other ASW colleagues and to provide feedback regarding any issues to the larger ASW forum, which all ASWs from across the Trust attend on a quarterly basis. The Service area also provides support to staff who are Designated Adult Protection Officers (DAPOs), Investigating Officers (IOs) and those trained in Achieving Best Interest (ABE) as the service area holds its own DAPO/IO Forum to give practitioners opportunities to discuss issues regarding adult protection work. A Service area DAPO support group ensures shared learning and consistency across the programme. This has proved to be extremely useful in transitioning to practice and service delivery requirements of the Revised Adult Safeguarding Policy, giving practitioners opportunities to keep up to date with research and to explore practice issues within a supportive setting. SW staff are also supported in other roles they fulfil through attendance at the Trust Designated Adult Protection Officer (DAPO) /Investigating Officer (IO) Support Fora and Achieving Best Evidence (ABE) Support Fora. 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.

	The service area has also recently established a social care forum which will meet quarterly. The focus of this forum will be on the reform of social care and how the recommendations from this can be taken forward. It will also provide the opportunity to offer support, for shared learning and compliance with NISCC standards.
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).**
	In May 2018, the service area completed an audit of the Families Matter Shared Lives Service delivered by Positive Futures. This is a family based service. It provides long-term caring arrangements or short breaks support for people with a learning disability, acquired brain injury or autistic spectrum disorder. The audit addressed a number of service delivery areas, including overall quality of the service users' placement experiences and engagement of service users and principal carers in placement review and planning arrangements. The audit outcome was positive across all standards reviewed. All Team Leaders and Operations Managers within Community Learning Disability have attended training sessions on ASCOT. ASCOT is designed to measure the impact of and outcomes for service users of social care service delivery. The Service acquired two easy-read versions of the ASCOT tool to assist in engaging service users. The service area has now completed 9 ASCOTs since 1/4/18. Given the large-scale investigation into the service area's hospital several initiatives have been implemented to support staff post incident or injury. For example, a pathway for staff who have been injured on duty whilst working in the hospital has been devised. This is currently in draft form but is due to be rolled out across the hospital site. Similarly a pathway for staff following an incident in the service areas hospital is currently being developed. There are regular monthly audits completed in relation to adherence to Promoting Quality Care (PQC): Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability, May 2012. To take forward learning from these audits a working group has been established looking at current practices, the development of a flowchart and ensuring documentation is compatible to the service information system PARIS. Additional training in PQC has also been provided to the community and hospital staff across the service area. An audit of the use of antipsychotic medication has also been carried out across the hospital site and we are awaiting the findings. In addition, a review of physical health checks was recently completed across the hospital and the outcome of this review is soon to be forwarded to the service area. Given the large scale, investigation into the hospital a review of seclusion has been completed and the Seclusion policy has been reviewed. The consultation period is still ongoing and it is envisaged this policy will be implemented prior to June 2019. The service continues to provide a governance information dashboard on a monthly basis, encompassing governance indicators; complaints; compliments; absence rates; SAI/incident, RIDDOR and RQIA inspection data.

The Service has continued its participation in the UK-wide Learning Disability Services benchmarking network. Forty-eight NHS Trusts and Health Boards made 68 submissions across England, Wales and Northern Ireland, as well as a number of independent sector organisations. The benchmarking metrics have afforded the opportunity for the Service to compare its performance and to identify areas for improvement utilising the network as a vehicle for sharing learning and exploring innovative service developments.

The introduction of safety pause has been a new initiative designed to provide the opportunity for the hospital staff to 'pause' for a one hour period and reflect on safety as the conversation. Since mid-March these weekly meetings (Wednesdays 2pm – 3pm) are facilitated by a Senior Manager and staff are encouraged to attend to represent their area, subject to care needs on the wards. One initiative that safety pause has discussed and is being piloted is a multi-disciplinary safety huddle in one ward area.

The weekly 'Situation Report' or SITrep is an executive reporting tool that summarises key aspects of care delivery, experience, safety and quality and any issues over the previous 7-day period. It provides a high-level overview of weekly patient numbers, admissions and discharges, occupancy, Patient care pathway, safeguarding, complaints, incidents, seclusion, patient feedback, staffing and staff support, Communications, finance, emerging issues and next steps / decision making. Population of the reporting tool has been incrementally developing over the last two month period.

During the current reporting period the service undertook a reassessment of service users who had been on community caseloads who have required minimal intervention. To date a social worker has reassessed all the clients living in West Belfast who had not been in touch with services for a considerable period of time. Service users and/or families were contacted and offered a social work assessment and care plan. A small number of service users and families did not wish to engage with services and they were provided with details of how they could easily access services in the future. For those who wished to engage, a social work assessment and care plan was completed, and a Carer's assessment offered. In many cases, the social worker was able to signpost the service user or their family to services within their community who could offer support re benefits issues, housing etc.

Following the reassessment, the service user either could be referred to the team for ongoing support / services or, with their agreement, could be discharged from the service, if no services were required at this time. For those service users not requiring further support the service user/family were then given a copy of a letter with contact details for the West Belfast team detailing how they could access the service in the future and a copy of this information was also forwarded to the service users' GP.

The social worker involved is currently working with the East Belfast team and will then move to the South and North Belfast teams.

There have been a number of Quality Improvement initiatives across the service area.

- Within the Children's Learning Disability Hospital and across a number of the community learning disability teams there are 'Joy in work' initiatives taking place.
- There is an improvement project taking place in a male ward in the hospital which is entitled 'On the move'. The objective of this project is to "To improve the physical

health and mental well-being of patients (8) in the ward as they will complete a minimum of 7 hours physical activity each week by June 2019".

- Another quality improvement initiative project 'Safe Spaces' aims to reduce incidents of violent aggression on the female ward. The project forms part of a wider quality improvement initiative working on the same objective across adult mental health, PICU and CAMHs wards.
- These are all linked to the Safety Quality Belfast (SQB) improvement programme or the Scottish Improvement Leader (ScIL) programme, both of which require participants to action learn and utilise improvement methodology through delivering a project. 'Safe Spaces' gathers daily incident data which is used to produce a 'safety cross' that visualises and shares incident data for the staff team. A current PDSA cycle is testing amended safety brief documentation to share, classify and discuss incidents and identify patients whose day may be stressful or who are cause for concern.
- A daily safety huddle is being piloted in one ward.
- There are weekly live governance meetings.
- The hospital SW team are also piloting receiving real time feedback from service users and their families in relation to whether they feel safer following Adult safeguarding intervention.
- The hospital SW team have also been piloting a Checklist for all new admissions, to ensure that at the point of admission all the relevant information is provided from community staff. This will ultimately assist in timely decision-making.

Over the last 25 years, the service area has being working in partnership with a variety of Housing partners, including the NIHE, registered Housing Associations, and the private sector to develop and provide a range of Supported Housing accommodation for adults with Learning Disability

Following the Bamford review recommendations and the associated capital & revenue investment from the DHSSPS and DfC for supported Housing a total of 12 new schemes creating 91 new tenancies were developed across Belfast for adults with Learning Disability between 2012 and 2018. This has significantly helped people with Learning Disability realise their right to live Ordinary lives in the community by enabling them to secure their own tenancies.

At 1st April 2018 there were 315 adults with Learning disability supported to maintain Housing tenancies across Belfast. The average weekly cost is £282 per week, with an annual care cost of approximately £12 m and £3m Supporting People income.

These supported housing schemes are almost always fully occupied with demand for new tenancies growing steadily. In order to best meet the emerging accommodation needs of this population a new five year Supported Housing development plan has been devised based on an accommodation needs assessment.

The service area has also developed a supported living scheme, Cherryhill. This is located opposite the hospital site. It is a Trust owned facility and registered with RQIA. Although Trust staff are employed in this scheme they are separate from the staff at the hospital site. This facility will accommodate 9 patients who are being discharged from the hospital in the near future.

Based on an analysis of the data the following Supported Housing priorities have been identified:

- **Care leavers**. The Trust has identified the need to provide specialist supported housing environments for young people leaving care often with learning disability and challenging behaviours. (Approximately 2- 3 persons per year). The Trust is engaged with one service provider in developing transitional housing for young adults wishing to develop independent living skills.
- **Forensic**. The Trust has identified the need for specialist supported housing for a number of people with learning disability and a forensic profile. The Service has identified twelve service users in this cohort, six of whom require accommodation urgently. There are 3 BHSCT patients from the hospital identified for a placement in an extension of an existing scheme. This is due to be completed in December 2019.
- **Challenging Behaviours.** Currently there is need for six to eight tenancies for adults with challenging behaviour including the return of people on ECR's. There are currently 6 patients in Muckamore and 1 patient in Iveagh who require tenancies for adults with complex challenging behaviour and the service is liaising with various providers in relation to this. There are plans in place for the return of two individuals on ECR's this year following the development of supported housing to meet the patients specific needs. There is also a need for the development of accommodation options for people currently living in placements, which are breaking down because of challenging behaviour.
- Adults with **lower level needs.** Currently there is a need for 5 to 10 tenancies per annum for adults with learning disabilities who require lower levels of support, and who prefer a shared living experience synonymous with L'Arche provision. There is a requirement for the service area to develop more single occupancy tenancies with 24 hour support, for those people who find it difficult to share accommodation.

The Trust has successfully completed its first Positive Action Employability Programme recruiting adults with learning disabilities into vacant permanent posts within Patient & Client Support Services.

The Service Area continues to utilise its Day Opportunities in a wide range of new opportunities for service users. The service has incorporated many different community based activities including hill walking, film making and creative and expressive arts projects into the ongoing programme. The community choir, Equal Notes, continues to grow from strength to strength and are in constant demand for public performances. It has also invested in personal development, training for work and independence programmes for individuals which will support them to take up day opportunities. These additional activities have provided a significantly enhanced range of day opportunities for service users and have been greatly welcomed by service users, carers and staff. There has been a focus on trying to secure city centred based opportunities to encourage service users to utilise and access a range of activities outside of their local community.

Through USEL (Ulster Supported Employment & learning) a Social Enterprise "Ability Café" based in a BHSCT Wellbeing & Treatment Centre has been established providing paid employment for 3 people with learning disabilities, in addition to a 6 further training opportunities. USEL have employed a Training Officer specific to the Café to provide the necessary skills for trainees to secure employment within the hospitality sector.

A review of the Intensive Support Service has been completed including a full scoping of the patients admitted to hospital and those on community caseloads who required intensive support as an alternative to hospital. The Collective Leadership team has now

	agreed in principle to the establishment of an intensive treatment team and a project group is being established. This service will provide a wrap around service to those service users on the cusp of hospital admission. They will gate keep beds for the service areas hospital and will provide a 7 day per week service working into the evenings. They will reduce hospital admissions by providing alternative supports in the community as well as facilitate early discharges from the inpatient wards. This team will be clinically led by a Consultant Psychiatrist and be multidisciplinary including SW, Nursing, Psychology and OT. It is also anticipated that they will clinically manage a small number of beds in a community facility for a short period of time as an alternative to hospital admission. The transition from children's services to adult services is often very challenging for young people with a learning disability and their families. It involves a change of service delivery arrangements at a time when they are also experiencing wider changes in their lives, for example in their educational circumstances. As a result of the process mapping exercise conducted last year the Service area, in conjunction with the Children with Disabilities Team, is reviewing current transitional arrangements with service users and carers and has now identified an action plan for improvement. This includes scoping of the needs of the young people long before they are transitioned to adult services to assist adult services to identify early their identified needs, greater engagement with young people and their families and better collaborative working with the educational authority. Additional funding has also been secured to assist in strengthening the work done by the service areas community teams in working better with children's disability teams to facilitate smooth transition from children's to adult services. As a consequence of the review of care management last year it was recognised that there were significant pressures on the workforce related to increased complexity of caseloads, particularly in relation to those service users with a forensic history, transitioning from children's services and the re-settlement/delayed discharge of patients from hospital. The service area is now pleased to report that an additional Care Manager and Assistant care manager is being recruited to address the workload pressures and work with those young people transitioning from children's disability services to adult Learning Disability services. Currently there is 1x 8a who operationally manages care management. There are 4x Band 7 SW trained Care managers and 1x Band 7 nurse-trained Care Manager. There are 2.5 WTE assistant care managers. A review across Community Learning Disability and the Hospital Social Work Team has identified the need to standardise documentation and processes to improve the safety, quality and seamlessness of service user pathways through the Service. The SW assessment and SW care plan has been reintroduced across the service replacing the About You, which was previously used by the service area. In order to enhance better multidisciplinary working each ward across the hospital site now has a dedicated social worker. They are also now based at ward level. This has improved working relationships and communication.
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.**
	During the reporting period, there were twenty-nine announced and unannounced RQIA inspections leading to fifteen recommendations.

The breakdown of inspections was as follows-

- 8 RQIA inspections for residential accommodation resulting in four recommendations; These were addressed via Quality Improvement Plans (QIPs).
- inspections to supported housing schemes with 3 recommendations; These were addressed via Quality Improvement Plans (QIPs).
- 2 RQIA inspections to day care resulting in no recommendations.
- There were 2 RQIA inspections to the hospital with 8 recommendations. These matters are still currently being addressed by the service area through an agreed action plan. These recommendations relate to a range of issues- staffing levels in the hospital, physical health care checks, financial governance, safeguarding practices, restrictive practices and hospital governance.

RQIA has also been involved in the ongoing adult safeguarding investigation in relation to the large scale investigation in the service areas hospital.

The Service area has been liaising with RQIA on adult safeguarding issues as they arise in relation to any registered facility. The Service area notifies the RQIA of any untoward incidents as per their reporting requirements.

During the reporting period the Service area had 4 social care staff referred to NISCC as a result of adult safeguarding investigations. NISCC has closed two of these referrals and a further 2 are in the process of being reviewed by NISCC.

All social work and social care staff are supported to meet NISCC's PRTL requirements through the provision of training and learning opportunities. Staff have been supported to complete Professional in Practice (PIP) post-qualifying bespoke programmes or to submit portfolios of learning to secure PiP accreditation. All Service-based social workers and social care workers have an annual Self Development Review (SDR). All social work and social care staff in the Service are compliant with NISCC registration requirements.

Each new staff member avails of a local induction and are required to attend the Trust's Corporate Induction. The Service area also provides a two-day bespoke induction for newly appointed staff. This induction is delivered by the Service Area twice per year with direct input from service users and carers.

The Service carries out a number of functions under The Mental Health (NI) Order 1986 and meets the requirements of 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 Mental Health Review Tribunals.

The Service has contributed as appropriate to MARAC and PPANI processes.

The Service has ongoing engagement with the PSNI and participates as appropriate, in Joint Protocol arrangements.

	The Service continues to work with the Office of Care and Protection (OCP) as required but remains, as reported in previous years, concerned about the changes in OCP practice in relation to the management of service users' affairs. A Declaratory Judgement in relation to deprivations of liberty regarding one community service user, who is also subject to Guardianship, was initially granted on 20/1/17, reviewed on 22/3/18 and is to be further reviewed in April 2019 by the High Court. No changes were made to the Order. The service area is currently in the process of seeking a further 4 Declaratory Orders in respect of service users who have or will be transitioning from hospital to a community setting and 1 Declaratory Order relating to a service user moving from a family home to supported living. Across the service area service users, who are currently subject to any deprivations of liberty, are subject to a Best Interests meeting. These meetings are chaired by a SW Team Leader and involve input from the multidisciplinary team, service user and carer. Any restrictions of liberty are clearly documented and the rationale for why they are in place is recorded. The Service area currently has responsibility for the management of two Supervision and Treatment Orders. One has been in place for almost 2 years and the second was made during the previous reporting period. Both require the service user to continue to live at a family address. In the first case, the Service commissioned specialist assessment by a Forensic Psychologist to enhance the risk assessment and management planning. This report was received in February 2018 and a multi-disciplinary meeting was held to update the risk management plan. Both these clients are subject to PQC/CRA and are reviewed regularly under this policy. There have been ongoing difficulties in securing additional resource through the NIHE for new supported Housing schemes. In the reporting year, the service was successful in making the case for the reprovison of Altnagarron Supported Living Scheme in West Belfast using capital only. However, the NIHE can no longer provide capital for new schemes and as a consequence, future schemes have halted and there has been a need for the service area to forge links with other private providers to meet the needs of our service users in respect of supported housing. This has impacted on service delivery, in particular for those patients in hospital whose discharge has been delayed due to a lack of community infrastructure.

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
	Lack of access to Physical Health care There have been ongoing issues in relation to patients within the adult and children's hospitals not having adequate access to primary health care. There have been ongoing discussions with HSCB for GMS services to be available to inpatients. A GP has been appointed for 2 sessions per week for the hospital and recruitment is underway for the children's learning disability hospital. A pharmacist has also recently appointed to the hospital to assist in medication management.	Recruitment is underway for GP sessions in the children's Unit. Physical health checks have now been offered to all inpatients across the hospital and the Trust is awaiting the report following this review. There has also been an audit completed in relation to antipsychotic monitoring in the hospital.	Risk to the quality of outcomes for patients in the adult and children's Hospital relating to lack of access to primary health care- This is categorised as medium on the LD Risk Register
	Staff levels across the hospital site. Given the ongoing large scale adult safeguarding investigation a number of staff have been suspended and others have gone off sick from work. Alongside this a number of staff have retired or resigned to take up career opportunities in other Trusts. This has resulted in difficulty maintaining the substantive acceptable	Recruitment processes are ongoing. Recruitment is being managed by central nursing. There has been backfill provided though an increase in the use of agency staff. The PICU ward is temporarily closed. The progression of the opening of Cherry Hill, a supported living scheme to support	Staffing levels across the adult hospital- this risk is categorised as Extreme on the LD risk register

	staffing levels across the hospital site. The Trust has a contract with external agencies and they have provided registrants which address the current deficit of staff. The staffing difficulties are exacerbated due to increased staffing required for special observations of patients whose hospital discharge has been delayed due to lack of suitable community placement. There are also current regional challenges in recruiting registrants across N. Ireland due to the limited number of available registrants for recruitment. Despite ongoing attempts to recruit registrants, this has proved difficult but the service has continued to be proactive in organising a job fair due to take place in May, to recruit substantive staff.	the discharge of 9 patients from the adult hospital is ongoing. Staff from Day Services in the Community are providing additional daytime activities for patients primarily at the weekends to support ward staff. Staffing levels are monitored on a daily basis. There is now a Manager On call at all times. There is now a minimum of 2 registrants on duty per ward per shift. At weekends (daytime) the aim is to have a minimum of 2 ward managers on duty across the hospital site. Ad hoc senior management walkabouts take place every week. Special observations are regularly reviewed by each MDT. An activity coordinator has been in place since Jan 2019. This has significantly improved the level of activities for inpatients across the Hospital Site. Therapeutic Day services are now also provided within the hospital at weekends and evenings activities. An E-Rostering review has taken place to ensure consistency of approach in allocation of shifts by Senior Nurse Manager. There is ongoing auditing in respect of this.	

		All staff on sick leave have attended a meeting to support them back to work. The admissions to the hospital have been very tightly monitored to ensure only necessary admissions take place. Recruitment is ongoing for 1x band 7 managers. 1 additional night coordinator is due to start in April. 7x band 3 (health care support workers) are also due to commence employment within the next month. Band 4 administration staff have now been recruited and appointed for all wards. Further roster reviews by senior managers. Review of non-mandatory training activities. Reduction of beds across the hospital site. Continuous workforce review including the re-profiling of wards and reallocation of staff and a review of all wards in relation to required staffing levels.	
	Accommodation Due to a lack of community infrastructure, the service area continues to have difficulty finding suitable accommodation for our service users with complex and challenging needs.	In the reporting year, the service area has completed a full scoping of the accommodation needs of our service users across the hospital and the community. This has enabled the service area to draw up a 5	Potential failure to meet assessed need due to lack of availability of appropriate service provision. This is categorised as medium on the LD risk register

	Care management staff have forged links with a range of providers in order to meet the needs of the service users. Given the complexity of the issues, particular attention has given to ensuring that the appropriate staff, care, accommodation and contracts are all in place to meet the needs of service users. Across the private and independent sector there remains ongoing difficulties recruiting and retaining social care staff. In order to try to address this, the Trust have agreed to pay increased costs for the placements so that pay rates for staff can be increased to reflect the complexity of the work role and therefore assist with recruitment and retention of staff. The Service has also been proactive to support the providers in order to help develop the skills base of their staff but also to try to maintain the placements for our service users. There has been outreach from hospital staff, input from the Intensive Support Service and the community teams to assist the providers but also to provide additional training in respect of the implementation of positive behavioural support plans. In addition, for those patients being resettled there has also been in reach into the hospital from	year supported housing development plan and thus begin to plan services in order to meet the needs of our service users. The service identified a total of 223 adults with a Learning Disability who are assessed as requiring supported housing tenancies over the next 5 years. The Service has been continuing to work jointly with external agencies from England to purchase, at risk, accommodation options. There are accommodation and support plans in place to return two very complex service users currently in hospital in England, back to Northern Ireland this year.	

	the providers to improve understanding of the patients' needs and ensure smooth transition from hospital to community. The Trust have also encouraged Providers to employ Behaviour Support staff and have agreed increased placement costs for this service. The Trust have also agreed to provide funding for transport for complex service users, in order to improve their quality of life and make community activities and facilities more accessible to them. There are a number of service users who require supported accommodation but due to their history of substance abuse and contact with the criminal justice system, providers are reluctant to offer placements because of the vulnerability of other tenants and potential risks towards them. This is an increasing population, which the service area continues to find difficult to support, and this will require the development of bespoke services.		
	Lack of appropriate acute admission beds Given the difficulties experienced by the service area in terms of staffing the admissions to the adult hospital have been very tightly monitored.	There have been a series of workshops with other Trusts looking at the admission pathway. A draft pathway to handle admissions from the BHSCT has also been drafted.	Lack of appropriate acute admission beds due to a lack of appropriate community placements is categorised as high on the LD risk register

	A number of service users requiring admission have therefore been admitted to adult mental health beds or in learning disability beds across the region. There remains a high demand for acute admission beds due to the lack of appropriate community placements.	There has been partnership working with adult mental health services in relation to the admission of patients with a learning disability to an adult mental health hospital. Notification of delayed discharges are made to HSC Board. There are plans for delayed discharge patients and they are discussed regularly with owning Trusts. There are established links with PHA, board and senior medical management to assist with out of area admissions when at full capacity. Realignment of male/female beds completed. Recent discharges have helped but the ongoing development of discharge plans is essential for patient flow. There are plans in place for the ongoing development of community treatment infrastructure to provide treatment options in the community to prevent admissions.	
	Adult Safeguarding- see separate report on Adult Safeguarding There have been several cases, historical and recent, of alleged abuse by staff to patients within the Adult Hospital. These have been identified on CCTV footage.	There is currently CCTV running 24 hours per day in the inpatient settings. All adverse incidents and incidents alleging abuse by staff are reported through the Adult safeguarding team (ASG) and senior	Categorised as High on the LD Risk register

	Those incidents deemed to meet a criminal threshold have been referred to the PSNI.	management are involved in the investigation. Any incidents that require reporting to PSNI are reported immediately. A new ASG team has been established to address the historical CCTV incidents. Further CCTV footage is still to be viewed. Protocol re. disciplinary hearings has been agreed. There is ongoing liaison with Trade Unions, affected patients, families and staff. A series of workshops for families have taken place following the SAI. A Carer Consultant has been appointed to take forward a carers forum with families on the hospital site. A series of workshops for staff have also been facilitated to provide information, advice regarding supports available. Contemporaneous CCTV viewing is ongoing. There is a counsellor employed at the hospital to offer support to staff. Reflective practice sessions are also available to staff. Health fair is planned for staff.	
	Adult Safeguarding- see separate report Risk of abuse and injury to vulnerable adults in shared settings, from other patients/service users (including inpatients	Safeguarding procedures including use of special observations to minimise targeting of vulnerable patients.	Categorised as Medium on the LD Risk register

	medically fit for discharge). Resourcing difficulties in meeting the demands of adult safeguarding protection plans.	Analysis of incidents. Timely discharge once patients are deemed medically fit. Discharge meetings convened to expedite community placements and notify Trusts of the number of safeguarding concerns for each patient remaining in hospital. Ongoing analysis of incidents. Pilot of live time feedback from service users and carers in respect of adult safeguarding input and whether they feel safer as a result. Ongoing training. Increase in activity levels of patients across the hospital site since appointment of activity coordinator in Jan 2019. Introduction of positive behaviour support to reduce incidents of challenging behaviour.	
	Re-settlement The Independent SAI report completed in respect of the hospital in relation to adult safeguarding this year advised that 'no one should have to call hospital their home in future'. This view was fully endorsed by the DOH Permanent Secretary who expects the resettlement process to be completed by the end of 2019. He also advised that the issue of delayed discharge should also be addressed as a top priority, with the HSC system tasked to provide an action	The Service area will continue to work with other Trusts and the HSCB in achieving the retraction plan for the hospital.	This issue is on the LD Risk Register and is categorised as a medium risk.

	plan to the Permanent Secretary in January. The Trusts meets with the HSCB finance and performance managers monthly to report on progress in achieving the resettlement of the remaining Community Integration Project PTL patients. There are currently 5 PTL patients still in the hospital. One of these patients will move back to the community in May 2019 and there are plans in place for the other 4 PTL patients to move back into the community in December 2019. The Trust have successfully resettled 6 very complex people to specialist supported living schemes within this reporting period. The Trust continues to work proactively with a number of providers including Positive Futures, Praxis, Triangle, M Care, Mencap and Autism Initiatives to identify appropriate accommodation and support options for a number of hospital and community service users in an effort to ensure appropriate plans are in place to ensure that no-one is delayed in hospital..		

	They are currently assessing individuals and scoping accommodation options in respect of the inpatients to meet the December deadline. When an analysis was done in relation to the inpatients in the hospital there are a number of inpatients who require specialist nursing care. The Trust is currently liaising with one Provider about providing specialist nursing support. In addition, there are a number of inpatients with forensic backgrounds who have been extremely difficult to resettle in the community. Currently there are discussions with Triangle and Extern to provide support and accommodation to those with a forensic background. The Trust continues to work with providers to build their capability and resilience to maintain these patients in the planned community settings.		
	During 2018/19, the Trust successfully resettled 1 PTL and 3 Complex Delayed Discharge patients into a specialist residential service.	The Service has been working proactively with a number of providers to plan for the discharge of a number of complex delayed	Potential failure to meet assessed need due to lack of availability of service provision is included on the Trust's Risk Register as a medium risk.

	Dympna Mews was completed in February 2018. This facility has supported the discharge plans for service users with complex needs. There are currently 8 people living in this service. Two service users returned to hospital and alternative plans are being developed to meet their needs. A further 3 service users will be moving in between April to June 2019. Lack of placement availability continues to be a major barrier to achieving discharge targets for those patients categorised as complex delayed discharges. There are currently nine complex delayed discharges in the adult hospital. One of these complex delayed discharges is living in a supported living environment but is awaiting an MHRT before he can be discharged from hospital. Another has completed his first overnight stay in a supported living environment and is expected to be discharged pending the outcome of the MHRT. Discharge plans are in place for six patients. One Patient does not have a confirmed discharge plan but the Trust are	discharge patients. This has included the residential and nursing home options. The Service strives to achieve discharge as soon as possible by commencing planning for discharge from the point of admission. The Service has scoped key data to profile its adult and children's population to inform its long-term planning priorities and resource requirements. A Service Development plan has been drawn up. The Service notifies the HSCB of delayed discharges while engaging directly with inpatients own Trusts on a regular basis to update on and review discharge-planning options. The Service has prioritised the development of community treatment infrastructure to provide treatment options in the community to prevent hospital admissions. There are weekly meetings between Co-Director, Service Manager and Operations Managers to update on discharge plans for all patients including those in core treatment.	

	working with a variety of providers in an effort to develop an appropriate placement. The Service continues to have difficulty in sourcing appropriate accommodation options for a range of complex needs including autism, challenging behaviours and complex health care needs. The Service Area is very dependent on independent sector providers choosing to make provision available. The Trust has developed a supported living service Cherryhill across the road from Muckamore, to facilitate 9 hospital discharges. Three Belfast Trust patients have been offered placements in this scheme which will be opening in June 2019.		
	The Service Area continues to struggle to make admission beds available as required. In this reporting period, there were 43 admissions to the hospital (20 detained- 7 BHSCT, 5 NHSCT and 8 SET) This level of activity is significantly lower than other years due to all admissions being closely monitored to ensure they were necessary. This has resulted in the admission of two patients to the Lakeview unit and three to the Mater with one	The service area continues to try to place delayed discharge patients in the community. A review of the Community Intensive Support Team is addressing service provision to reduce hospital admissions and, at the same time, facilitate early discharge from hospital.	Lack of appropriate admission beds is on the LD risk register as high

	transfer back to the service areas Learning Disability hospital, one to Avoca x2.		
	Domiciliary Care The Service has continued to experience increasing difficulties in providing domiciliary care packages across the service there are 27 outstanding care packages. This is primarily due to a lack of capacity to meet demand levels across independent sector providers.	There are currently plans underway to access the Care Bureau to enhance the service areas potential to source care packages. The Service continues to proactively promote SDS uptake and the accessing of Direct Payments to obviate demand pressures for domiciliary packages	The issue of the potential failure to meet assessed need is on the Trust's Risk Register as a medium risk.
	Deprivation of Liberty During the reporting year the Service has remained significantly concerned about deprivation of liberty safeguards for those who lack capacity. The Service remained of the view that the Departmental guidance of 14/10/10 was not sufficiently robust in light of the current legislative vacuum. The Service therefore adopted a pragmatic approach to decision-making in relation to applications for Declaratory Judgements. The Service pursued such Judgements only in those circumstances service user is actively resisting or a carer/relative is objecting to a placement. In all other cases, the Service uses a "Best Interests" approach to inform key decision making.	Consultation with HSC Board and DHSSPS in relation to Trust's requirements and responsibilities. Consultation with DLS. Recognition of DOLs issues in practice guidance. Consultation at Director level re how we proceed to put in place Declaratory Orders for those individuals who lack capacity where restrictive practices are in place. The Mental Health Capacity Legislation is due to be partially implemented by October 2019. The Trust has continued to engage in the regional consultation processes linked to the development of Regulations,	Potential failure to provide people deprived of their liberty with adequate safeguards and to meet legal requirements in relation to this- this is categorised as High on the LD risk register.

	The Mental Capacity legislation, which is due to be implemented, will fundamentally change the procedures in relation to restrictive practice.	guidance and policy related to the implementation of the Mental Capacity legislation. A Mental Capacity workforce planning day is scheduled for 2nd May 2019.	
	ASWs Recruitment, retention and workload capacity of ASWs remains a major difficulty for the Service. The Service has three ASWs contributing to the Trust Daytime ASW Rota. The Trust is also struggling to secure sufficient practice assessors to support ASW candidates on the Regional ASW Programme. The implications of the Mental Capacity Legislation are yet to be fully realised but are likely to bring significant challenges in respect of workforce issues, training etc.	The service has currently one ASW candidate engaged in the Regional ASW Programme-the accredited ASW training pathway. Additional training will be required in respect of the new Mental Capacity Legislation.	The risks related to ASW Daytime Rota service delivery are currently being reviewed.
	Recruitment of Psychology staff: There continues to be a lack of Psychology input into Learning Disability Day Centre's. Service users with highly complex needs and associated challenging behaviours are being supported in Day Centres without appropriate support from Psychological services.	There is ongoing recording and review of incidents by day care Manager and Operations Manager to ensure that associated learning from incidents applied to prevent harm from reoccurring. Funding for B7 Psychology post was	Lack of psychology input in day care is categorised as a Medium risk on the LD risk register.

	In general, the Service is experiencing major difficulties in recruiting psychology staff. The Service has not had a Consultant Clinical Psychologist in post since April 2016 and recruitment to date has been unsuccessful. The Service area has also attempted to get locum cover via external national agencies but this has been unsuccessful to date. The staffing difficulties have had and will continue to have a significant impact on service provision. The Service is not currently able to offer autism or dementia assessments with priority given to eligibility assessments and high-risk situations. A significant number of service users continue to wait longer than we would wish for psychological therapies.	secured in 18/19 year but this has not yet been recruited. Information has been collated regarding all outstanding positive behavioural support plans that require review. Head of Psychology Service to release staff member part-time to commence reviews. Timetable agreed for first centres to have updated positive behavioural support plans. Recruitment fair is planned for June to recruit behavioural practitioners. Temporary clinical and management supervision arrangements are in place.	

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.**
	Service SW workforce has gone through changes this year with the appointment of a Divisional Social Worker, a change in Service Manager, retirement of an Operations Manager and long term absence of another Operations Manager. One team leader vacancy (created by a move by previous team leader to the Service Manager role on a temporary basis) has been covered by an Expression of Interest. The remaining 3 community teams and the SW team in Muckamore have all retained social workers as their lead. Within the community teams there has been a number of changes in the permanent staff – there are currently 3 permanent vacancies in the West Belfast Team (one SW moved to another post within the service, one took up a post in another Trust closer to home and one resigned with a change of career). All vacancies have been covered by agency staff. The remaining teams have remained stable with some agency cover for Career Breaks, secondment to ASG teams etc. Within the hospital SW team there is one vacancy currently and this is currently being recruited. In the interim agency staff have provided cover. The service is currently in the process of recruiting an additional social worker for all 5 teams. The service has decided to recruit social work staff across all teams including the hospital with the intent of developing one waiting list for any further vacancies. The plan to partially implement the Mental Capacity Act (2016) in October 2019 will have widespread implications for the service area in particular the training timescales and resource implications given the current challenges facing the ASW workforce in terms of recruitment and retention. The code places additional roles and responsibilities on the ASW workforce to not only assess for detention but other extended responsibilities. In addition, it requires the establishment of panels who will be responsible for authorising treatment, detention which involves a deprivation of liberty and community residence requirements. The draft code of practice is currently out for consultation and a workshop has been scheduled by the DOH on 2/5/19. There are concerns in relation to how the service area will be prepared for the partial implementation. The service needs to give urgent attention in relation to- the need for additional training in relation to the new code of practice to clearly outline roles and

	responsibilities; the new processes involved; skills in carrying out capacity assessments; the additional demands that will be placed on an already stretched ASW workforce; the need for appropriate documentation detailing reasons for decision making in line with human rights considerations; governance arrangements; the setting up of authorisation panels and clarity around who sits on these panels, the frequency they sit, their roles / responsibilities and governance arrangements; the process for applying to Tribunals.
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.
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**
	The Hospital Social Work Team provides social work support to the inpatients in both Muckamore and the Children's Iveagh Centre. The team structure remains the same with a Senior Social Worker, one Band 7 Designated Adult Protection Officer (DAPO) and four Band 6 social workers. One of these social workers provides social work support 2.5 days per week to the Iveagh Centre, the Children and Young Peoples ward. Although a Belfast Trust Facility, the hospital is a regional facility and patients are admitted from all Trusts. Each patient admitted receives the same social work service. Our input varies according to need. Initial assessment is required. During this year, we have introduced a new Social Work Assessment and Care plan tool. This is currently being implemented and is providing a clear structure to the social work role for individual patients. The assessment highlights the need for provision of support during initial admission, as an inpatient and on discharge. The admissions to the hospital have been very tightly monitored and this has reduced the number of admissions to the hospital in recent months. This is providing the social workers with an opportunity to complete their assessment and care plans accordingly and contribute to discharge planning. Social workers are a core part of the multidisciplinary team. Each ward has an assigned social worker who attends weekly ward meetings. During these meetings, the social worker actively participates in the assessment and consideration of treatment for patients. Social Workers have a key role in discharge and resettlement planning. It is part of the social work function to liaise closely with relatives and carers, assessing the home situation and offering carers assessments etc. As part of the discharge planning the social worker

	will also co-ordinate and communicate with relatives and carers, community social workers and patient and carer advocates across the Trusts. If appropriate social workers will liaise with other agencies in the community, PPANI, MARAC, the PPU, Gateway services and Adult Protection services. A holistic view of the patient living in the community is developed and a review of risks in their environment considered to develop appropriate care plans. One of the key functions of the social work team is to represent the Belfast Trust as the detaining authority at Mental Health Review Tribunals. In preparation for the Tribunal the allocated social worker will compile a report to adopt as their evidence to the Tribunal. They will speak to this evidence at the Tribunal and present the current risks and proposed plan for the patients. In preparation for the Mental Health Review Tribunal the social worker will also coordinate a Contingency Planning meeting inviting key professionals and reviewing what is available for the patient if discharged by the panel. The Social Work Department have provided evidence to the Mental Health Review Tribunal on six occasions. Four of these have been for the Belfast Trust and two for the Northern Trust. The Children's team provide written evidence for Tribunal's for children in the Iveagh Centre. They are supported by Muckamore Social Work staff given their experience in the completion of these reports. The social work department continues to lead in relation to safeguarding patient on patient incidents in the hospital. As aforementioned, there is one Band 7 Lead DAPO. She processes the hospital adult safeguarding referrals under the Adult Safeguarding Policy. The DAPO has the lead role in investigations for patients. Two of our social workers are now trained as Investigating Officers. Together they support the Multi-disciplinary team in the development of risk management, alternative safeguarding responses and protection plans. Support is also provided to the patient and a referral to the PSNI if deemed appropriate, or at the request of patient or carers. If required, CCTV will be also be viewed by the DAPO. In the last year, the service have implemented a new process in the management of safeguarding. This process is in keeping with the Adult Safeguarding Policy and provides opportunity for ward managers to become Safeguarding Champions. They can now make decisions regarding incidents that take place on the ward involving patient on patient and adopt an Alternative Safeguarding approach. The hospital SW department continues to provide support and advice to ward managers and nursing staff. The Senior Social Worker has been auditing this new initiative and raising any issues with hospital management.

	Providing the Keeping You Safe Training to patients remains a key function of the team. Within the last year, 21 patients have been provided with the training. Various methods have been used, group and individual sessions, depending on the ability of patients. The Social Work Department continues to offer placements to ASW candidates. Social Workers provide support and advice to them throughout their placements. The Social Work team have a key function in assisting nursing staff in the implementation of Promoting Quality Care guidance, completion of Comprehensive Risk assessments and development of Risk Management Plans. Social Workers have experience and developed skills in assessing and managing risks therefore, they provide support to the nursing staff undertaking this role.
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 based approaches remain central to all aspects of the Service's work. The Service continues to work in partnership with service users and carers in the review and delivery of services. The Service's investment in co-production, engagement with and empowering service users, carers and communities provides the template for rights-based, compassionate, qualitative and safe discharge of statutory functions to people with learning disabilities and their carers. The Service Area is committed to service delivery, which promotes respect and dignity for each individual in line with corporate and professional values. The service has just recently appointed a carer consultant. She sits as part of the Collective Leadership Team and ensures a carer perspective is provided at a strategic level in the development of services. This contributes to the embedding of a human rights approach and carer focus. Since appointment she has been proactive in working in partnership with our carers and has co produced a draft Family/Carer booklet for the hospital. She has held her first family workshop, which included discussion on the booklet, the potential content of a quarterly newsletter and inclusion of families in resettlement plans. A carer forum is being established where there is more active involvement with families and their voice is elevated and respected throughout Learning Disability Services. Through working together better outcomes can be achieved for families in the areas of health, safety and quality of life. The forum will also develop effective lines of communication and ensure families are fully involved in the future decision making for their relative.

	It is planned the forum will consist of a core group of 4/5 family members initially and include different members of staff to progress different processes/policies for family participation, input and joint decision making. By increasing involvement and engagement with families and frontline staff, a human rights approach will be adopted so that staff and families work in partnership to have full ownership of any changes proposed. There is ongoing consultation with service users and carers via various groups including Friends and Carers of Muckamore Abbey, groups allied to day centres, parents and friends groups allied to residential services. The Service continues to work alongside advocacy groups such as TILLI (Telling it like it is) and independent advocates through Bryson House and Mencap. Following a review of day care in the hospital in October 2018 a more human rights approach is applied as the Therapeutic Day Service is a much more flexible service currently open Monday – Friday 9am to 5pm but moving to a 7-day service, which will include evenings and weekends. Patients are referred by their ward and are then individually assessed in relation to what type of day services/activities/ opportunities would be most suitable to meet their needs. These activities are therefore tailored to meet the patient's choice of activity and venue. A range of activities for example, can now take place in range of venues e.g. the Therapeutic Day Service building, the Gardens, on the grounds of the hospital, in the community or in the ward. Activities for patients will be provided by all staff working with them. This ensures the holistic needs of patients is catered for with intervention, which may include recreational input, social input or skill development. By extending the frequency and range of appropriate and meaningful activity the mental, physical and emotional wellbeing and social needs of patients is promoted. Therapeutic day services are now working with a broad range of providers thus providing greater choice for the patients e.g. Community Roots, Street Soccer, Social Farming, training placements, TCV Green Gym, Art and Music Therapist sessions and open swimming sessions etc. Patient weekly timetables are a human rights based approach in that it gives patients the opportunity to plan ahead. Joint Therapy Aims and Free time Plan/Activity Boxes have been introduced which allows ward staff to work on individualised therapy aims with patients, which forms an important part of their treatment. The box can also be used to deescalate a situation or redirect a patient from a difficult situation, which promotes the safety and well-being of patients.

The Learning Disability Day Services Forum has utilised Appreciative Inquiry methodology to review and then develop future provision. The Service has valued the contributions from service users, staff and carers and this has positively impacted on service delivery.

There have been a number of initiatives across the service to engage our service users and carers and staff to provide feedback. For example, the hospital SW staff are using interviews pre and post an adult safeguarding intervention with service users and families to assess how safe they feel; SLT are using talking mats to engage service users in identifying their wishes and choices in respect of activities they wish to engage in; the use of feedback cards for families to complete after they visit a ward are due to be piloted; there have been pilots carried out across the hospital site using a smiley machine to receive real time feedback on staff and Patient Fxperience etc. Working in partnership with carers/ service users and staff in an open and honest way, showing respect and dignity and valuing their contribution ensures that we are living our Trust values to ensure services are improved, developed and delivered to a high quality in a safe, effective, and compassionate way.

Specific Human Rights based approach is embedded in the training available to staff across the service area. This includes human rights awareness training; capacity and consent training; human rights considerations in discharging statutory functions under the Mental Health (N.I.) Order 1986 in relation to applications and admissions for assessment, Guardianship and Declaratory Judgements.

Within the service area human rights considerations are embedded in Policies and related guidance. These weigh up the human rights considerations in those circumstances in which interventions might impact on a service user's exercise of independent choice or where a service user's vulnerabilities require their access to independent advocacy and/or legal representation. These areas include for example:

- Adult Safeguarding.
- Capacity, Consent and Best Interests issues.
- Decisions relating to the use of powers under Guardianship.
- Applications for compulsory admissions for assessment.
- Risk assessment and risk management decision-making processes.
- Restrictive practices and the use of physical interventions.
- Observation Policy
- Care Planning.
- Use of CCTV to capture aspects of a service user's experiences of care.
- Seclusion and positive behavioural support.

Human rights considerations are clearly documented in SW case notes, assessments, care plans, Adult safeguarding, risk assessment and agency and legal reports etc. The Service uses the Best

	Interests Decision Making Tool to inform complex decision-making. This recording should set out the context, weigh up the service users/carers choice, needs, wishes against the needs of the service user. Potential intervention options are identified within a human rights focus and their rationale for adopting a particular approach. The staff have also availed on bespoke training on ‘Recording- the legal issues’ which is facilitated by a barrister highlighting the need for accurate, timely recording which explains the rationale for decision making with reference to human right considerations.

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?
	As previously reported, the use of compulsory powers under the Mental Health (NI) Order 1986 continues to require careful balancing of 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.	ASW refresher and re-approval training. The provision of ASW fora to support good practice. Staff updates on legislative developments. Staff training in human rights awareness. 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. The provision of accessible information to service users and carers about their rights. The provision of advocacy services.	The new mental capacity legislation and additional responsibilities for ASW and the introduction of authorisation panels will add further to the challenges encountered when balancing a range of human rights. There is currently a review into the advocacy service in learning Disability
	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 awaits the introduction of the new capacity legislation, which should address this issue. Provision of advocacy services.	With the introduction of the new mental capacity legislation and the establishment of panels it is likely there will continue to be challenges in this respect however there will need to be consistency in approach across service groups and indeed across the region.

	As outlined in previous reports 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 strives to be as accommodating as possible in arranging early Tribunal dates but this remains a major difficulty.	The introduction of panels as a result of the mental capacity legislation will ensure reviews are held in a more timely fashion however it remains unclear how quickly Tribunals will be set up and what format they will take.
	Adult safeguarding-generally involving a balancing of the statutory duty to promote and protect the welfare of a vulnerable individual and their right to self-determination. It can also involve complex decision-making with regard to risk management in non-adjudicated situations, balancing an individual's right to privacy with potential risks to the wider society of failure to share information. There are also wider implications, as has been highlighted in the recent large scale adult safeguarding investigation into the hospital, which also relates to the balancing of the rights of staff and ensuring action is proportionate and necessary. There has been issues regarding how the disciplinary policy, safeguarding policy and joint protocol interface with each other.	Review of adult safeguarding- learning from the SAI 'a way to go'. A task and finish group is being established to review BHSCT procedures in relation to adult safeguarding. 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 best practice. The use of adult safeguarding tools which prompt consideration of human rights issues. The provision of advocacy services.	Ongoing

	The implementation of the Promoting Quality Care guidance on risk assessment 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.	Review of the PQC guidance-review of process, audit of current compliance, guidance checklist to be developed to guide staff through the process. New roll out of additional staff training on the Promoting Quality Care guidance. Staff training on human rights. Staff training on data protection. 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 is sought on individual cases	Ongoing
	The use of compulsory powers under the Mental Health (NI) Order 1986	The Service is cognisant of the need to exercise its statutory remit in a balanced proportionate and least restrictive manner.	Ongoing

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	One social worker completed her MSc and was awarded the Diana Jones prize for the highest scoring dissertation. She had an abstract accepted for the 6th Social Care Research Conference and presented this on the day and has been successful in securing a scholarship to complete a PhD. Another social worker successfully completed her Specialist Award in Practice Teaching. A social work team leader continues on the Strategy and Leadership award and will complete her MSc next year. The Learning Disability Day Services Forum was established in 2017 to shape the future of day services across Belfast. Staff, carers and service users were involved in the future planning of services facilitating Empowerment through Participation and the Appreciative Inquiry method of engagement. This involved trained family carers facilitating group discussions along with staff and the TILII group (Tell it Like It Is – a community based advocacy group of adults with Learning Disability). An event was held with the Trust Chief Executive leading in the praise for all involved in this initiative. Day Opportunities are utilised in a wide range of new opportunities for service users incorporating different community based activities for example, hill walking, filmmaking and creative and expressive arts projects into the ongoing programme. It has also invested in personal development, training for work and independence programmes for individuals, which will support them to take up day opportunities. Equal Notes, the community choir, continues to grow from strength to strength and are in constant demand for public performances. This year we can report that a Social Enterprise “Ability Café” based in a BHSCT Wellbeing & Treatment Centre has been established through USEL (Ulster Supported Employment & learning). It provides paid employment for 3 people with learning disabilities in addition, to a 6 further training opportunities. USEL have employed a Training Officer specific to the Café to provide the necessary skills for trainees to secure employment within the hospitality sector. The Trust has successfully completed its first Positive Action Employability Programme recruiting adults with learning disabilities into vacant permanent posts within Patient & Client Support Services. This initiative was launched by Michael Wardlow, Chief Commissioner at the Equality Commission on World Job Shadow Day. Participants completed a 14 week OCN endorsed employability programme covering the entire PCSS Induction programme and on successful completion 9 trainees took up permanent posts within the Trust. It is hoped that this will become an annual recruitment drive

	within the Trust. This Positive Action initiative is part of the Trust's drive to ensure that staff are reflective of the community we serve and that all reasonable adjustments are made to support them. This initiative has been shortlisted for a number of awards as well as being asked to present at the EUSE Union of Supported Employment annual conference. The manager of one of our Residential Units won the Northern Ireland Learning Disability & Autism Award for the Best Registered Manager. The award celebrated a manager who has demonstrated a high level of expertise, exceptional skills in leadership and management, great support for colleagues and a positive commitment to person centred support to meet the ever-changing needs of the people the service supports. There has been a huge drive across teams to ensure people with a learning disability and their carers are centrally and meaningfully involved in co designing and coproducing everything we plan and develop. A Carer Consultant post has now been appointed. This will ensure co-production is at the heart of all our initiatives. Significant work has been achieved to develop community support services and partnerships with community & voluntary sector, along with reviewing hospital discharge processes. This has allowed timely discharge from hospital. Engagement and contractual work has been done with our providers to set realistic expectations and accountability when signing up to sustainable community placements. The service is striving to ensure people with learning disability will be supported to live as independently as possible, with the support they need in their communities. In partnership with our colleagues in Children's disability services, a review and process mapping exercise has given better insight into the transition process and what the protocol needs to 'look like' so both teams are achieving the best outcomes for transitioning service users and their carers. This will ensure young people with learning disability will be supported in their transition to access education, training, accommodation, employment and a full range of health and social care needs as adults. Significant work has been undertaken to develop a range of flexible and responsive community services aimed at delivering assessment and treatment at home, avoiding hospital admission where possible.

3.16	SUMMARY
	This has continued to be a very challenging year in light of the high profile, large scale adult safeguarding investigation in the hospital. This has had a detrimental impact on our service users and carers and staff. Given the media coverage this has resulted in a perceived lack of public confidence in the service. The investigation is still ongoing and there is further CCTV to view which therefore continues to cause uncertainty for our services users and families and staff. Despite these challenges the outcomes of the SAI report, the actions arising from the RQIA inspections and general themes emerging have all helped focus the service on developing and implementing action plans to improve our service so it delivers safe, effective and compassionate care. There has been significant work undertaken with our carers and service users. There has been carer engagement throughout the reporting period in the form of workshops, the establishment of a carer forum and one to one meetings with the families affected by the investigation. The recent appointment of a carer consultant will be instrumental in ensuring there is a greater focus on co production and the needs of families and services is central to everything we do. There has been some preventative work completed with our service users through the roll out of the keeping yourself safe programme and the appointment of an activity coordinator to increase meaningful activity and reduce the likelihood of incidents. There has been a huge focus also on identifying suitable placements for our patients who are delayed discharges. There has been significant work done in forging working relationships with a range of private providers to meet our service user needs in the community. The Trust has also developed Cherry hill supported living scheme to support 9 service users in the community. In addition, the community teams and care management have been strengthened. The intensive support service is also being redesigned to provide intensive input at home and reduce admissions to hospital in the future. There has also been a review of policies and procedures including CCTV, the use of seclusion, observation etc. There has also been a significant amount of work undertaken to support our staff at this difficult time for example, there is a full time counsellor on site, reflective practice sessions are available, staff workshops, joint OH and OH sessions were available, a massage day was provided for staff and a health fair and ‘be-well’ sessions are planned. Due to staffing issues there has been backfill through agency and bank. There service area has also undertaken a range of organisational and workforce developments as part of its focus on distilling learning, improving and providing compassionate, safe and qualitative care. The Service has pursued a person centred care approach through working in partnership with service users and carers.

	The Service has committed to promoting service user choice by developing flexible and bespoke care packages to meet needs. The service continues to promote SDS and all direct payments are now under SDS with a support plan. There are ongoing substantial challenges in securing domiciliary care services. The issues relating to legal authority for deprivations of liberty continue to cause major uncertainty but this will be addressed through implementation of the Mental Capacity legislation. The roll out of the new Mental Capacity legislation will present significant pressures for the service in terms of workforce, training and resources.

Programme of Care / Directorate:- Family and Childcare

3.1	**Named Officer responsible for professional Social Work**
	The Co-Director Family and Child Care Services has overarching responsibility and accountability for the operational delivery of statutory functions by the Family and Child Care Service. 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**
	Trusts must make reference to: Assessed Year in Employment (AYE) and compliance and Caseload weighting arrangements. The Service continues to provide supervision to its social work workforce in line with the Regional Supervision Policy. The Service continues to implement a professional social work supervision exception reporting system. Monthly returns from the Service evidence satisfactory compliance with the requirements in respect of the frequency of supervision and facilitate monitoring of non-compliance. The Service 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. The Service is in the two-year implementation phase of Signs of Safety. One of the central tenets of this practice model is 'Group supervision' in respect of individual cases to promote a culture of reflection and improve decision-making. Group supervision was introduced during this reporting period and is now being implemented across all of the Family Support teams and is being supported by the Implementation Lead, Practice Leads and members of the Implementation Team. This does not replace individual supervision but is very beneficial in enhancing the knowledge and skills of social workers and managers as the whole team benefits from group supervision. Group supervision is also being rolled out across the LAC teams. Additional support is being provided to a group of new team leaders on a monthly basis from the PPSW Child protection and to all Family Support team leaders via Therapeutic Support Services focusing on strengthening the role and function of this key group of staff in supporting frontline practitioners. A training programme for management has been developed within the Residential Service, co-designed by the Trust's Therapeutic Support Service, the LAC Principal Practitioner and the Training Team which focuses on Leadership and Reflective Practice as components of supervision.

	Caseload weighting has not been fully applied during this reporting period due to pressures on the team leaders and frontline staff due to vacancy levels. This is an area that will be revisited once the staffing levels improve.
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 has undertaken/participated in a number of thematic reviews/audits during this reporting period. A recent audit of re-referrals to the Gateway Service within a year identified a significant percentage of cases being re-referred with a higher threshold of need and therefore requiring a statutory social work assessment. Many of these cases had previously been sign-posted to Tier 2 Services. Evidence from the audit sample would suggest that these services were either not accessed or the outcomes had not prevented the need for intervention from statutory services. Further work is required to fully understand the practice implications of this audit for Gateway. The implementation of Signs of Safety as the overarching practice framework, with other approaches including ACEs (Adverse Childhood Experiences), BBF (Building Better Futures) and UNOCINI integrating with the Signs of Safety, continues apace within the Belfast Trust. The Belfast Trust is committed to implementing Signs of Safety in line with the Implementation Plan in order to support the Service to deliver enhanced quality services and practice. Through working together in partnership with families, the Service will strive to achieve strong and sustainable outcomes for children, young people and their families, and empower our families and our staff. The Service is implementing the 'dashboard' as a means of measuring Signs of Safety activity across the service. The Service Area's Case Conference Chairs have met within the context of the continuing implementation of Signs of Safety and the training required for them to facilitate and implement this practice model within Child Protection Case Conferences. This training, development and support will continue in line with the trajectory of full implementation of the Signs of Safety within the Case Conference process. Following on from the Thematic Review in relation to Child Sexual Exploitation (CSE) in November/December 2016, a further audit is about to commence into how the SBNI member agencies are effectively responding to and managing CSE within Northern Ireland. A timetable for this audit to begin has been received by the Trust and will be completed within the next reporting phase. The Trust's Senior Practitioner (SP) for CSE has continued to work with her regional peers and PSNI to capture data with regard to the numbers

	of young people at significant risk of CSE and the number of young people who go missing from home/care. The Trust reports on this data to the HSCB. Joint working between the PSNI and Trusts is crucial and has enhanced service delivery in the area of missing children. The PSNI Missing Children's Team continues to be a particularly positive initiative in this regard. The sharing of information has facilitated analysis of trends, patterns and networks in assessing and managing risks by predatory individuals and groups to vulnerable young people. During the reporting period, there has been a reduction across the Trust of 46% in the number of young people going missing. The Service will be engaging in an audit in the next reporting phase examining the referral processes and services for children and young people who display Harmful Sexual Behaviour (HSB). This audit is in the beginning phase. The NSPCC will undertake the audit with a view to developing an evidence informed operational national framework for children and young people who display harmful sexual behaviour. 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. Non-Executive Directors and Directors also visit the Homes on a rotational basis throughout the year. Due to capacity issues across the Senior Management Team, reflective practice sessions for managers relating to the findings and recommendations of Case Management Reviews, SAIs, complaints and Internal Case Reviews have been put on hold during this reporting period although learning has been disseminated down through the line management arrangements and staff have been encouraged to attend wider Trust events. The Trust continues to participate fully in the Case Management Review arrangements under the auspices of the Safeguarding Board for Northern Ireland (SBNI). The Service 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 Executive Director of Social Work/ Director of Childrens Community Services represents the Trust on the SBNI. The Trust's representatives on the Belfast Safeguarding Panel are the Co-Director Family and Child Care; Designated Doctor for Safeguarding Children; Co-Director Mental Health Services; CSM for Gateway in her capacity as Chair of the BAD&SV Partnership and Named Nurse for Safeguarding Children. A

	number of staff from a range of Services are currently engaged in various SBNI sub-groups. The Service 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 Director for Childrens Community Services chairs the Belfast Area Outcomes Group, which is driving forward the operationalising of a Belfast-wide Early Intervention Service (EIS). The EIS 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 EIS 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 operationalising of the ten Family Support Hubs which signpost families with specific needs to appropriate services is of central importance. The EIS continues to provide a range of training/capacity building opportunities for Hub leads and Hub member organisations and this is key in building knowledge, capacity and skills across the service delivery organisations grouped around Hubs. A Celebratory Event was held in February 2019 to celebrate the work of the Hubs and the organisations that provide services to families and children through the Hub network. Following this, the Lord Mayor of Belfast invited the Hub Co-ordinators to her Parlour to each accept an Award from her for their work in the local community. The Trust welcomed the additional investment through transformational monies this year to further support the work of the Hubs. The Service has met with Belfast City Council on a number of occasions to consider the engagement of the BAOG in the planning for and the delivery of a Belfast Community Plan-a vision for the city predicated on collaboration, partnership and optimising of resources across the spectrum of city stakeholders. This work will continue during the next reporting period. RQIA have continued with its Inspection programme across all of the Services children's homes. During this reporting period RQIA continued to work with the Service in relation to a quality improvement project which involved the development of a new monthly reporting template. A recent Court of Appeal judgement in relation to EPOs found that the Court was "plainly wrong" and acted "unlawfully" in proceeding to hear

	an EPO application in the manner that it did. Arising out of the judgement is the requirement of applicant Trusts to draw attention to the "Mumby points" in their application. This will have implications for Social Workers particularly when out-of-hours applications and awareness raising sessions are being carried out.
3.5	**Summary of difficulties or issues in regard to the ability to discharge Delegated Statutory Functions**
	FAMILY SUPPORT AND CHILD PROTECTION CASELOADS The Trust continues to experience significant difficulties in allocating cases within its Family Support Teams. Caseloads within these teams continue at a level which is not conducive to ensuring families are appropriately supported in a timely manner. Additionally these caseloads are impacting on the Trust's ability to retain and recruit staff to these vital front line posts. The Trust is seeking to effect a reduction in caseload numbers and equity of workloads across sectors, particularly in fieldwork services. The embedding and ongoing evaluation of the Service's Care Pathways Protocol has continued to monitor its impact on caseload numbers across services. The Transfer Protocol between services provides a sound basis to manage the effectiveness of transfer arrangements between teams/ services in the context of complexity, volume of service demands and workforce capacity. **UNALLOCATED CASES** Unallocated cases continue to be an area of significant pressure within the Family Support Teams given the difficulties with recruitment and retention of staff. As at March 31st, the total number of Directorate-wide unallocated cases was 246, 80 of which were Family Support. Family Support services have robust unallocated cases management, assurance, monitoring and reporting processes in place with regard to unallocated cases. These cases are reviewed on a weekly basis by the team leader and reprioritised as necessary. In addition, all unallocated cases have been reviewed by the PPSW Child protection during the reporting period to ensure consistent decision making across the service. Due to ongoing staffing vacancies within the LAC service a number of children/young people have not had a named social worker/allocated social worker. A number of measures have been put in place to manage this situation whilst the service awaits the arrival of new staff in the summer: weekly review of these cases by SSW/PSW and CSM; cases prioritised if before the court or recently through the court; Kinship support staff and residential staff ensuring visits are undertaken to children in these placements; and band 4 staff being employed on a temporary basis to support the social work teams. **CHILD SEXUAL EXPLOITATION (CSE)** The Senior Practitioner (SP) with responsibility for CSE remains co-located with the Public Protection Unit in Antrim Road PSNI. The SP supports staff with the identification of CSE, and provides consultation

and supports to staff in responding to this vulnerable group of young people. They have a key role in working with the PSNI in identifying and gathering intelligence relating to potential networks of adults who pose a risk to young people.

The Trust has continued to provide in-house training on CSE to a range of staff and has facilitated briefing sessions for voluntary and community groups. The Senior Practitioner for CSE provides on-going training input on CSE risk assessments to other agencies and to Trust staff. The complexity of assessing and supporting young people with regard to CSE where their behaviour changes and they at times become perpetrators of Harmful Sexual Behaviour (HSB) is recognised. The SP for CSE has completed AIM2 training (validated risk assessment tool for HSCB). This enhances her ability to risk assess these complex young people and to provide guidance to Trust staff.

A second audit is about to commence into how the SBNI member agencies are effectively responding to and managing CSE within Northern Ireland. A timetable for this audit to begin has been received by the Trust.

LEGAL DUTY TO ACCOMMODATE YOUNG PEOPLE

On occasion, the Trust's Intensive Adolescent Support Teams have been managing safeguarding concerns in relation to young people who have been the subjects of paramilitary/community threats. The Trust is keen to see the full implementation of the draft guidance agreed regionally by the HSCB, Health and Social Care Trusts, PSNI, and PBNI "When a Child/ Young Person is subject to a Threat to Life'. This approach promotes greater co-operation across agencies in the discharge of their safeguarding responsibilities and is waiting formal approval. Difficulties remain at times in verifying threats. Often the young people cannot be supported in their homes and require alternative accommodation outside their own localities. This presents challenges and risks that require safety planning with the young person and their networks.

The Trust has a statutory duty to provide accommodation to a young person assessed as being "in need". In a number of instances, this duty requires the Trust to provide accommodation to young people who have a history of offending/anti-social behaviours, including drug and alcohol misuse and/ or have experienced a breakdown in relationships at home. Due to ongoing recruitment challenges, the homeless SW post has remained vacant during this reporting period, which has placed significant strain on the intensive Adolescent Support Service. Effective working relationships have been established with the NIHE and Joint Commissioning providers to assist in the development and delivery of accommodation for homeless young people. Challenges remain in relation to sourcing appropriate accommodation for those young people whose needs cannot be met in residential care or current jointly commissioned accommodation due to the risks and challenging behaviours they present with.

Availability of and access to bespoke accommodation and supports for young care leaver mothers and young mothers who are Looked After children is a pressing issue.

CASE CONFERENCE MINUTES

As at 31st March 2019, the Trust had a 17.5% compliance rate with the required time-line for dissemination of case conference minutes. The reduction in compliance has resulted from a number of factors including significant challenges associated with the introduction of new business and related data quality assurance processes across administration and social work staff and ongoing recruitment difficulties across all grades of staff. The improvement in compliance is a priority area for Principal Social Workers and Minute Takers. A Quality Improvement Project has begun to focus on the compliance rates and the improvement of these.

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, experience marginalisation, have difficulties in understanding statutory, legal processes and English is not their first language. They require substantial supports, including financial supports to meet basic living and housing costs on occasion.

CARE PATHWAYS PROJECT

The Care Pathways Project has been operational since 2016 and a planned review was due to be completed by the end of 2017 as part of the transformation process. Unfortunately, there has been delay in the report being finalised due to operational reasons. Feedback from within the Family Support Service is generally positive with staff seeing the benefits of remaining involved with families until the granting of the final Care Order. Feedback from both LAC staff and young people is positive although, due to the increasing demands on the LAC service, staff managing the complexity of the 16+ age group of young people, increasing caseloads and difficulties with staff retention, the full benefits have not been seen. Young people and social workers report, however, that in principle, the preferred choice is that those young people under 18 remain in the Looked After Service.

ADOPTION AND PERMANENCE SERVICES

Whilst the recruitment of potential adopters with appropriate skills and abilities to meet the often-complex needs of young Looked After Children, including sibling groups, in need of permanent adoptive homes has improved, this area none the less is one which the Service keeps a focus on. The recurring themes of chronic neglect, foetal alcohol syndrome, attachment difficulties and developmental delay are prominent in the profile of those children for whom permanency through adoption is determined as the optimal option for their future care.

Protracted Court proceedings in many cases impact adversely on the securing of timely permanence, especially where adoption is the Care Plan. Twenty-two Freeing Orders were granted during the period 1 April

2018 – 31 March 2019. The Trust is committed to improving performance in this key area. The implementation of the Revised Permanence Policy affords the opportunity to improve timely decision- making and planning to progress permanence through adoption.

On a positive note, at period end the Trust had no children freed for adoption who were awaiting placement with perspective adopters.

Once adoption has been identified as the Care Plan, the Principal Social Worker for Adoption (PSW) is responsible for monitoring timescales for presentation to the Adoption Panel and tracks the progress from "best interest" recommendations to achieving adoption. The Trust's Adoption Service database captures key data across all aspects of adoption service delivery and performance.

With regard to the recruitment of adopters, all applicants complete a dual approval assessment and are matched with children who have a 'best interest' recommendation. Concurrent care is discussed with potential adopters as part of the Trust's ongoing focus on promoting this model. While concurrent care is not appropriate for all prospective adopters, the number of carers open to considering concurrency is increasing. The Trust has eight approved dual/ concurrent carers awaiting matching and two concurrent placements. The Adoption Service works with colleagues in the Family Centre to provide bespoke parenting assessments for parents of children placed in concurrent placements. This is the consolidation of the HOT Project into mainstream services.

The Trust also continues to see a steady increase in the number of same sex applicants seeking to adopt. With the NHSCT and QUB, the Trust is participating in a research project in relation to adoption service delivery to same sex adopters.

The Trust continues to make improvements in the reduction of the number of applicants on the waiting list for assessment. With the retained bank of fieldwork staff supporting the Adoption Service staff resource, there is a rolling allocation of assessments. Waiting times for both assessment and training are often dependent on the applicants' individual personal/home circumstances. The Trust is currently undertaking 9 adoption assessments at period end.

CARE ORDERS AT HOME

The Trust recognises there is a significant number of children placed at home with their parents under the auspices of Care Orders. Following a workshop the Service has established a Project Team to collate and analyse a range of data with regard to this placement cohort to inform its review of practice and wider service delivery themes. The Project Team has collated and analysed the data, undertaken interviews with social work staff with case responsibility and following the outcome, key staff are now involved in a QI project due for completion in June 2019.

PERSONAL ADVISOR (PA) SERVICE

Pressures on the Personal Advisor Service remain, primarily because of the increasing volume of young people who have a statutory entitlement to a PA and the challenges of retaining and recruiting to the Service.

At the period end, the Trust had 79 young people awaiting the appointment of a PA. Unfortunately, within the PA Service, there has been one vacancy during the reporting period and a long-term absence. This had led to an increase in the waiting list for PA case allocations. The vacant post has recently been recruited to and it is hoped that the other PA will soon be able to avail of a phased return to work.

Even with a full staff complement, it is unlikely that the PA service will be able to meet all its statutory responsibilities within the number of core funded staff. It is anticipated that the PA service would require at least an additional 1.5 PAs to meet the entitlement for eligible, relevant and former relevant young people.

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 some of the financial pressures from the GEM Scheme, if current demand trends continue, this will lead to a further increase in pressure on the current budget.

The Trust is involved in the regional work to review the funding to GEM placements, particularly with regard to fee paid foster placements in the projected care plans for post 18 care leaver placements.

SUPPORTED ACCOMMODATION

The Trust currently has access to a number of jointly commissioned accommodation resources, which support young people transitioning into independent living. These options provide a spectrum of peripatetic supports, which meet the diverse needs of young people leaving care. The Trust had identified a need for supported lodgings and had secured recurrent funding for same from the HSCB, however, the Trust in partnership with South Eastern Trust, felt this was no longer a priority area at the present time. The South Eastern and Belfast Trusts are now jointly exploring with the NIHE and current providers of jointly commissioned accommodation, the possibility of alternative placement options and support packages for those older young people whose needs cannot be met in either residential care or joint-commissioned accommodation, due to the challenges and risks they present. This work is being taken forward by both Trusts with further additional funding provided by the HSCB to provide intensive packages of support for vulnerable Looked After young people 16+ and care leavers.

There is a particular pressure on the Service 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, tailored supports and more specialist accommodation with attendant additional costs.

Placement Pressures:
There are substantial 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 and the complexity and range of their needs. The Trust's Fostering and residential services continue to face ongoing pressures in sustaining their present placement capacity.

The Service has noted a growing trend of younger children presenting at the point of referral with complex emotional and behavioural needs, who require access to specialist therapeutic services and bespoke fostering and residential resources. During the reporting period, the Trust placed two young children under eleven years in residential care.

The professional, governance, organisational, logistical and resource implications of placing a young child in residential care are considerable. During the reporting period access to Children's House was not available to the Trust which placed pressures on its existing residential provision, and current specialist therapeutic support services. This resulted in significant costs associated with individual placement arrangements, bespoke supports and overarching workforce capacity. This issue requires a particular focus at policy and regional levels.

Placing young children in residential placements out with their Statement of Purpose, breaches regulatory requirements and results in a temporary hold on admissions to the individual home. The placement of one of these young people resulted in a JR application by the child's mother and an judicial process over a number of months. This has had a direct impact on the whole-system residential placement capacity and has generated indirect pressures within the fostering system.

A specialised, bespoke home has been developed in response to the specific needs of one young person. There have been issues with regard to recruiting a full staff team, which in turn has led to a temporary hold on admissions to one of the ISUs where the young person is currently residing.

One of the ISUs in Glenmona will be moving into the community, to College Park Avenue in the early Autumn. There are plans in place for two of the children's homes on site, the remaining ISU and the Unaccompanied Minors and Separated Children home.

One of the children's homes, Donard, provides placements regionally. This provision is being reviewed with the HSCB and Trusts.

	SEPARATED CHILDREN The Glenmona Resource Centre provides a specialist residential service to separated children. It is recognised that this group of young people are particularly vulnerable. The Trust continues to manage these young people via the Intensive Adolescent Support teams, which support the development of expertise and skills base in this complex area of work. The focus of the Teams' interventions includes age assessments; ensuring a young person's cultural and religious needs are met; overcoming communication barriers through the effective use of interpreting services; and building relationships with young people. This service has developed positive working relationships with the newly established Independent Guardian Service. In March 2019 CSIB approved the 'Practice Guidance Note on the Legal Position of Separated and Trafficked Children'. This practice note provides the Trust with the rationale as to why the mandate of the Court should be sought to ensure judicial protection of the young people's human rights and UNCRC rights. This has placed additional pressures on the IAS teams who have now retrospectively made applications in cases that were previously known and managed on a voluntary basis. The Intensive Adolescent Service, residential and community staff support continuous practice development in this area. Staff attend multi-disciplinary Regional Practice Network meetings chaired by the HSBC. The Network has also developed a practitioner forum to share good practice with staff members and a consistent response across the region in work with unaccompanied asylum seeking and trafficked children, which is ever changing. There is also the current development of a regional fostering team to identify specialist carers for separated children given their specific and complex needs.
3.6	**Provide a progress report and emerging learning in relation to remedial action to improve performance including financial implications**
	Implementation of Signs of Safety Within Belfast Trust, the Service is committed to our aim that Signs of Safety will be our framework for interventions with children and families, setting the processes through which the work is undertaken with individual service users in partnership with other agencies. Whilst Signs of Safety provides many opportunities and improvements in the way we carry out child intervention work, it is also important to recognise the challenges. These include the capacity of staff to implement Signs of Safety along with other practice directions for example, Building Better Futures (BBF) and Adverse Childhood Experiences (ACE). There are significant pressures related to workforce recruitment and retention and outstanding challenges with the integration of Signs of Safety and the various Trust information systems.

Adoption and Childrens Bill
The Trust would wish to continue to highlight the significant resource, capacity and workforce planning requirements that will be necessary to deliver the implementation of this new legislation.

Increase in Costs relating to Permanency
The increasing costs of Residence Order Payments linked to the rise in Residence Orders continues to be a significant cost pressure to the Trust.

The number of Adoption Allowances continues to increase, reflecting the range and complexity of needs of children placed for adoption.

Contact
The Trust continues to experience significant difficulties in meeting the demands presented through the provision of contact with families. High levels of contact, demographics and family dynamics have continued to present as a substantial pressure on social work capacity. The Trust is continuing its review of the levels of contact, the time spent by social workers and the impact on caseloads. It is hoped that this review will highlight not only the pressures experienced by teams in managing contact and capacity to maintain contact demands, but also begin to identify how this can be addressed in order that future contact provision meets the needs of children and families.

Fostering Placements
The Trust continues to experience significant difficulties in securing appropriate placements for children and young people.

PARIS
The implementation of PARIS has continued to present significant resource, logistical, professional and organisational challenges. It is a crucial strategic, transformational improvement project and will require significant resources to optimise the potential of digital working and to position children's social care services to respond to the challenges and maximise the opportunities of the roll-out of Encompass.

Specialist residential provision
A specialised, one-bedded children's home has been developed in response to the specific needs of one young person in circumstances in which an ECR placement was not an option. There are substantial related resource and financial issues associated with the recruitment of a staff team to provide full-time care for this young person.

Younger age children requiring residential placements
The past year has seen an increase in the number of children at a younger age requiring residential placements due to complex behavioural and emotional difficulties. These young people have often had a high level of fostering breakdowns in a short period of time and have presented with behaviours that are too challenging for foster placements. Consequently, the Trust has had to reconfigure one of its children's homes for the younger age range and provide additional

	training to staff on how best to meet the needs of this very complex group of young children. This Home will continue to be required during the next reporting period due to the ongoing needs of this group of children. This continues to impact significantly on the number of residential placements available for 13-17 year olds and has resulted in our mainstream homes increasing the number of young people placed within them – a move which is counter strategic.
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 31st March 2019: ➢ Potential for young people to come to harm as a result of poly substance use; ➢ Risk of young people engaging in risk taking behaviour eg substance misuse and vulnerability to CSE while having unauthorised absences and going missing from care; ➢ Risk to delay in children and young people receiving services due to the number of unallocated cases within Family Support; ➢ Risk of homeless young people aged 16+, who present to Family Support, becoming further involved in CSE, drugs/alcohol or crimes as result of being placed in unregulated placements such as B&B; ➢ Risk of verbal abuse and or injury/harm to staff due to violence and aggression from others; ➢ Risk of mis-management of child protection cases due to the volume of cases and current staffing complement; ➢ Risk of staff not being up to date with current practice because they have not undertaken statutory mandatory training; ➢ Risk of some of the high volume of very sensitive information being forwarded incorrectly or not appropriately managed in line with Information Governance policies; ➢ Risk associated with the implementation of Paris across the Family Support and LAC teams, the impact on Social Worker's time and the potential for information to be entered incorrectly. ➢ Risk of verbal abuse or injury/harm to staff due to violence and aggression from others ➢ Risk of not being able to access appropriate foster care/residential placements ➢ Risk of not being able to fully discharge statutory functions due to high levels of vacancies in FS and LAC ➢ Risk of mis-management of Child Protection cases due to the volume of cases and current staffing complement.
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 past twelve months has been an extremely challenging time for the Children's Community Services in terms of recruitment and retention of staff across all areas of frontline provision. The Directorate has held monthly workforce meetings to focus on the recruitment and retention

	of staff and when required weekly meetings with senior managers of particular service groups to review how vacancies are being managed. Whilst the Trust has a scrutiny process in place for review of vacant posts, the Executive Team has fully supported all recruitment requests for children's community social work posts. The main issues have been the timeliness of getting successful applicants through the recruitment process and the lack of available social workers in the latter part of the year. The Directorate has significantly increased its reliance on the use of agency social work staff although the availability of this group of social workers was limited as the year progressed. Throughout the course of this reporting period, the Gateway Service has experienced significant workforce challenges with staff leaving post for various reasons, including promotion/ a change in career pathway/ wishing to seek out opportunities in other programmes of care. Due to the demography of the workforce, maternity leave has also been a particular feature. The Service has developed a pro-active recruitment and retention strategy with substantial HR supports incorporating a series of recruitment campaigns, development of incentives and accessing of agency staff. It has pursued a dynamic staff engagement and listening approach with a sustained focus on staff well-being, ongoing investment in a spectrum of training and development programmes and a commitment to flexible, family friendly approaches. The Directorate has sought to consolidate and further develop its links with the Degree course providers and to optimise the potential of its student placement programmes for future recruitment opportunities. There are continuing workforce pressures across the Family Support Service in fieldwork posts. Stressors related to caseload size, service delivery volumes, demands and complexity of service user needs, levels of risk and related accountability remain substantial issues. The demands placed on field social work and senior social work grades has a detrimental impact on the recruitment and retention levels within Family Support. Given the volume of new Band 7 SSW staff within the Trust and the crucial role they have, emphasis is being placed on the support available to staff via the SSW forum. This also incorporates psychological support available via the TFSS wraparound service. Over recent months, the LAC service has experienced difficulties in recruiting and retaining social work staff. The bedding down of the Care Pathways Review, alongside increasing complexity of the casework, increasing caseloads with the rise in the Looked After population, ongoing Court work with Freeing Order Applications, other legal challenges from parents, for example arrangements for contact, have all contributed to experienced staff either leaving to go to other programmes of care or leaving the Trust to try to achieve a better work-life balance. The development and support of our workforce has been a key priority for the Directorate during the year and will continue as such during the next reporting period.

	Overall, the Residential Service teams are at capacity although there are issues in relation to recruiting a full team for a new children's home recently developed. The Service has continued to support investment in learning and development opportunities for staff. As part of a Trust-wide process, the Service was assessed for IIP re-accreditation during this reporting period. IIP affords a framework within which the Service has sought to develop its workforce support and engagement structures to promote staff resilience. The framework's emphasis on reciprocity of respect, communication and transparency reflect the wider organisational values and principles. By building clear channels for staff to contribute to the Trust's realisation of its ambition, the Service hopes to achieve IIP Silver Award accreditation to maximise 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?**
	Inter-country Adoption Services – Costs related to assessment and approval process.
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**
	This will be addressed in the Children with Disabilities section.
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. The Trust's vision, values and principles reflect the importance it attributes to the human rights of service users. All Trust policies and procedures comply with statutory requirements relating to its Section 75 responsibilities Professional and corporate mandatory training and accredited learning programmes embrace a focus on consideration of the impact on an individual's human rights in decision-making with regard to statutory services delivery. 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 which affects them and the proportionate exercise of statutory authority, while retaining a focus on the paramountcy of a child's welfare, provide the template underpinning the Service's discharge of statutory functions. Under the auspices of the Trusts New Directions 2 document the Service is reviewing its arrangements to engage service users in the evaluation, planning, design and review of service. In addition to the involvement of service users in meetings such as child protection case conferences, LAC reviews, the Service has well-established service user involvement in a number of areas including the Care- experienced

	Young Peoples Forum, Family Nurse Partnership Project Board. The service will build on this over the next reporting period to incorporate a co-production approach.

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 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 these families, the Trust is required to balance their rights 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. 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.	This is still an expanding area of work across the Trust. The Trust has developed staff with a skills base in working with NRPF families and has sought to develop its relationships with key agencies involved e.g. the United Kingdom Border Agency (UKBA). 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	The HSCB has published guidance on access to social care for people from EEA and non-EEA countries. The operationalising of the guidance has reinforced the complexities and ambiguities of the legislative framework. 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.

	The area of post adoption contact for children who are subject to Freeing Orders and subsequently placed for adoption presents complex rights and professional challenges in balancing the rights of a natural parents and the paramountcy of a child's welfare	in all decisions which impact on their Human Rights is fundamental to practice. The Service has sought to build its knowledge, skills and evidence base in adoption and the area of post adoption contact to support evidence informed decision-making, which fully addresses the rights of the individuals involved.	To continue to develop professional practice base and review the evidence base to inform decision-making. To ensure relevant, up to date research is available for all staff and contributes to practice and planning approaches.

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	The implementation of Signs of Safety on a regional basis presents an opportunity to transform service delivery approaches and outcomes across the Service. However, it also presents significant challenges. It is crucial that the concerns in relation to the challenges are managed and overcome in order to ensure that it is implemented within the timeframe and leads to the anticipated changes. The Trust have developed a Therapeutic Family Support service (TFSS). This is a specialist service focusing on supporting social work teams in the Belfast Trust by providing access to psychological thinking across the different social work positions within family support. This service was developed in recognition of the intensity and complexity for our family support teams in their assessments and interventions with families. There is increased awareness and understanding of the impact of work on practitioners and staff well-being as central in providing better decision making and support to our families. There is increased emphasis towards reflective practice. The aim of the TFSS is to contribute to overall high quality safeguarding and support of vulnerable children/young people and families who have family support involvement. The Belfast Trust's residential service, in collaboration with the PSNI and IFA, have developed the 'Dare to Win' initiative, which is a twelve week programme, that aims to redirect young people from risk taking behaviours, teach young people sport and coaching skills, and in the long term provide work opportunities to young people The GEM scheme continues to grow with continuing improved outcomes for care leavers in terms of education, employment, vocational/training opportunities as well as offering enhanced stability in emotional and social wellbeing. The enhanced collaboration between Adoption and Fostering continue to provide a much better framework to engage in joint recruitment initiatives to identify permanent foster carers, dual approved adopters and concurrent carers. Following on from the HOT Project, the Trust has embedded concurrent placements and tailored parenting assessments into its core business. The Adoption Service has been very successful in the recruitment and approval of same sex adopters and this continues to be an area of growth. 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 range of potential opportunities for young people in the workplace and in education. There continues to be a 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 as reflected in the Scheme's "ring-fencing" of employability opportunities for young care leavers in partnership with HR and other Directorates. The service is now working with two other departments within the Trust to develop a potential method of a paid one year internship and is also looking at opportunities for apprenticeships. The Residential Specialist Assessment has been integral to informing Care Planning and identifying interventions responsive to the presenting needs of each individual young person. With particular reference to the bespoke arrangement for two nine year old children, the specialist assessment has been critical in placement matching for each child. Aran House was shortlisted for the Social Work Awards – Children's team award- for the expertise and skills they have developed in working with separated minors. The Trust led on a regional review of the recruitment and retention of foster carers in conjunction with ASG. The final report was presented to all relevant staff and a number of recommendations/actions agreed for moving forward.
3.16	**SUMMARY**
	This has been a challenging year for the Directorate in a number of areas: **Workforce** The Directorate has experienced a high number of vacancies at every level. The Interim Executive Director of Social Work Mr Growcott remained in post for the first 6 months of the year until the permanent position was recruited for in September 2018. 50% of the Tier 3 senior management positions remained vacant throughout the reporting period and following restructuring two new Co-Directors and a Deputy Executive Director of Social Work were successfully appointed to in March 2019. The Tier 4 management level also experienced a degree of instability with 5 new service managers being appointed out of a total of 8. The Directorate has developed its collective leadership model with the introduction of two new posts: Divisional Nurse and Deputy Executive Director of Social Work/Divisional social worker. It has also invested in strengthening the Directorates infrastructure in relation to ICT, information and governance. A high turnover of staff was experienced at band 7 and band 5/6 levels and, despite two recruitment campaigns, not all posts have yet been recruited to. This has had an impact in parts of the service being able to fully discharge its statutory functions. It is hoped that the stabilisation of the Senior Management Team and the recent recruitment of social workers will improve this situation in the first quarter of the next reporting period.

	Current placement pressures The current difficulties relating to placement availability across both fostering and residential care have continued to give rise to challenges for the Trust in the discharge of its statutory functions. The Trust has been creative in developing two new specialist residential arrangements for young people to respond to their specific needs through the development of a residential home for 8-12 year olds and a residential home for one young person who displays sexually harmful behaviour. Whilst both options have been in the best interests of the children involved, this has been a cost pressure for the Trust. **PARIS CIS** The Directorate has implemented the new PARIS CIS across its frontline services with fostering and adoption to follow in the next reporting period. This has proved to be a substantial challenge for the staff involved and is still bedding down. Despite these challenges the Directorate have maintained its focus on quality improvement, continuing to build its skills and knowledge base as it works with the Trust to achieve its ambition to be a top performing high quality and compassionate organisation. The Service is committed to the valuing and the development of its workforce, to facilitating their access to training and accredited learning linked to career pathway opportunities and to promoting a strong reflective, outcomes and evidence based practice culture. The Directorate has had a focus on improving staff engagement at all levels to ensure both a bottom up and a top down approach to planning and involvement and has a People and Culture Plan in place to support this work. The Directorate has worked with the rest of the Trust towards achieving IIP Silver accreditation.

Programme of Care / Directorate:- Children with Disabilities

3.1	**Named Officer responsible for professional Social Work**
	Oversight of professional social work practice and standards within the Children with Disabilities Service is the responsibility of Mrs Pauline McDonald, Childrens Services Manager, who is accountable to Ms Kerrylee Weatherall Co-Director for Child Care and Child Health and a qualified Social Worker, in respect of safeguarding and social work governance issues as well as service delivery and quality. An unbroken line of accountability for the discharge of statutory functions by the social work workforce runs from the individual practitioner through Service 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 Manager for Children with Disabilities, Assistant Service Managers, Childrens Home manager and Team Leader posts are all designated social work posts. Supervision was delivered to the Service's professional workforce in line with their respective regulatory requirements The Service is compliant with the requirements of the regional Children's Services Supervision Policy. All 3 Team leaders have completed the Trust Supervision training programme. **Forest Lodge**, (Short Break Service) is a registered Nursing Home, managed by a qualified nurse. RQIA nursing and Childrens social care inspectors jointly inspect the Home against Nursing Home and Childrens Standards. Supervision is provided to staff on a monthly basis by the Team Leader. **The Regional Interdisciplinary Service Team (RISE) and Childrens Therapeutic Services** have multi-disciplinary workforces. (There is one designated social work post in RISE Team). **AYE STAFF** As at 31/3/19, the Service had 7 AYE social workers in fieldwork and hospital social work teams, who were employed via a Recruitment Agency and two were recently successful at interview for permanent posts in the service. The Service has complied with the regulatory requirements in relation to induction, supervision and workload of AYE staff. The Service links closely to CCS Learning and Development Team to ensure that AYE staff, including Agency staff are appropriately supported to meet all learning objectives and required competences. The Service has assurance processes to monitor compliance with the discharge of its statutory functions and maintenance of good practice as follows: ➢ Monthly/Supervision ➢ Regular team meeting

	➢ Release to attend AYE forum ➢ Mentoring from experienced Social Workers ➢ Regular training and development opportunities ➢ Regular file reviews ➢ Reflective case discussion opportunities ➢ Multi-Disciplinary reviews and consultation ➢ Staff consultation and support events
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).**
	Somerton Road Children's Home This is registered as a home for children with Learning Disability and behaviours of challenge. This has been a mainly positive year for the home. The acting Manager has moved to a post outside of the Trust however, the deputy manager post has been permanently filled by an experienced Residential Social Worker and the service will recruit a replacement as soon as possible. One resident recently admitted to the home following a breakdown in his home circumstances has adjusted well to his new surroundings. The other residents have made significant progress throughout the reporting period, achieving increasing levels of personal independence and self-regulation. One young person is working with staff to get ready for his move to adult Learning Disability services, which though challenging for him is going well. Monthly monitoring and file reviews are ongoing (via Monitoring Officer). Recruitment of social work vacancies is now complete and the Service has adapted well to both new residents and staff. The Service continues to embrace Positive Behaviour Support (PBS) as its primary ethos and there has been a continued low-level use of physical restraint and restrictive practices within the home since our last report in line with appropriate practice guidance. Four members of staff have been trained as PBS coaches and a PBS reflective practice group continues to meet across the CWD Service. The Service remains committed to developing PBS as a cohesive and unifying framework across teams, services and with other departments within the Trust and is involved in regional PBS development work. In the last year, the Service has continued to provide regular structured reflective practice sessions for staff facilitated by a member of the Children's Services Learning and Development Team. The pressure for places within Somerton Road has continued throughout the year with the Service identifying a number of children/young people on the edge of care. The Trust would request further discussion with the Commissioner in relation to developing the range and number of placement options for children with Learning Disability and behaviours that challenge both within Belfast Trust and regionally.

Forest Lodge (Short Break Service) is a registered Nursing Home for children with Learning Disability and Complex Health Care Needs. The Home is inspected on a joint basis by both 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 Children's Home Regulations. The Divisional Nurse provides professional nursing governance advice, guidance and monthly supervision to the registered manager. Monthly agency/management supervision is also provided to the manager by the Assistant Service Manager with responsibility for Residential and Short Break services.

This short break service continues to be evaluated positively by families and professional colleagues. Work is on-going to develop more effective ways to engage and understand the views of children.

Willow Lodge (Short Break Service): Willow Lodge is a Children's Home with two registered beds and currently has eight children using the service at various times and at varying levels, depending on assessed need. Several discharges have taken pace of children whose levels of support were beyond the remit of a Short Break service and LAC regulations and these young people are now in full time placements. New residents are being introduced and the service expects to be supporting at least an additional 4 families within the next four months. The service has noted continued increase in complexity of need and family breakdown within a cohort of children identified to HSCB as being on the edge of care. Children with complex behavioural presentations are likely to present with increased need across a variety of services in the next few years, including residential placements, which the Trust has highlighted in discussions at Childrens Services Improvement Board (CSIB) and to HSCB.

A regional workshop was held in June 2018 to address regionally strategic themes, pressures and priorities. To date, a draft action plan has been shared with all Heads of Service, but no firm regional action plan has been agreed and no specific actions have resulted. This is regrettable and is an issue which requires focus from HSCB and Trusts.

Wherever possible SDS is provided and utilised to provide greater breadth of support and choice. Many Families describe the administrative requirements of SDS, lack of available and suitable PAs and lack of training and support as reasons for their reluctance to request SDS, or as the reasons why SDS is limited in its application. The most complex children require an increased range of direct and stable family support services such as Short Breaks, Shared Care and residential placements.

Access to Services
The Service has written referral and allocation criteria for each of its services detailing the responsibilities and accountabilities of Team Leaders and practitioners. The Service continues to adhere to its

	comprehensive referral pathway process (aligned to UNOCINI requirements), which takes account of all services managed by CWD. In effect, this creates one “front door” for specialist Family Support services. All urgent or child protection referrals are responded to within twenty-four hours. The Service has a long term issue in respect of the reduction of unallocated cases and has engaged with the commissioner to try to resolve the situation. These are reviewed by the SSWs on a weekly basis and reprioritised as necessary. **Community Nurse Learning Disability Service (CNLD)** The CNLD has an active caseload of 111 children. All children referred to the CNLD service have an initial assessment to ensure that there are no safeguarding concerns and to understand family support needs. The Service has delivered a number of parent and carer workshops on sleep, toileting and behaviour management. 76 parents availed of these and reported that they found them to be very helpful. Outcomes are currently being evaluated. For those children who are assessed as having significant health or disability related issues, the CNLD service provides health promotion advice guidance, medication monitoring ,advice, guidance and support in management of epilepsy, sleep, anxiety management ,continence and challenging behaviour. **Childrens Therapeutic Service** The Children’s Therapeutic Service (CTS) provides Clinical Psychology, specialist behavioural, Speech and Language Therapy, Occupational Therapy and Family Support worker inputs. The Service works closely with community social work, Community Nursing Learning Disability teams and ID CAMHS colleagues and is currently providing specialist assessment, interventions and supports for approximately thirty-five children. CTS continue to hold a waiting list of ten children for Psychology and ten for behavioural assessment. Waiting times are reviewed regularly and kept to a minimum. During the reporting period, the waiting list and referral process underwent significant review to ensure that only those children whose needs could not be met by another more appropriate service were accepted for assessment and support. In order to ensure that children and families with significant behavioural and psychological challenges are supported holistically, all children referred to CTS must be known to the CWD Social Work service. This has ensured that need has been appropriately assessed and identified and family support services put in place as per Pathway Plan. CTS has also developed a weekly consultation service for professionals, which has facilitated access to specialist advice and consideration given in a timely way as to whether or not a child or young person needs to be referred to the Service for more specialist assessment. Waiting times and outcomes for the service are measured and recorded and information gained is used to appropriately target resources and improve the quality of the service provided. The service is working collaboratively with other teams and a much better understanding of its role, function and capacity is evident.

Regional Integrated Support for Education RISE NI (BHSCT)
The RISE NI BHSCT work to a tiered interdisciplinary, early intervention model supporting children, schools and families at universal, targeted and specialist levels, to ensure that children are fully engaged with the school curriculum and have the best chance to succeed in school and at home. RISE has facilitated service user focus groups and has led within the Service in shaping and improving practice in relation to service user involvement and outcomes-focussed service delivery. Both teachers and parents rate the Service highly and provide valuable feedback and perspectives on service delivery, which enables the Service to improve on an ongoing basis. During the reporting period, 415 referrals for specialist assessment were made and 4500 were seen through whole school/class or targeted programmes.

800 teachers and 500 attended RISE training programmes. The Service has links with statutory and voluntary agencies, which ensure that the right services are involved with children and their families and avoid duplication.

Parent/carer engagement has led to the development of a range of parent workshops, which are provided within school settings and enhance the supports delivered by both health and education services with parents reporting them as less stigmatising-in particular Solihull and Sleep Scotland workshops and training.

Selective Mutism services for children within the BHSCT are now embedded within the Service and 40 children have taken part in these programmes with successful outcomes. Outcomes look promising and this contributes to a reduction in need for more intensive psychological and other core services.

The Service notes increased need and complexity of children now attending mainstream nursery and primary schools and requiring assessment and support from RISE. This reflects current pressures in Educational Services, which would previously have provided specialist advice and support. The threshold for access to Educational Psychology services continues to increase the demand on the RISE team.

Community Teams
The Service has now recruited a third Team Leader and new team structures and arrangements have been created to enable efficient use of our limited social work resource and to ensure good governance of services. Social work teams have settled well and a positive culture is developing. We have finally concluded recruitment and are pleased to have appointed 3 staff who were formerly employed as Agency and who know the Service well.

The Service continues to prioritise the reduction of unallocated cases, but this has been challenging. The Trust has continued to raise this

pressure to the Board and is awaiting the outcome of regional plans for increased staffing to remedy the situation. The Service asserts that it will be unable to achieve a sustained reduction of unallocated cases without further investment.

PARIS is now fully implemented across all services and staff have had appropriate training. The Service notes the benefit of appropriate information sharing and access to professional assessments.

During the reporting period, managers have continued to develop systems for managing referrals and unallocated cases, linked to improvements in the Duty system. This has assisted the Service to understand risks and issues inherent in cases which cannot be fully covered. The Social Work service has collaborated with colleagues in CNLD and CTS services to provide early intervention workshops and support to families who have not yet been allocated a SW. To date feedback from parents has been very positive, with parents advising that they feel supported and enabled to manage their child and the challenges which they face.

RISE NI again ran a “Stress Less” workshop for parents and carers. Funding was provided from the Carer budget and included access to various therapies and treatments, including neck and shoulder massage for parents. Thirty-two parents in total attended these sessions. These afforded opportunities for carers to come together, relax and have some time for themselves while exploring how they might build resilience and manage stress. The programme was well-evaluated by parents who attended.

Carer support continues to be a priority for the Trust and 406 Carer Grants have been made and 136 Young Carer assessments completed. The service delivered 2 carer away days and workshops as outlined earlier in the report.

Community Teams are increasingly dealing with significant safeguarding cases. They have submitted 30 PJI1 forms and completed associated investigations during the reporting period. Three of these investigations resulted in ABE investigations with PSNI colleagues.

Private Law applications:
During the reporting period, there have been private law applications, which have required social work assessment, including visits to child, parents and family, observations of contact, attendances at Court, and provision of Court reports and update reports.

The Service also co-works a number of cases with LAC and FIT colleagues, which can be complex and time consuming.

Unallocated cases are reported on a monthly basis to the HSCB. Team Leaders assess and prioritise work referred into the Service to ensure they maximise the available staff resource, minimise and

manage unallocated cases and adhere to UNOCINI assessment and review timeline requirements insofar as possible. As at 31.3.19, the Service had 166 unallocated cases and continues to work to manage and reduce these. As reported earlier, the Service believes that this is a long term capacity issue, which requires additional professional social work resource to address and which requires additional investment.

As a service, Children With Disabilities is experiencing serious Cost Pressures linked to the increase in numbers and allocation of Self Directed Support packages based on assessed need. In addition, the Service has had to place three young people in full time placements outside of the Trusts commissioned arrangements and without additional funding. The service has also had to increase waking night staff numbers in children's homes due to increased complexity of residents.

Children with Complex Health Care Needs – the Service continues to work closely with the Community Children's Nursing (CCN) Service to ensure co-ordinated discharges from hospital and joint assessment where possible to support the families of these children. The lack of appropriate housing and care providers can often cause long delays in the discharge process.

The Disability Fostering Project provides placements for 4 children with complex needs on the edge of care. The Service is working closely with fostering colleagues to deliver appropriate placements. The project has led to improved communication and understanding between Children with Disabilities and Fostering Services and a more streamlined pathway for accessing foster placements for children with disabilities.

ABI
The Service is contributing to the development of the Trust Brain Injury Strategy Action Plan and is taking the opportunity to profile the care and support needs of children.

Service User Audit, Engagement and Feedback.
The Service seeks feedback from children and parents who access Short Break and residential services via the LAC processes and annual surveys. It continues to report on this in monthly reports to RQIA. During the reporting period, the Service 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 has increased partnership working with the independent sector with particular emphasis on early intervention. This has also involved working more closely with parents and carers. The Service is working with the Carer Co-Ordinator for children to develop a more regular and relevant Carer Forum. The Service has also run a number

of workshops/sessions for siblings, which have been positively evaluated.

The Service has invested funds in Early Intervention initiatives with Sleep Scotland and MENCAP/epats.

Increasing Complexity of need in younger children
As previously reported the Service continues to experience increased demand for family support, behavioural support, and treatment for the most challenging children. It has noted the increasing complexity and range of needs across the children with disabilities population. Children are presenting at a younger age with more complex conditions and difficulties, the most resource and time intensive being behavioural needs and the lack of diversionary and therapeutic services is significant. These children generally present with several co-occurring conditions- SLD, Autism, ADHD and Epilepsy (usually 3 or more). Community Teams and CTS are working closely to support families to maintain these children at home, but this is increasingly difficult within existing budgets. The Service believes that, without continued investment in community services, referral thresholds and waiting lists will rise and the risk and incidence of family breakdown will increase, placing considerable additional resource pressures on already stretched services.

Risk register
All risks are reviewed at least quarterly by the Service Manager in conjunction with Risk and Governance colleagues. Community teams are increasingly involved in this process.

Looked After Children (LAC) Reviews
The Service Area is compliant with requirements in respect of the scheduling of LAC reviews (with one exception during the reporting period due to staff sickness).

Self-Directed Support
The Service's Self-Directed Support (SDS) Implementation Plan has been progressed and staff in Community Teams is working hard to deliver full implementation. The service has made good progress in ensuring that all cases are managed within a SDS framework, but will require another year to fully implement this. To date 498 active cases have an SDS plan and the service is continuing to press for full delivery of services in this way. The Trust wishes to highlight the fact that new responsibilities, business processes and expectations of services are creating significant additional work for staff. The Service Manager represents CCS on the Trust's SDS Steering Group and oversees progress in respect of service levels of compliance.

Family Group Conferencing
The Service continues to offer access to Family Group Conferencing (FGC) in appropriate cases and has one manager trained in chairing FGCs. The Service has used the model in discharge and care

	planning for children and will continue to offer this option when appropriate. **File Review** During the reporting period, the Service has undertaken monthly file reviews within Social Work, Residential and Short Break services This has evidenced satisfactory standards of recording and care planning. Formal Audits are scheduled for the next reporting period. **HEALTH AND SAFETY AUDIT-BRAAT 3** The Service has embraced the new arrangements for assessing and evidencing compliance with Belfast Risk Assessment and Audit Tool (BRAAT) expectations and standards and all managers have attended training on the new approach. The service is on track to meet all required standards.
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 is compliant with NISCC registration requirements pertaining to its social work and social care workforce. **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's Services Improvement Board (CSIB) Sub-group. CSIB has completed work on regionally agreed criteria for CWD services. **Adverse and Serious Adverse Incident Reporting.** Service processes in relation to RQIA and HSCB reporting requirements have been audited to ensure full compliance with same This has been achieved in-year. All incidents were reviewed quarterly at First Line Managers meetings and CCS Governance Meeting. There were no SAI's during the reporting period. **Judicial Review and Court Judgements-** The Trust has received pre action Protocol correspondence in respect of a complex case and has been conjoined with NIHE and EA in this action. DLS have complemented the service on the extent and quality of its assessments and focus on the needs of the children concerned. The service is concerned at the low threshold currently applied by the courts, which avoids local resolution and is expensive to respond to. **Regulation Quality and Improvement Authority** The Service has experienced a challenging year and has had to breach Statements of Purpose on two occasions due to a lack of placement options.

	The Service has achieved satisfactory levels of compliance with the relevant regulatory standards. Each Children's Home has had a number of inspections during the reporting period. The Service is addressing recommendations/requirements through the Quality Improvement Planning. Issues relating to inappropriate placements due to lack of options is noted and unlikely to resolve without investment locally and regionally.

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
	Unallocated Cases- IA-	A bid has been made to HSCB for additional workforce investment	On CCS Risk register
	Stat Visits- missed due to sick leave of SW	Tracking system developed.	Not on Risk Register
	Lack of suitable placement options for Children with Disabilities with complex behavioural presentations	Service has made internal capital bids to move forward	On Service Area Register
	Lack of funding for the above	See Above	Not on Risk register
	Unmet Need in respect of levels of Short Breaks required to support those with complex physical and behavioural difficulties	The service prioritises and allocates resources as per Children Order requirements	On service area risk register
	Lack of Shared Care placement options Lack of funding for Shared Care development	Service has made internal capital bids to move forward	On service area risk register
	Lack of Domiciliary Care Agency support for complex children(physical care needs)	Service has made internal capital bids to move forward	Not on register
		The market is limited and shows no sign of maturing to meet these needs.	On CCS 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.**
	The Service complies with the corporate 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. BSO/Recruitment delays have caused slow recruitment and extended vacancies. The last quarter of the reporting period saw some improvement in this due to the efforts of managers and HR colleagues. Vacancies have been filled in a more timely way however this has required a significant amount of management time, creating pressures elsewhere Agency staff availability remains variable – managers continue to link closely with providers to minimise delays in recruitment and management of workloads. Retention of staff is good within the Service and it has been positive to see former Agency staff successful at interview. Unallocated cases remain a serious concern and the deployment of 2 additional social work posts has stabilised teams, but not led to sustained reduction in unallocated numbers. No additional investment has been provided for frontline social work disability services in over a decade despite the increasing complexity of cases referred into the service and additional demands on staff from UNOCINI, PARIS and SDS. In addition this service has never received funding for senior practitioner posts despite the growing complexity of cases. This needs to be addressed by the Commissioner to bring this Service on a par with the mainstream children's services teams. The Trust will continue to pursue this through CSIB. One staff has retired on medical grounds this year and another redeployed for similar reasons. Overall, the workforce has remained stable. An increase in Court and Private Law work is notable, which has impacted negatively on caseload management. The Service is watching this trend and its impact closely. The introduction of Signs of Safety is welcomed within the Service and staff are embracing the approach and ethos.
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 that work within designated hospitals? Give an account of how these duties are fulfilled by Social Workers working in these designated hospitals**

	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 concerns and the social and emotional vulnerabilities of families of children in treatment and palliative care. A close partnership exists with the Clic Sargent cancer charity in respect of supports 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 remain consistently high. Files are regularly reviewed by the team leader and senior manager responsible for the service. In RJMH staff work in a task centred way to determine the need for referral to Gateway or FIT Teams and to ensure that 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 management of risk. The ante-natal clinic for pregnant women with socially complex issues such as drug and alcohol abuse has placed considerable demands on the Maternity Social Work Service. Social workers in RJMH also provide a service to the Neonatal Unit, which is situated within in the same building (RJMH). 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, disabilities and support needs. 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.

	The Service works closely 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 service users and carers with respect and dignity regardless of status, religious, economic or sexual orientation**.** **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 and the service ensures compliance for its staff. The Service Area ensures the promotion of a human rights-based 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 which support the upholding of human rights are described below. **Mental Health Order** All staff involved in activities and actions under the Mental Health (NI) Order 1986 are required to give consideration to any potential breaches or engagements of rights referenced in Articles 5 and 8. **UNOCINI** The UNOCINI framework reflects the significance of partnership and respect in working with service users and parents/carers. **Safeguarding** Staff are required to ensure that any statutory interventions with an individual or families are proportionate to the risk presented and fully respectful of parents and children's rights. **Transitions Practice** The Service Area is currently updating transitions arrangements with Learning Disability service colleagues to review and improve current practice and protocols and will ensure that arrangements are 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 and promoting choice wherever possible.

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 endeavours to assist parents to support their children's wishes and feelings where they have sufficient capacity to exercise informed choice and where their best interests/welfare/safety will not be compromised.	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 parent/child/advocate's participation. All such practices are subject to regular review.	On-going monitoring and review of trends pertaining to use of restrictive practices.

	Ensuring the child's voice is heard and Their wishes fully considered in all decision- making processes.	The Service is pleased to note that VOYPIC has become involved in supporting Looked After Children with disabilities to comment on services and have their voices heard.	The Service seeks to develop mechanisms and structures to promote engagement with children and young people in the review, planning and delivery of services.

3.15	**Identify key achievements or awards within the Trust that specifically support the delivery and quality of your delegated statutory functions.**
	Positive Behaviour Support The Service won the Chairman's Award in "Our People" category during the last reporting period for its promotion and implementation of Positive Behaviour Support within Children with Disabilities Service. The prize money was invested in further training for new staff and parents. **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. Managers and staff encourage families with concerns to make direct contact and resolve matters as early as possible. Six complaints were received and resolved during the reporting period. One complaint remains unresolved and is currently with NIPSO office for adjudication. The Service also responded to three constituency enquires/FOI requests. **Interdisciplinary Working and User Engagement** RISE works to an interdisciplinary model, facilitates service user focus groups and has 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. RISE has achieved significant successes in early intervention, accessibility, trans-disciplinary working and the upgrading of the OCNNI/BHSCT Classroom Assistant course from an accredited programme to a Level 2 qualification. This is a significant achievement and evidence of the Team's ethos of working in partnership across professional and organisational boundaries. The Service's OCNNI Classroom Assistant course, which won the PHA Advancing Heath Care Award in 2016, has now been delivered to over two hundred classroom assistants within the BHSCT area and has been successfully rolled out regionally across Northern Ireland with over two hundred and fifty classroom assistants undertaking the course and being successful in gaining their level 3 accreditation. **Autism** The Service continues to work collaboratively with colleagues in the Belfast Autism Assessment and Intervention Service (BAAIS). The Service continues to focus on meeting the needs of parents and carers of children with autism via carer support events to develop

	resilience at an earlier stage and to promote good mental health and wellbeing. **User and Carer Involvement** Carer support events and measures have continued to develop during the reporting period.
3.16	**SUMMARY**
	The current service delivery context remains challenging. The Service is continuing to ensure that structures, financial and staff resources are organised and utilised as efficiently and effectively as possible and are focussed on improved and demonstrable outcomes for children and their families. During the reporting period, 284 referrals were received. The Service has developed therapeutic and psychological services for children with challenging behaviours, their parents and families following HSCB investment. The Children's Therapeutic Service has worked closely with community, residential teams and schools to support children to achieve good standards of emotional health and wellbeing and increasingly to deliver workshops to support parents to care and stay well. The Service has experienced significant difficulty in recruiting a Consultant Psychologist due to limited pool of candidates and this limits the impact which the Service can make. Recruitment of this post is a priority for the Trust. The Service is continuing to engage in joint working opportunities across children and adult services to ensure better experiences of transition for young people and their families. New structures are emerging and the Service is fully engaged in the process of revision of existing arrangements. Services to children with complex health care needs continue to deliver flexible short breaks, and provide essential equipment. The Service is fully engaged in the Trust Carer Strategy delivery and has taken forward plans to expand the use of personalised budgets and self-directed care despite the pressures outlined throughout this report. Direct Payment reviews place considerable pressures on social work practitioners. Direct Payment provision has increased during the reporting period, leading to a significant unfunded pressures. Unmet need for residential placements is a growing concern and we have identified an increasing number of children and young people who are deemed as being on the Edge of Care, Lack of investment in short break and Shared Care placement options in the last decade has led to an effective crisis and difficulties in accessing timely treatment at Iveagh. The continued reliance on Glencraig Boarding School for placements of young people whom the Trust cannot accommodate in its own residential provision is a source of concern for the service and has been raised previously with the HSCB.

	One out of jurisdiction placement of a seven year old girl was made during the period due to the lack of appropriate facilities within Northern Ireland. The service is monitoring the placement carefully. The service applied for this placement via ECR process but was turned down. The apparent inconsistency of application of the ECR process by the ECR panel is a matter of concern for the Trust. The service appointed a Carer and QI support Worker this year and has seen its early intervention support workshops develop and support the social work service. Residential and SDS Cost Pressures have significantly increased and are likely to continue to do so in the next year. Funding models do require review to keep pace with this pressure and trends. Over half of community teams' social work staff have been trained in Signs of Safety and the Service has had improved access to PPSWs following the implementation of SOS across CCS. The Service Manager is a member of the Trust's Residential Model Review Group, working with colleagues to develop a Trauma-informed model of practice for specialist residential homes. The Service has begun a workforce review, which will support the development of a workforce and succession plan. The context of service delivery to children with disabilities and their families remains challenging. The Service has prioritised the effective and efficient organisation of structures, financial and staff resources. Services to children with complex health care needs continue to be a funding priority - to deliver flexible short breaks, and provide essential equipment. The Service is fully engaged in the Trust Carer Strategy delivery and has expanded the use of personalised budgets and self-directed care despite the pressures outlined throughout this report.

DATA RETURN 1 – PoC / Directorate – Older People Services / Adult Social & Primary Care

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?		3709
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?		2338
1.3	How many adults are in receipt of social work or social care services at 31st March?		6485
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?		291
1.4	How many care packages are in place on 31st March in the following categories:		
	i. Residential Home Care		584
	ii. Nursing Home Care		1538
	iii. Domiciliary Care Managed		2966
	iv. Domiciliary Non Care Managed		701
	v. Supported Living		123
	vi. Permanent Adult Family Placement		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. ***A BSO Audit into compliance with the Care Management Circular in February 2019 indicated limited assurance across all divisions in relation to compliance with the Circular. An action plan is in place to address deficits.***		
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. ***All new cases are assessed and managed by professional Social Work staff. The BSO audit has highlighted areas where compliance needs to improve particularly in evidencing care planning. The service area has established a working group to address all recommendations.***		
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.		

	The service area has undertaken an audit within CReST to ensure that service users, residents and carers are being included in their assessment, care planning and review process. Within the CReST team, 76% of all families attended the service user review.		
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		701
	- Independent sector ***The service area notes that this figure is dependent upon a manual count. The service area is currently working to improve the integrity of this data point.***		460
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities		34
1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector		151
	- Independent sector ***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 ***The service area have a new referral criteria and screening allocation process in place. New referrals are now triaged as emergency, urgent, non-urgent. The area are managing a waiting list of approximately 300 waiting allocation for assessment across the whole service area. There are measures in place to manage this and on-going communication with those who are waiting.***		
1.8b	Please identify possible new service innovations that are currently supported by non-recurrent funding ***The service area have recruited a Senior Practitioner role to develop the capacity within Specialist Oncology and Palliative Care Service, this is funded on a non-recurrent basis.*** ***The service area have also appointed Service Development posts for the Shared Lives and***		

	development of Regional Domiciliary Care model. Funding for both of these posts is also non-recurrent.		
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?		5
1.10	Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations. ***The service area is currently developing a new information leaflet for people in receipt of Domiciliary Care in response to a complaint.*** ***Due to a significant number of complaints associated with Continuing Healthcare, the service area has developed a response template to ensure a consistent response, in the absence of regional continuing healthcare guidance.*** ***The service area is currently undertaking a quality improvement project in relation to how it manages its complaint responses, to improve response times.***	~~*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 _____

This is reported in a separate Statutory Function Report

1 GENERAL PROVISIONS – HOSPITAL

DATA RETURN 2 – PoC / Directorate – Older People Services / Adult Social & Primary Care

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65		X
2.2	Number of adults known to the Programme of Care who are:		
	Blind		448
	Partially sighted		225
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech		56
	Deaf without speech		32
	Hard of hearing		1988
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind		91

DATA RETURN 3 – PoC / Directorate – Older People Services / Adult Social & Primary Care

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 – PoC / Directorate – Older People Services / Adult Social & Primary Care

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	30
	Total expenditure for the above payments	£4183
4.2	Number of TRUST FUNDED people in residential care	436
4.3	Number of TRUST FUNDED people in nursing care	**1024**
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	**514**
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	PHD reporting

DATA RETURN 5 – PoC / Directorate – Older People Services / Adult Social & Primary Care

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.			**1498**
5.2	Number of adult individual carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*			**724**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*			**774**
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?			**0**
5.4	Number of adult carers receiving a service @ 31st March			**287**
5.5	Number of young carers offered individual carers assessments during the period.			**0**
5.6	Number of young carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards)*			**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	**214**
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	**214**
	(c) Number of adults receiving direct payments @ 31st March	**209**
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.	**496**
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		
Due to the high level of Band 4 staff in community Social Work and the transition of all initial assessments to Social Workers, the service area is struggling to prioritise carers assessments unless in crisis situations. There are some 200 carers awaiting assessments at the end of March 2019 and the service area is concerned about this trend. ***The service area has been significantly impacted by the absence of the two Trust Carers Co-Ordinators during this reporting period and this has impacted upon the quality of the data available for reporting. The service area has been unable to disaggregate the data by the age of Carers. Staff have not consistently recorded this data, in the absence of Carers Co-Ordinators they are uncomfortable requesting the personal data of carers, particularly in relation to those who have refused the assessment. The service area is continuing to work to cleanse the carers data and is reviewing its processes and are confident reporting will improve going forward.***		

DATA RETURN 6 – PoC / Directorate – Older People Services / Adult Social & Primary Care

6 SAFEGUARDING ADULTS

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

DATA RETURN 7 – PoC / Directorate – Older People Services / Adult Social & Primary Care

7 SOCIAL WORK STAFF

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 8 – PoC / Directorate – Older People Services / Adult Social & Primary Care

8 Assessed Year in Employment

TRUST-WIDE RETURN SUBMITTED BY TRUST SOCIAL SERVICES LEARNING AND DEVELOPMENT SERVICE IN SEPARATE REPORT

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate – Older People services / Adult Social & Primary Care

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	43	
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	32	
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 ***These figures are in line with previous trends***		
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 ***These figures are in line with previous trends***		
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 the service area can provide this assurance	

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?	13
	Comment on any trends or issues on the use of holding powers ***These figures are in line with previous trends***	

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	43
9.3.a	How many of these were completed within 5 working days	39
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken. ***The Trust takes a corporate approach to ASW provision and this will be reported in the Mental Health Statutory Function Report***	

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 applications to MHRT in relation to detained patients (provide total number)	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	1
9.6.a	New applications for Guardianship during period (Article 19(1))	0
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	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)	1
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	1
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24) 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	3
9.7.a	Number of Approved Social Workers removed during period	6
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	32

	Commentary *Please give assurance that the number of authorised ASW, and ASWs in training is adequate to enable the Trust to continue to discharge its statutory duties* ***The Trust takes a corporate approach to ASW provision and this will be reported in the Mental Health Statutory Function Report.***	
9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If so please provide detailed explanation for each and every instance including their age and relevant powers used.	0
9.9*	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?	
	Issues or trends relating to notifications to the office of care and protection and on-going management of such arrangements ***Increasingly the Service Area is challenged in assessing Mental Capacity Assessments to understand financial capacity or support referrals to the Office of Care and Protection. We continue to have to fund private financial capacity assessments.*** ***The service area notes that there can be significant delays in the OCP progressing applications. Staff have on occasion had to support a small group of people, through the provision of Article 15 payments, where they have been deemed to lack capacity and cannot access their own funds for extended periods of time.*** ***Staff from the service area have attended training with the OCP during this reporting period.***	30

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:	0
	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)	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)*	

DATA RETURN 1 – PoC / Directorate – Hospital Social Work / Adult Social & Primary Care

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	114	3259	8105
1.2	Of those reported at 1:1 how many assessments of need were undertaken during the period?	114	3259	8105
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?			1574

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

DATA RETURN 1 – PoC / Directorate – Physical & Sensory Disability Services / Adult Social & Primary Care

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	***1470***	***858***
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?	***1248***	***786***
1.3	How many adults are in receipt of social work or social care services at 31st March?	***1348***	***353***
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?	***488***	***353***
1.4	How many care packages are in place on 31st March in the following categories:		
	vii. Residential Home Care	***25***	***N/a***
	viii. Nursing Home Care	***112***	***N/a***
	ix. Domiciliary Care Managed	***506***	***N/a***
	x. Domiciliary Non Care Managed	***155***	***N/a***
	xi. Supported Living	***62***	***N/a***
	xii. Permanent Adult Family Placement	***0***	***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. All the care packages have an identified key worker and are reviewed according to the BHSCT standards which are in line 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. There is a robust system of supervision for the team providing a Care Management service and this is overseen by an Assistant Care Manager. Difficulties being experienced are in relation to the shortage of domiciliary care provision and the increase of referrals with complex needs including non-compliant cases.		
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 are involved in care planning and included in the review process. Their carers and families are also invited to participate, with the service user's consent.		
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	***195***	***550*** *(OPS DC's)*
	- Independent sector	***55***	***0***
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	***509***	***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 There are ongoing difficulties in accessing domiciliary care packages and the service area takes part in a twice weekly priority call.		
1.8b	Please identify possible new service innovations that are currently supported by non-recurrent funding There are none at present.		
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. None.	~~*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 – PoC / Directorate – Physical & Sensory Disability Services / Adult Social & Primary Care

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

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

DATA RETURN 1 – PoC / Directorate – Physical & Sensory Disability Services / Adult Social & Primary Care
This is reported in OPS

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

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

DATA RETURN 2 – PoC / Directorate – Physical & Sensory Disability Services / Adult Social & Primary Care

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	**1**	**X**
2.2	Number of adults known to the Programme of Care who are:		
	Blind	***293***	***448***
	Partially sighted	***131***	***225***
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	***131***	***56***
	Deaf without speech	***86***	***32***
	Hard of hearing	***510***	***1988***
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	***18***	***91***

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

Adults who are visually impaired: **Under 65: 199**

Over 65: 807

DATA RETURN 3 – PoC / Directorate – Physical & Sensory Disability Services / Adult Social & Primary Care

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.	***2328***
	Number of Disabled people known as at 31st March.	***1701***
3.2	Number of assessments of need carried out during period end 31st March.	***1867***
3.3	This is intentionally blank	
3.4	Number of assessments undertaken of disabled children ceasing full time education.	**0**

DATA RETURN 4 – PoC / Directorate – Physical & Sensory Disability Services / Adult Social & Primary Care

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	**29**
	Total expenditure for the above payments	**£1451.85**
4.2	Number of TRUST FUNDED people in residential care	**47**
4.3	Number of TRUST FUNDED people in nursing care	**140**
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	**8**
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	**3**

DATA RETURN 5 – PoC / Directorate – Physical & Sensory Disability Services / Adult Social & Primary Care

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.	**12**	**452**	**43**
5.2	Number of adult individual carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	**11**	**280**	**24**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	**1**	**172**	**19**
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**	**87**	**9**
5.5	Number of young carers offered individual carers assessments during the period.		**16**	
5.6	Number of young carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards)*		**14**	
5.7	Number of young carers receiving a service @ 31st March		**14**	
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March		**36**	

	(b) Number of new approvals for direct payments during the period 1st April – 31st March	***20***
	(c) Number of adults receiving direct payments @ 31st March	***171***
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	**3**
5.11	Number of one off Carers Grants made in-year.	**479**
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		
Commentary		

DATA RETURN 1 – PoC / Directorate – Mental Health Services / Adult Social & Primary Care

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	3557	46
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?	*3475*	*45*
1.3	How many adults are in receipt of social work or social care services at 31st March?	*3130*	*184*
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?	*1826*	*4*
1.4	How many care packages are in place on 31st March in the following categories:		
	xiii. Residential Home Care	*46*	*32*
	xiv. Nursing Home Care	*121*	*56*
	xv. Domiciliary Care Managed	*38*	*10*
	xvi. Domiciliary Non Care Managed	*0*	*0*
	xvii. Supported Living	*161*	*10*
	xviii. 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. 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		
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. Care Managers are professionally qualified staff, currently registered with their respective professional bodies, The Care Management team are responsible for completing the assessment of needs, The delivery and review of packages of care for individual service users. The BHSCT Mental Health Care Management Service is organisationally managed and responsible to the MH Community Services Manager. The Assistant Service Manager in turn provides the operational management to the service, including service planning, supervision and governance **TYC Challenges and Action**		

	Reflecting the strategic shift from hospital to community-based care and the priority afforded to seamless and time-bound discharge pathways, Care Management works with service users with increasingly complex needs. In partnership with Housing Associations, Community and Voluntary (C&V) providers and the Independent sector, the Service has developed a Stepped Care Model that provides nursing, residential and supported housing options in response to the needs of service users. In the context of the achievements and success of the first phase of the Service's community-infrastructure development programme, it is now clear that the Service's future challenge will be to meet the bespoke needs of smaller groups of service users with highly complex support needs in partnership with other sectors. This cohort of service users would formally have remained in hospital on a long-term basis or experienced lengthy and repeated admissions. Due to the complexity of the needs of this group, placement is often difficult, resulting in delayed discharges from acute wards, in particular, Clare Ward and Shannon Clinic Regional Medium Secure Unit. This places an on-going pressure on community statutory facilities with a limited number of places. **Projects** The PiPA project that commenced in Summer 2018 to help support the flow of service users from the above mentioned inpatient wards is well under way and evaluations to date are demonstrating positivity and a valuable additional resource from Care Management to the ward staff and medical Consultants. Altagarron decant – is a project about the quality of the Housing accommodation and increasing placements serving the West Belfast area. This is working in a Tri-patriate partnership with the Housing association, Care Provider and the BHSCT A future project that is in prelim discussions is working with the private sector to explore future developments in the Belfast area. **ECR/IFR Patients returning to NI** The continued lack of appropriate facilities to meet the needs of service users returning from ECR placements has impacted on statutory supported housing. Transitions from specialist inpatient care are often difficult, particularly in the absence of appropriate accommodation. **Self-Directed Support (SDS)** With the first phase coming to an end and the first ministerial target being met, and the second phase consultation		

	commenced, the implementation of SDS has presented significant additional workload pressures on care managed services in the absence of additional resources to support this work. All new packages are assessed under SDS. A key challenge in implementation has been in ensuring that service users already receiving commissioned services have an understanding of the model and are re-assessed as part of the "roll-out." The Service has embraced the ethos of SDS and has used the implementation process to improve collaborative working across services. SDS is being developed through co-production with the involvement of service users and carers at every stage, including staff training and strategic decision-making. SDS remains to be an excellent example of collaborative working across services and of the benefits of a co-production approach with service users and carers Monthly monitoring is carried out by Care Managers in the statutory Supported Housing schemes. Service users, carers and other professionals are asked for their views on the services provided.		
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 involved in all aspects of assessment, decision-making, review and care planning. Where it is apparent that a service user or carer would benefit from additional supports, the Care Manager will link with advocacy services. Service user and Carer feedback questionnaires have commenced and are in place. Further discussions are taking place regarding the mental health '10,000 voices' and linking this to the current strategy to strengthen the voice of the Service user and their Carers. Reviews are generally held within the requisite time-frame. Service users are encouraged to engage in their reviews and care planning arrangements. Care Management recognise the opportunity that SDS brings to ensure each service user is empowered and central to the support planning process, giving increased ownership and choice in the future.		
1.5	Number of adults provided with respite during the period	*PMSI return*	*PMSI return*

<table>
<tr><td rowspan="3">1.6</td><td>Number of adults known to the Programme of Care in receipt of Centre based Day Care</td><td>0</td><td>0</td></tr>
<tr><td>- Statutory sector</td><td>276</td><td>10</td></tr>
<tr><td>- Independent sector</td><td>30</td><td>5</td></tr>
<tr><td>1.6a</td><td>Number of adults known to the Programme of Care in receipt of Day Opportunities</td><td>217</td><td>0</td></tr>
<tr><td rowspan="3">1.7</td><td>Of those at 1.6 how many are EMI / dementia</td><td></td><td></td></tr>
<tr><td>- Statutory sector</td><td></td><td></td></tr>
<tr><td>- Independent sector</td><td></td><td></td></tr>
<tr><td>1.8</td><td>Unmet need (this is currently under review)</td><td>X</td><td>X</td></tr>
<tr><td>1.8a</td><td>
<table>
<tr><td></td><td>Domiciliay Care</td><td>Direct Paymts</td><td>Supported Housing</td><td>Residential Care</td><td>Nursing Care</td><td>Hos</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Acute Hospital</td><td>0</td><td>0</td><td>8</td><td>4</td><td>4</td><td>3</td></tr>
<tr><td>Community</td><td>4</td><td>2</td><td>5</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Shannon</td><td>0</td><td>0</td><td>2</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>NRU</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1 ph</td></tr>
<tr><td>General Hospital</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td>ECR</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>0</td></tr>
<tr><td>Prison Service</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total</td><td>4</td><td>2</td><td>16</td><td>5</td><td>10</td><td>4</td></tr>
</table>
Please report on Social Care waiting list pressures

Data for 1.5, 1.8 and 1.10 will be sourced by Board officers from existing returns.

A total of 41 individuals are waiting for placements or packages. This is an increase of eleven from the previous year.

➢ Two individuals waiting on Direct Payments

➢ Sixteen individuals are waiting on Supported Housing.

➢ Five individuals are waiting on Residential Care. Ten individuals are waiting for Nursing Home placements
</td><td></td><td></td></tr>
</table>

	➢ Four individuals are delayed discharge from Acute wards There is a need to consider the continuing provision for patients who require in-patient neuro-rehabilitation treatment. Acute or low secure psychiatric wards are unsuitable and overly- stimulating environments for patients with an ABI. For patients in the community or acute services who previously would have transferred to NRU, future provision has not been resolved to date.		
1.8b	Please identify possible new service innovations that are currently supported by non-recurrent funding In the absence of additional funding, since August 2018, a pilot project has commenced to enhance the PiPA model undertaken by the Acute Mental health Wards. A Care Manager attends the Inpatient Mental Health wards on a daily basis. This gives an opportunity for decisions to be made, about service provision, by the whole Multi-Disciplinary Team who are present at these meetings. Packages and placements agreed at these meetings, these are then reviewed in keeping with Care Management processes, 6 weekly, then 6 monthly and then yearly.		
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	*8*	
1.10	Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations. Care Management receive a low number of complaints. Outstanding issues from the previous year remain linked to the resettlement of the long stay service users and declaratory orders yet to be raised in court. This has included the implications of financial assessments for community placements. To date, in each of these situations, the Service has been able to reach an agreed resolution. The Service has used the learning from these episodes to ensure that families and carers are provided with information by staff who have experience and knowledge of this area at an earlier stage.	~~*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 – Mental Health Services (Inpatient team) / Adult Social & Primary Care

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?		135	
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?		*135*	
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?		*29*	

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

DATA RETURN 1 – PoC / Directorate - Acute Hospital (general setting) Mental Health / Adult Social & Primary Care

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

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

DATA RETURN 2 – PoC / Directorate – Mental Health Services / Adult Social & Primary Care

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65		X
2.2	Number of adults known to the Programme of Care who are:		
	Blind	1	0
	Partially sighted	5	1
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	0	0
	Deaf without speech	5	1
	Hard of hearing	9	0
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	0	0

DATA RETURN 3 – PoC / Directorate – Mental Health Services / Adult Social & Primary Care

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.	**14**
	Number of Disabled people known as at 31st March.	**105**
3.2	Number of assessments of need carried out during period end 31st March.	**36**
3.3	This is intentionally blank	
	Narrative	
3.4	Number of assessments undertaken of disabled children ceasing full time education.	

DATA RETURN 4 – PoC / Directorate – Mental Health Services / Adult Social & Primary Care

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	**205**
	Total expenditure for the above payments	**£10,856**
4.2	Number of TRUST FUNDED people in residential care	77
4.3	Number of TRUST FUNDED people in nursing care	**116**
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)?	0

DATA RETURN 5 – PoC / Directorate – Mental Health Services / Adult Social & Primary Care

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**	**453**	**59**
5.2	Number of adult individual carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	**0**	**270**	**30**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	**0**	**181**	**8**
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	**0**	**1**	**0**
5.4	Number of adult carers receiving a service @ 31st March	**0**	**152**	**2**
5.5	Number of young carers offered individual carers assessments during the period.		**9**	
5.6	Number of young carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards)*		**5**	
5.7	Number of young carers receiving a service @ 31st March		**5**	
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March		**12**	

	(b) Number of new approvals for direct payments during the period 1st April – 31st March	
	(c) Number of adults receiving direct payments @ 31st March	**6**
		52
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?	**2**
5.10	Number of carers receiving direct payments @ 31st March	**2**
5.11	Number of one off Carers Grants made in-year.	**562**
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		

Commentary

It is acknowledged that due to a change in the method of collating the data for carer assessments due to the carer co-ordinator being on sick leave long term at the beginning of the reporting period, that the totals are unlikely to be accurate. As a result, numbers indicate that the number of adults that were offered a carer assessment has reduced by almost 300 compared to last year, the number of assessments completed has reduced by more than half and also the number of carers receiving a service has reduced compared to 2017-2018 figures. This is a concerning outcome and will be addressed through the collective leadership framework and the Social Work forum.

However, there has been an increase of 27% in the number of carer grants made. This may indicate an increase in carers declining assessments but agreeing to a grant. This is now clearly reported on in the annual report and can be monitored in terms of patterns of uptake. There were also 106 therapy grants awarded and there were 33 sessional social events including lunch, meals, overnight at a hotel, relaxation workshops and Psych-Social workshops for Belfast carers provided within the reporting period at a variety of locations.

In addition, there has been a reduction in the number of young carers assessments completed following the successful work completed last reporting period to increase awareness of this service. This will be addressed through renewed work with action for children, young carer co-ordinator and the acting PSW and Social Work Development Lead to address this reduction and continue to raise awareness within the service area to prioritise the needs of young carers.

DATA RETURN 6 – PoC / Directorate – Mental Health Services / Adult Social & Primary Care

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

6 SAFEGUARDING ADULTS		
6.1	Number of safeguarding adult referrals within the period	
6.2	Of the referrals at 6.1, how many were received from acute settings?	

6.3	Number of investigations commenced within the period	
6.4	Number of investigations completed within the period	
6.5	Of the completed investigations at 6.4, how many required a Multidisciplinary Agency Risk Assessment Conference (MARAC)?	
6.6	Number of adult protection plans commenced within the period	
6.7	Number of adult protection plans in place on 31st March	
Commentary		

DATA RETURN 7 – PoC / Directorate – Mental Health Services

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

7 SOCIAL WORK STAFF

7.1a	Provide an overview of social work management staff in this Programme of Care/Directorate that are required, as a condition of their employment, to be included on the NISCC register.	Data Return 7 spreadsheet – 7.1a
7.1b	For those reported in 7.1a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.1b
7.1c	For those reported in 7.1a, return the numbers that are enrolled on/have completed PQ awards during the current reporting period.	Data Return 7 spreadsheet – 7.1c
7.2	How many teams are there within this Directorate/Programme of Care?	
7.3a	Provide an overview of the social work staff based within a team, who are required as a condition of their employment, to be registered with NISCC. NOTE: The number of team returns should match the number of teams reported at 7.2	Data Return 7 spreadsheet – 7.3a
7.3b	For those reported in 7.3a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.3b
7.3c	For those reported in 7.3a, return the numbers that are enrolled on/have completed PQ Awards during the current reporting period.	Data Return 7 spreadsheet – 7.3c
7.4a	'Singleton Practitioners' who are required, as a condition of their post, to be registered with NISCC. Guidance: These are social workers that are not easily identifiable with a social work team and are not classified as management.	Data Return 7 spreadsheet – 7.4a
7.4b	For those reported in 7.4a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.4b

7.4c	For those reported in 7.4a, return the numbers that are enrolled on/have completed PQ Awards during the current reporting period.	Data Return 7 spreadsheet – 7.4c
7.5a	'Singleton Practitioners' in a post which requires registration with a professional body and the current post holder is registered with NISCC. Guidance: These are social workers that are not easily identifiable with a social work team and are not classified as management.	Data Return 7 spreadsheet – 7.5a
7.5b	For those reported in 7.5a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.5b
7.5c	For those reported in 7.5a, return the numbers that are enrolled on/have completed PQ Awards during the current reporting period.	Data Return 7 spreadsheet – 7.5c
7.6	How many Practice Learning Opportunities were provided by the Trust during the period?	Data Return 7 spreadsheet – 7.6
7.7	Provide a breakdown of DHSSPS PQ training targets	Data Return 7 spreadsheet – 7.7

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate – Mental Health / Adult Social & Primary Care

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	309	X
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	234	
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	1	
	Comment on any trends or issues in respect of requests for ASW assessment or ASW applications Increase in assessment requests after 3.30pm from GP's resulting in an increase in out of hours working by ASW's on the day time rota. audit September to december 2018 indicated that 25% of all assessments requested after 3.30pm.		
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. The Nearest Relative is informed of the patients progress under the Mental Health Order and of discharge planning. This is supported by the PIPA framework also. Currently the acting PSW has completed amendments to the information forwarded to nearest relative throughout each stage of the admission process under the Mental Health Order. The regional ASW working group has also reviewed the information given to the nearest relative and to the service user at the		

	point of admission under the Mental Health Order and this will be used regionally to promote consistency across the region and will also be translated into commonly used languages.	

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	110
9.2a	Of these, how many resulted in an application being made?	98
	Comment on any trends or issues on the use of holding powers	

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	309
9.3.a	How many of these were completed within 5 working days	26
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken. There has been an increase in reports that have not been completed within the recommended 5 days. The reasons given by ASW's has been due to workload capacity and sick leave. The full time ASW in the team has only one day to completed reports in the week due to being on rota 16 times per month and this has impacted on time to complete reports due to the demands of the rota on a daily basis.	

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 applications to MHRT in relation to detained patients (provide total number) **Applications 122** Withdrawals 16 Adjournments 27 Re-graded prior to Tribunal 36 Remained detained 26 Discharged by Tribunal 11 Discharged to another trust 6 14 Day Assessment Period 4 in total (3 remain detained , 3 regraded at tribunal) Beechcroft MHRT applications for individuals under 18 years;

DATE OF APPLICATION	DATE OF TRIBUNAL	OUTCOME
09/04/18	14/05/18	Detention Upheld
24/04/18		Withdrawn
08/01/19	13/02/19	Withdrew on 11/02/19
14/02/19	20/03/19	Patient regraded 13/03/19

	Comment on any trends or issues in respect of Mental health Review tribunals There have been several requests for MHRT within the 14 day assessment period and it is considered that this trend will increase in upholding the patients right to challenge their detention within the assessment timeframe thus negating further detention for treatment and need to if they are discharged by the MHRT.
9.5.a	This is intentionally blank

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	6
9.6.a	New applications for Guardianship during period (Article 19(1))	1
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	1
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	1
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	5
9.6.f	Number of Guardianships accepted by a nominated other person	0

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>9.6.g</td><td>Number of MHRT hearings in respect of people in Guardianship (provide total number)

One MHRT hearing was been postponed until early April due to difficulty in achieving a suitable date.

One MHRT has been postponed pending declaratory Order application.

One MHRT has been postponed due to the service users physical health.</td><td>1</td></tr>
<tr><td>9.6.h</td><td>Total number of Discharges from Guardianship during the reporting period (Article 24)

<table><tr><td>Discharges as a result of an agreed multi-disciplinary care plan</td><td>0</td></tr><tr><td>Lapsed</td><td>0</td></tr><tr><td>Discharged by MHRT</td><td>0</td></tr><tr><td>Discharged by Nearest Relative</td><td>0</td></tr><tr><td>Total</td><td>0</td></tr></table></td><td>0</td></tr>
<tr><td></td><td>Comment on any trends or issues in respect of Guardianship</td><td></td></tr>
</table>

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period 2 trained staff are pending ratification by QUB with one further to resubmit in September 2019.	3
9.7.a	Number of Approved Social Workers removed during period	6
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	25

Commentary

Please give assurance that the number of authorised ASW, and ASWs in training is adequate to enable the Trust to continue to discharge its statutory duties

Due to the number of staff moving post and retiring, the number of trained ASW available to participate on the ASW rota has fluctuated significantly in recent years. As a result, the Trust has committed to training 6 ASW candidates per year. However, this is mostly represented by candidates from mental health service area, with only 2 ASW's based in CAMHS, 3 in older persons services and one in the physical disability/sensory impairment service who is currently unable to participate on the rota. Each service areas has been reminded of their responsibilities in recruiting ASW's as a corporate responsibility. This will be more pressing with the implementation of the Mental Capacity Act which will require significant representation from olders persons services, physical disability and sensory impairment and CAMHS.

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.

Admissions for individuals under 18 years;

Date	Age years	Relevant powers used (i.e. admission or guardianship)
16/04/2018	16	Admission
16/07/2018	16	Admission
12/09/2018	17	Admission
03/10/2018	12	Admission
24/01/2019	16	Admission
29/02/2019	16	Admission
13/02/2019	16	Admission
29/03/2019	16	Admission

Beechcroft MHRT applications;

DATE OF APPLICATION	**DATE OF TRIBUNAL**	**OUTCOME**
09/04/18	14/05/18	Detention Upheld
24/04/18	None given as withdrawn	Withdrawn
08/01/19	13/02/19	Withdrawn on 11/02/19

	14/02/19	20/03/19	Patient regraded 13/03/19

No applications made to the MHRT or guardianship in respect of individuals under 18 years old at Iveagh hospital.

9.9 *	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?	3
	Issues or trends relating to notifications to the office of care and protection and ongoing management of such arrangements *All instances of referral to the office of care and protection have been in relation to concern in regard to the persons capacity to manage their financial affairs. This will be considered in future under the Mental Capacity Act where Trust Authorisation Panels will make decisions in regard to any deprivation of liberty based on capacity.*	

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	
	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)	
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period.	
	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)* Most service users who are discharged under STO are under the care of the community forensic mental health team. However, currently the team only have one ASW due to one ASW requesting to come off the rota and another moving post. While the role is uncommon with currently no STO's, provision needs to be accommodated should this role be required again.	

DATA RETURN 1 – PoC / Directorate- Learning Disability / Adult Social & Primary Care

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	129	2
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?	129	2
1.3	How many adults are in receipt of social work or social care services at 31st March?	1576	240
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?	1552	230
1.4	How many care packages are in place on 31st March in the following categories:		
	xix. Residential Home Care	107	25
	xx. Nursing Home Care	103	73
	xxi. Domiciliary Care Managed	21	5
	xxii. Domiciliary Non Care Managed	86	28
	xxiii. Supported Living	240	40
	xxiv. Permanent Adult Family Placement	14	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. All service users have a full assessment of their needs to ensure that the appropriate service is put in place. All placements are subject to regular review (at least annually). The Learning Disability Programme has recently been involved in process mapping in order to improve our adherence to the 2010 Circular and we have reviewed our processes and updated the forms that we use for data collection. This process has not been piloted yet. A Care Manager and Assistant care manager is currently being recruited to address the workload pressures and work with those young people transitioning from children's disability services to adult Learning Disability services. Currently there is 1x 8a who operationally manages care management. There are 4x band 7 SW trained care managers and 1x band 7 nurse-trained care manager. There are 2.5 WTE assistant care managers.		
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. Care Managers gather the information, request the assessments and liaise with the keyworker, the service user and/ or the family to find out their views. Based on this information the care manager recommends an appropriate package of care. The key worker submits a New Service Request form to The New Service Request Panel for discussion. The Panel will then agree funding for the package, if deemed appropriate. The Care Manager will liaise with all relevant people to share the outcome of the assessment and will arrange a care planning meeting to agree the details of the package and plan the commencement of the package. All information shared with the Provider will be agreed with the person and/or family prior to sharing. The person and/or family will receive a copy of the Care Plan. Providers in residential/ nursing placements are asked to provide a weekly update about the residents. Domiciliary providers will be contacted several days after commencement to ensure there are no issues. When the package commences, the Care Manager reviews it 6-8 weeks later to ensure it is effectively meeting the person's needs. When the package is not effective, additional supports are put in place. Subsequent reviews are held as required depending on individual needs but at least annually. There are current pressures in the service due to increased workload and caseloads but this is being addressed by the recruitment of additional staff.		
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. The views of service users and families are gathered as part of the assessment process. Service users and families are involved in Care Planning meetings and they get a copy of minutes as well as a copy of the Care Plan. Service user and families are fully involved in reviews where possible and are asked to comment on the service as appropriate. Service users and families are involved in all decision relating to care provision.		
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	475	55
	- Independent sector	64	4

1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities There has been a change in numbers from the last reporting period for a number of reasons – firstly the focus has been on developing Day Opportunities in local communities in line with regional expectations and this has been hugely successful. Secondly, the service have increasing numbers of people with more complex needs in our centres which impacts on the numbers of people who can attend as they may require 1:1 staffing due to behaviours/needs and have complex physical needs.	527	44
1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector	9	11
	- Independent sector	1	0
1.8	Unmet need (this is currently under review)	X	X
1.8a	Please report on Social Care waiting list pressures We continue to have a waiting list for supported accommodation and we have developed a 5 year accommodation plan to identify those people who are likely to require accommodation during this period. We also have a waiting list for domiciliary packages and we are joining Care Bureau in order to try to secure domiciliary packages. Currently within the service area we have- 5 PTL's 9 Delayed Discharges 27 waiting for Domiciliary Care There is a huge difficulty accessing supported accommodation for people who have addiction or forensic backgrounds.		
1.8b	Please identify possible new service innovations that are currently supported by non-recurrent funding Last year, the Service reported that it secured £43923.00 non-recurrent funding from 01 May 2017 to 30 April 2018 to support service users routinely excluded from services because of their challenging behaviour and forensic history. The Extern Reminiscence Community Hub provided three reminiscence projects, (total 252 attendances), to include costs for preparation, evaluation, travel related to Reminiscence (630 Hours) and additional Community Hub activity (1850 hours). This service still remains in place.		

	The Service also reported last year that it secured £10,230.40 non-recurrent funding from April 2017 to March 2018 for TILII Group (ARC NI) to: support the delivery of 24 group meetings (total 84 service user attendances and 24 ARC attendances); 12 TILII Forum Meetings (total 8 service users and 12 ARC attendances); 3 peer knowledge learning sessions (total 40 service users and 3 ARC attendances); and 2 Trust induction sessions. The service can now report that this funding is now recurrent. There was no non recurrent funding allocated 2018/19. There has been an agreement for £10,000 recurrent funding to commence in April 19 for the Now project. This funding will provide an evening social opportunity for up to 20 people with autism once per week for 48 weeks per year.		
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland? There are currently two service users placed outside Northern Ireland. Plans are well developed for both to return to Northern Ireland.	2	0
1.10	Complaints – Please describe any service change or improvement implemented or intended as a result of complaint investigations. The breakdown of complaints/ enquiries this year has been as follows for the service area- 7 related to Treatment & Care 1 related to an Appointee 3 related to Environmental issues 8 related to Service Delivery 1 related to Injury from another service user 1 Safeguarding concern 1 related to Patients Personal care 1 related to a Change of HCP 1 related to Incorrect Medication Given The learning for the service included additional training, additional recruitment and issues related to transitioning from children's to adult services is being addressed through a working group. There are a number of recommendations from the SAI panel into the hospital, themes emerging from the Adult safeguarding investigation and RQIA recent inspections that are currently detailed in action plans and currently being addressed.	~~*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 – PoC / Directorate - Iveagh and Muckamore Abbey Hospital / Learning Disability / Adult Social & Primary Care

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?	9	43	1
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	9	43	1
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	7	65	0

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

DATA RETURN 1 – Acute Hospital (general setting) _____N/A_____

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

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

DATA RETURN 2 – PoC / Directorate - Learning Disability / Adult Social & Primary Care

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65	0	X
2.2	Number of adults known to the Programme of Care who are:		
	Blind	27	0
	Partially sighted	38	0
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	12	0
	Deaf without speech	15	0
	Hard of hearing	28	1
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	3	0

DATA RETURN 3 – PoC / Directorate - Learning Disability / Adult Social & Primary Care

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.	87
	Number of Disabled people known as at 31st March.	1816
3.2	Number of assessments of need carried out during period end 31st March.	87
3.3	This is intentionally blank	
	Narrative	
3.4	Number of assessments undertaken of disabled children ceasing full time education.	10

DATA RETURN 4 – PoC / Directorate – Learning Disability / Adult Social & Primary Care

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	41
	Total expenditure for the above payments	£11,173
4.2	Number of TRUST FUNDED people in residential care	112
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?	0
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	3

DATA RETURN 5 – PoC / Directorate - Learning Disability / Adult Social & Primary Care

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.	7	90	17
5.2	Number of adult individual carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	5	69	11
5.2a	Number of adult individual carers assessments declined during the period and the reasons why *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	2	21	6
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	0	996	160
5.5	Number of young carers offered individual carers assessments during the period.	7		
5.6	Number of young carers assessments ~~undertaken~~ completed during the period *(to be collected from 2019/20 onwards)*	5		
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	29
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	29
	(c) Number of adults receiving direct payments @ 31st March	155
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?	138
5.10	Number of carers receiving direct payments @ 31st March	17
5.11	Number of one off Carers Grants made in-year.	311

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

Commentary

The 2018/19 the overall carers budget was £64,723.00

This year there has been a significant reduction in the number of carer assessments offered / completed by the community teams. This reduction in carers assessments has largely been due to the additional pressures placed on the community teams to assist with investigating adult safeguarding issues. Given the pressures on the specialised team to address the historical CCTV viewing of the hospital, the community teams had to take on the specialised teams' normal work. This meant that the community teams were involved in investigating all community referrals including large scale ones involving institutions and a sizable number of historic referrals generated from the adult safeguarding investigation in the hospital. The community teams are in the process of recruiting additional SWs per team and a new ASG specialised team is now in place to deal with the ASG investigation relating to the referrals generated from the historical viewing of CCTV. The service area now has a robust plan in place to address this issue in relation to offering and completing carer assessments.

The service area is pleased to report that there has been an increase in SDS and all patients have been transferred to SDS from direct payments with a support plan in place.

DATA RETURN 6 – PoC / Directorate - Learning Disability / Adult Social & Primary Care **- see separate report**

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

7 SAFEGUARDING ADULTS

6.1	Number of safeguarding adult referrals within the period	977
6.2	Of the referrals at 6.1, how many were received from acute settings?	789
6.3	Number of investigations commenced within the period	560
6.4	Number of investigations completed within the period	560
6.5	Of the completed investigations at 6.4, how many required a Multidisciplinary Agency Risk Assessment Conference (MARAC)?	1
6.6	Number of adult protection plans commenced within the period	536
6.7	Number of adult protection plans in place on 31st March	536
Commentary See separate report		

DATA RETURN 7 – PoC / Directorate - Learning Disability / Adult Social & Primary Care

7 SOCIAL WORK STAFF

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

7.1a	Provide an overview of social work management staff in this Programme of Care/Directorate that are required, as a condition of their employment, to be included on the NISCC register.	Data Return 7 spreadsheet – 7.1a
7.1b	For those reported in 7.1a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.1b
7.1c	For those reported in 7.1a, return the numbers that are enrolled on/have completed PQ awards during the current reporting period.	Data Return 7 spreadsheet – 7.1c
7.2	How many teams are there within this Directorate/Programme of Care?	

7.3a	Provide an overview of the social work staff based within a team, who are required as a condition of their employment, to be registered with NISCC. NOTE: The number of team returns should match the number of teams reported at 7.2	Data Return 7 spreadsheet – 7.3a
7.3b	For those reported in 7.3a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.3b
7.3c	For those reported in 7.3a, return the numbers that are enrolled on/have completed PQ Awards during the current reporting period.	Data Return 7 spreadsheet – 7.3c
7.4a	'Singleton Practitioners' who are required, as a condition of their post, to be registered with NISCC. Guidance: These are social workers that are not easily identifiable with a social work team and are not classified as management.	Data Return 7 spreadsheet – 7.4a
7.4b	For those reported in 7.4a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.4b
7.4c	For those reported in 7.4a, return the numbers that are enrolled on/have completed PQ Awards during the current reporting period.	Data Return 7 spreadsheet – 7.4c
7.5a	'Singleton Practitioners' in a post which requires registration with a professional body and the current post holder is registered with NISCC. Guidance: These are social workers that are not easily identifiable with a social work team and are not classified as management.	Data Return 7 spreadsheet – 7.5a
7.5b	For those reported in 7.5a, return the numbers that have attained PQ training outside the current reporting period.	Data Return 7 spreadsheet – 7.5b
7.5c	For those reported in 7.5a, return the numbers that are enrolled on/have completed PQ Awards during the current reporting period.	Data Return 7 spreadsheet – 7.5c
7.6	How many Practice Learning Opportunities were provided by the Trust during the period?	Data Return 7 spreadsheet – 7.6

7.7	Provide a breakdown of DHSSPS PQ training targets	Data Return 7 spreadsheet – 7.7

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate - Learning Disability / Adult Social & Primary Care

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	18	10
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	16	10
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 Requests for second ASW input have remained low through the directorate.		
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 This remains low throughout the Directorate		
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 Trust engages with service users and carers in a timely manner and ensures where practicable that at least seven-days' notice is given of planned discharge from hospital.		

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	13
9.2a	Of these, how many resulted in an application being made?	11
	Comment on any trends or issues on the use of holding powers	

	The use of the Form 5 is reflective of the number of patients who initially agree to a voluntary admission but then decide to leave contrary to medical advice.

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	26
9.3.a	How many of these were completed within 5 working days	26
	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	N/A
	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 applications to MHRT in relation to detained patients (provide total number) There was a total of 10 however 4 of these patients were regraded to Voluntary prior to the Mental Health Review Tribunal.	
	Comment on any trends or issues in respect of Mental health Review tribunals The vast majority of the Mental Health Review Tribunals in Learning Disability services are as a result of a mandatory request by the Trust and are therefore reviews. There are ongoing issues in relation to the MHRT deciding to discharge patients from detention with immediate effect resulting in difficulty for the MDT, despite contingency planning to find alternative safe placements in the community.	
9.5.a	This is intentionally blank	

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	2

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)	1
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	1
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	

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

	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	3 left day time rota
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	4

	Commentary *Please give assurance that the number of authorised ASW, and ASWs in training is adequate to enable the Trust to continue to discharge its statutory duties* 3 ASW staff left the ASW day time rota this year – 2 were team leaders and 1 DAPO. It is not in their job description to undertake this role and function. They have however been on the rota for sometime but due to the additional pressures placed on these staff this year due to an increase in Adult safeguarding work associated with the large scale investigation they came off the rota. We have 1 staff member currently undertaking the ASW course. There are ongoing concerns about the number of ASW's who have other roles such as Team Leaders, DAPO's. The service has now included in the SW job descriptions that there is a requirement to complete the ASW course within 2 years of taking up post and participate on the day time ASW rota.
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. Belfast Trust Patient Under 18 years of age admitted to Iveagh between 1st April 2018- 31st March 2019 who are / were subject to detention. **Patient A** **Date of Birth** : 2001 **Female** **Transferred from a CAMHS unit as Detained patient on a Form 9 under Mental Health (NI) Order 1986** **Date of admission; 12/06/18 - Current** **Reason for admission** Patient A has a diagnosis of Intellectual disability, Autism spectrum disorder. Prior to admission there was a deterioration in Patient A's mental health with associated anxiety and behaviours that challenge. There was an increasing change in presentation, becoming anxious, fearful about everyday objects that previously did not cause any distress. There were daily episodes of verbal and physical aggression towards mother. Recent incident of physical aggression towards mother, hitting and kicking, locking herself and her mother in a room at home to assault. Patient A has also made threats to kill her father. Patient A was placing her fingers in her ears and engaging in repetitive hand movements/finger movements on a more frequent basis. Patient A can present with low mood, anxiety and depressive symptoms. Has been overheard to whisper/mutter to herself when alone, appearing to be

	responding in conversation, statements or words cannot be understood. Patient A will throw things that are near to her when she becomes frustrated. Patient A required a period of assessment and treatment to manage these behaviours and prevent serious risk. Subject to LAC Review **Patient B** **Date Of Birth 2003** **Male** **Detained under the Mental health NI Order 1986** **Date of admission: First admission 23/5/18 – 6/6/18** **Reason for Admission** Patient B is diagnosed with severe learning disability, autistic spectrum disorder and ADHD. Escalating level of aggression displayed over the week prior to admission. Patient B was displaying challenging behaviours, absconding, stripping and putting himself at risk on equipment in the environment, climbing naked onto tractors, resulting in bruising. Patient B had been using Google to ask how to burn accommodation and how to run away. He had been breaking latches on windows in an attempt to abscond. Prior to admission, Patient B had absconded from his placement and ran to nearby rail tracks. PRN medication was administered with no impact. Patient B did not appear to know staff; he was crawling about the floor and had bitten a number of staff. Patient B's level of staffing was normally 2:1 however immediately prior to admission 4-8 staff were required. Patient B's level of aggression towards staff intensified e.g. hair pulling, slapping, biting and kicking. He also stripped and urinated on his clothes when in a state of heightened emotion. He also pulled clothes from his wardrobe and urinated on them. Patient B was displaying some sexualised behaviours that included self-stimulation using furniture and he also attempted to insert objects such as toothbrushes into his back passage. He also pulled his trousers up and down several times a day, exposing himself. Patient B can be self-injurious biting himself and nipping his stomach when he is in a state of emotional distress. **Patient B**

Date of Admission : Second Admission 12/06/18

Reason for Admission

Patient B was re-admitted on **12/06/18** due to challenging and unpredictable behaviour in placement. There was an incident prior to admission, Patient B absconded and displayed a high level of aggression towards staff. He went to an area that was deemed unsafe. As well as displaying aggression towards staff, he engaged in self injurious behaviour, slapping and nipping himself. PSNI assistance was required to assist with managing Patient B's behaviour. He was readmitted under the Mental Health NI Order.

Patient C

Date of Birth: 2001

Male

Detained under the Mental health NI Order 1986

Date of Admission 15/08/2018 – 04/03/2019

Reason for Admission

Patient C has a severe Learning disability.

Patient C was admitted to hospital following an aggressive outburst which resulted in injury to two staff members of Residential Children's Unit. He was admitted on a voluntary basis from 07/08/2018 – 14/08/2018. Patient C settled quickly during this time and was discharged back to Residential Children's Unit. Initially he appeared to be calm and settled. Patient C's demeanour then changed and he became agitated. He was destructive of property in his room, throwing objects and smashing things. Staff withdrew until he ceased and then attempted to re-engage, when he had calmed. Patient C declined PRN medication, and went on to repeat his destructive behaviour. PSNI were called however, Patient C had settled by the time they responded. A short time later, Patient C's behaviour became threatening toward staff and other residents. There was a threat to kill and there was evidence of broken glass in his room giving staff serious concern re risk to staff, residents and himself. Measures such as reassurance from familiar staff and positive reinforcement did not prove effective. GP and ASW were requested to attend and an admission under the Mental Health Order was deemed necessary.

Subject to LAC Review

Patient D

Date of Birth: 2006

Male

Detained under the Mental health NI Order 1986

Date of Admission: 27/09/2018

Reason for Admission

Patient D is diagnosed with a Severe Learning Disability, Autism Spectrum Disorder and co-morbid Attention Deficit Hyperactivity Disorder, he presents with behaviours that challenge at home and at school, displaying physical aggression towards others.

Prior to admission Patient D exhibited a significant deterioration in his presentation. He experienced emotional upset and distress, sudden mood swings accompanied with aggression towards his parents. This included violent attacks escalating to involve more prolonged physical attacks. He focused on targeting their eyes, with him exerting pressure on their eyes/orbits raising the risk of serious eye injury to both parents.

Patient E

Date of Birth: 2006

Male

Detained under the Mental health NI Order 1986

Date of Admissions: First admission 04/04/18, discharged on 17/04/18.

Reason for Admission:

Patient E has a history of ASD with Pathological Demand Avoidance Profile. Patient E has a long history of high levels of anxiety manifesting as challenging behaviour. In the weeks prior to admission Patient E brandished a knife at his parents. There was an escalation in behaviours, displaying high levels of aggression. Hitting out at his parents, nipping, biting and pulling their hair. Parents were finding it increasingly difficult to manage Patient E at home.

Second admission 06/06/2018 - ongoing

Reason for Admission

Similar presentation as previous, long history of periods of agitation and anxiety, which manifests into behaviour that challenge. Patient E had presented as very difficult to manage in days leading up to his admission.

	A voluntary admission was attempted on 4.06.18. Patient E presented as extremely difficult to manage. An ambulance was arranged to transport, however, failed due to Patient E being unsafe and destructive whilst in the vehicle. He presented as highly aggressive to community professionals and absconded from community offices. Parents returned home with Patient E due to how distressed he was presenting. Patient E was assessed and brought to hospital under the Mental Health NI Order 1986 on 06/06/18, required assistance of PSNI to transport. Not subject to LAC Procedures.	
9.9*	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?	1
	Issues or trends relating to notifications to the office of care and protection and on-going management of such arrangements	

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	2
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	2
	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)	2
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)* Both these STOs have been in place for over a year. There have been no problems with accessing services for either service user.	

DATA RETURN 1 – PoC / Directorate – Family & Childcare / Social Work and Children's Community Services

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?		
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?		
1.3	How many adults are in receipt of social work or social care services at 31st March?		
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?		
1.4	How many care packages are in place on 31st March in the following categories:		
	xxv. Residential Home Care		
	xxvi. Nursing Home Care		
	xxvii. Domiciliary Care Managed		
	xviii. Domiciliary Non Care Managed		
	xxix. Supported Living		
	xxx. Permanent Adult Family Placement		
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. ***Narrative***		
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***		
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***		
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		
	- Independent sector		

1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities		
1.7	Of those at 1.6 how many are EMI / dementia		
	- 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?		
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.

DATA RETURN 1 – Family & Childcare / Social Work and Children's Community Services

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?			
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?			
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?			

Age is at date of referral for 1.1 and 1.2
Age at 31st March 187 for 1.3

Hospital Social Work Service data is recorded in the Children with Disabilities Data Return 1.1 to 1.3

DATA RETURN 1 – Acute Hospital (general setting) _____

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

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

DATA RETURN 2 – PoC / Directorate – Family & Childcare / Social Work and Children's Community Services

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

DATA RETURN 3 – PoC / Directorate – Family & Childcare / Social Work and Children's Community Services

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.	
	Number of Disabled people known as at 31st March.	
3.2	Number of assessments of need carried out during period end 31st March.	
3.3	This is intentionally blank	
	Narrative	
3.4	Number of assessments undertaken of disabled children ceasing full time education.	

DATA RETURN 4 – PoC / Directorate - Family & Childcare / Social Work and Children's Community Services

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

4.1	Number of Article 15 (HPSS Order) Payments	172
	Total expenditure for the above payments	£18,283.70
4.2	Number of TRUST FUNDED people in residential care	
4.3	Number of TRUST FUNDED people in nursing care	
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	
	See Physical Health and Disability Return	

DATA RETURN 5 – PoC / Directorate - Family & Childcare / Social Work and Children's Community Services

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65 +
5.1	Number of adult carers offered individual carers assessments during the period.	**n/a**		
5.2	Number of adult individual carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	**n/a**		
5.2a	Number of adult individual carers assessments declined during the period and the reasons why *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*	**n/a**		
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	**n/a**		
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.	**37 – Action for Children**		
5.6	Number of young carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards)*	**37 – Action for Children**		
5.7	Number of young carers receiving a service @ 31st March	**83 – Action for Children**		

5.8	(a) Number of requests for direct payments during the period 1st April – 31st March	**0**
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	**0**
	(c) Number of adults receiving direct payments @ 31st March	**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.	**405**
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		
Commentary The Trust understands that information in relation to young carers will be available through the future suite of PARIS reports.		

DATA RETURN 6 – PoC / Directorate - Family & Childcare / Social Work and Children's Community Services

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

8 SAFEGUARDING ADULTS

6.1	Number of safeguarding adult referrals within the period	
6.2	Of the referrals at 6.1, how many were received from acute settings?	
6.3	Number of investigations commenced within the period	
6.4	Number of investigations completed within the period	
6.5	Of the completed investigations at 6.4, how many required a Multidisciplinary Agency Risk Assessment Conference (MARAC)?	
6.6	Number of adult protection plans commenced within the period	
6.7	Number of adult protection plans in place on 31st March	
Commentary		

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate - Family & Childcare / Social Work and Children's Community Services

N.B. This return has been amalgamated with the return from Learning Disability

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

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO		
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)		
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)		
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)		
	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.		

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

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	
9.3.a	How many of these were completed within 5 working days	
	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.	
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.	

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients (provide total number)	
	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	
9.6.a	New applications for Guardianship during period (Article 19(1))	
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	
9.6.c	How many were Guardianship Orders made by Court (Article 44)	
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	
9.6.f	Number of Guardianships accepted by a nominated other person	
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	

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

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

	Commentary *Please give assurance that the number of authorised ASW, and ASWs in training is adequate to enable the Trust to continue to discharge its statutory duties*	
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.	
9.9*	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107?	
	Issues or trends relating to notifications to the office of care and protection and on-going management of such arrangements	

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). **Schedule 2A Supervision and Treatment Orders.**		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	
9.11	Of the Total shown at 9.10 how many have their treatment required as:	
	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)	
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period.	
	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)*	

DATA RETURN 1 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	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*	
1.3	How many adults are in receipt of social work or social care services at 31st March?	*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*	
1.4	How many care packages are in place on 31st March in the following categories:	*n/a*	
	xxxi. Residential Home Care	*n/a*	
	xxxii. Nursing Home Care	*n/a*	
	xxiii. Domiciliary Care Managed	*n/a*	
	xxiv. Domiciliary Non Care Managed	*n/a*	
	xxv. Supported Living	*n/a*	
	xxvi. Permanent Adult Family Placement	*n/a*	
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. ***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		
	- Statutory sector		
	- Independent sector		
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities		
1.7	Of those at 1.6 how many are EMI / dementia		
	- 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*** N/A		
1.8b	Please identify possible new service innovations that are currently supported by non-recurrent funding ***Narrative*** N/A		
1.9	How many of this Programme of Care clients are in HSC Trust funded social 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. ***Narrative***	~~*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 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

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?	944	1014	
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	*944*	*1014*	
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	*453*	*134*	

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

DATA RETURN 1 – Acute Hospital (general setting) _____

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

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

DATA RETURN 2 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

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

DATA RETURN 3 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

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.	**24**

DATA RETURN 4 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

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

4.1	Number of Article 15 (HPSS Order) Payments	2
	Total expenditure for the above payments	£200
4.2	Number of TRUST FUNDED people in residential care	**n/a**
4.3	Number of TRUST FUNDED people in nursing care	**n/a**
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	**n/a**
4.5	How many occasions in-year has the Trust been called upon to support Emergency Support Centres (ESC)?	**n/a**

DATA RETURN 5 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65 +
5.1	Number of adult carers offered individual carers assessments during the period.		**406**	
5.2	Number of adult individual carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*		**406**	
5.2a	Number of adult individual carers assessments declined during the period *(to be collected from2019/20 onwards – it is hoped to collect from PMSI)*		**0**	
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?		**406**	
5.4	Number of adult carers receiving a service @ 31st March		**565**	
5.5	Number of young carers offered individual carers assessments during the period.		**138**	
5.6	Number of young carers assessments ~~undertaken~~ completed during the period *(to be collected from2019/20 onwards)*		**138**	
5.7	Number of young carers receiving a service @ 31st March		**83 – Action for Children**	
This was returned under Family and Child Care Section.				

5.8	(a) Number of requests for direct payments during the period 1st April – 31st March	**32**
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	**32**
	(c) Number of adults receiving direct payments @ 31st March *This figure represents DP/SDS allocated solely to support Carer.	**7***
5.9	Number of children receiving direct payments @ 31st March	**102 – DP 138 – SDS**
5.9.a	Of those at 5.8 how many of these payments are in respect of another person? 73 Direct Payments/126 SDS * This figure relates to DP/SDS iro children but managed by parent/carer	**199***
5.10	Number of carers receiving direct payments @ 31st March	**5**
5.11	Number of one off Carers Grants made in-year.	**405**
As per response at F&CC Section		
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		
Commentary ***Direct Payment numbers have risen as have the number of hours delivered.***		

DATA RETURN 6 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED IN ADULT SAFEGUARDING REPORTS

9 SAFEGUARDING ADULTS		
6.1	Number of safeguarding adult referrals within the period	**n/a**
6.2	Of the referrals at 6.1, how many were received from acute settings?	**n/a**
6.3	Number of investigations commenced within the period	**n/a**
6.4	Number of investigations completed within the period	**n/a**
6.5	Of the completed investigations at 6.4, how many required a Multidisciplinary Agency Risk Assessment Conference (MARAC)?	**n/a**
6.6	Number of adult protection plans commenced within the period	**n/a**
6.7	Number of adult protection plans in place on 31st March	**n/a**
Commentary		

THIS RETURN IS NOW SUSPENDED AS INFORMATION REQUESTED IS PROVIDED AT YEAR END 31ST DECEMBER

DATA RETURN 9 – PoC / Directorate – Children with Disabilities / Social Work and Children's Community Services

N.B. The Children's Return has been included in the return by Learning disability POC.

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	n/a	
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	n/a	
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	n/a	
	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)		
	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.	n/a	

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	n/a
9.2a	Of these, how many resulted in an application being made?	n/a
	Comment on any trends or issues on the use of holding powers	

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	n/a
9.3.a	How many of these were completed within 5 working days	n/a
	Please provide an explanation for any ASW Reports that were not completed within the requisite timescale, and what remedial action was taken.	n/a

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.*	n/a
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	n/a

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients (provide total number)	
	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	n/a
9.6.a	New applications for Guardianship during period (Article 19(1))	n/a
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	n/a
9.6.c	How many were Guardianship Orders made by Court (Article 44)	n/a
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	n/a
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	n/a
9.6.f	Number of Guardianships accepted by a nominated other person	n/a
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	n/a

9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24) Discharges as a result of an agreed multi-disciplinary care plan: Lapsed: Discharged by MHRT: Discharged by Nearest Relative: Total:	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	n/a
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

	Commentary *Please give assurance that the number of authorised ASW, and ASWs in training is adequate to enable the Trust to continue to discharge its statutory duties*	
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?	
	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 50A(6). **Schedule 2A Supervision and Treatment Orders.**		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	
9.11	Of the Total shown at 9.10 how many have their treatment required as:	n/a
	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.	
	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)* N/A	

APPENDIX A

DATA RETURN 8 – PoC / Directorate All

8 Assessed Year in Employment

Assessed Year in Employment (AYE) 2018-2019

Return for Employers year ending 31st March 2019

1. The Standards referred to in this document are the "Minimum Standards for Completion of the Assessed Year in Employment (AYE)" as published by NISCC in Revised Guidance for Registrants and their Employers NISCC November 2015 (Version 2).

Please complete the sections below which provides an overview of all staff who were subject to an assessed Year in Employment (AYE) in your organisation for the period 1st April 2018 to 31st March 2019. These are staff that are in a post which is suitable for the verification of practice against the required Standards, such that they are eligible to be registered without the AYE condition with the NISCC.

Table 1 asks for the number of Newly Qualified Social Workers who are subject to an AYE by setting. The table requires numbers of AYEs that were in post at any time during the year and those who are still in post at 31st March 2019. These should be counted as mutually exclusive, that is if the person is in post on 31st March they should not be returned in the column for 'during' the year.

Table 1 **Job setting**		**During year 1/4/18 to 31/3/19**	**At 31st March 2019**
1	Gateway	6	3
2	Family support/intervention team	12	10
3	Looked after team	6	4
4	Fostering team	0	0
5	Adoption	0	0
6	Leaving and after care	0	1
7	Children's disability(*1 Children's Hospital)	8	6*
8	Residential child care	12	6
9	Early years	0	1
10	Other Children's CAMHS	2	2
11	Hospital social work team	8	4
12	Older people	15	6
13	Mental health	6	8
14	Health and Physical disability (Adults)	3	1
15	Sensory impairment	0	1
16	Learning disability	3	3
17	Vulnerable adults	0	0
18	Other (Adult)	0	0

	Total number of AYEs	**81**	**56**

Of the 81 registrants: 30 staff left the Trust without completing their AYE.
8 staff left having completed the AYE.
43 staff completed their AYE and are still with the Trust.

2. Of the Total AYEs employed, describe their employment status?

Table 2 **Employment Status**	**During year 1/4/18 to 31/3/19**	**At 31st March 2019**
Permanent	22 (7 left 15 presently in post)	5
Temporary	8 (1 left 7 presently in post)	3
Recruitment agency	51(30 left during the year 21 presently in post))	48

Commentary on Question 1 and 2:

Of the 81 AYE's who were in post during last year.

- 38 were employed for a short period and then left employment of BHSCT
- Of these 38 staff, 8 had completed their AYE with the Trust.
- 43 staff were endorsed by BHSCT as competent to complete the AYE.

Trends over the last 5 years:

- **Increase in staff turnover:** In the last five years there is a significant increase of staff turnover within the AYE group. In 14/15 of the cohort of 30 AYE staff four (31%) left to seek employment elsewhere. In 18/19 of the cohort of 81 staff 38 left to seek other employment (47%). See Appendix 1 for graph.
- **Increase in Agency Staff:** This has continued to increase over the last 5 years. In 18/19 a cohort of 99 staff are either in post having completed their AYE this year or are still in the process of completion. All of these staff will likely have under two years experience and 69% are agency staff.
- **Increase in numbers.** The number of AYE Registrants within the workforce has continued to rise. See Appendix 1 for graph. In summary: in 14/15 30 staff completed/worked towards completion of their AYE and by 18/19 this figure has risen to 81.This is almost a threefold increase of AYE numbers.

What does this mean?

- Staff turnover is likely to have an impact on service delivery: as new staff move on there will be disruption for the service users.
- Team Leaders are spending increasing time on induction and supporting new staff to have a good understanding of their service user's assessment/care plan plus teaching and mentoring staff in a new area of work.
- The Learning and Development Team meet/greet, track, manage the administration, audit and support. The increase in AYE Registrants and turnover has increased their work by threefold.

3. **How many Newly Qualified Social Workers (NQSW) were employed by the Trust during the year in posts that did not require a Social work Qualification. That is they were not able to undertake their AYE, and in what capacity were they employed.?**

Table 3 Employment area	No. of NQSW not undertaking AYE
None	

4. **What processes has the Trust put in place to ensure that every AYE produces a Summary of Learning upon commencement of post? (narrative)(Standard 1)**

The Learning and Development Consultant meets with all AYE Registrants and New Line Managers and both are informed of the requirement to provide a Summary of Learning. An audit monitors compliance and of the 15 files reviewed, one registrant had not filed the document.

Clarification Note in relation to Question 5,6,7,8
Question 5-8 ask for commentary on the totals that are noted on Table 1. The Trust is not in a position to comment on all AYE Registrants. As outlined in Circular HSS(OSS) AYE2/2015, the Trust sample 25% of performance appraisals.

5. **How many AYEs from the total given in Table 1 failed to produce a Summary of Learning?**

1

6. **Have all AYE's a Personal Development Plan (PDP)?**

Yes [ ] No [x]

The sample confirmed a 60% compliance with this standard.

Please describe the process you have in place to ensure PDPs are relevant and up to date.
There is no evidence of registrants returning to update the Personal Development Plans. The mid and final reflective statements however confirm that registrants are identifying learning and future learning needs. While the PDP is not updated the Trust accept the Reflective Statements as meeting this requirement.

7. **Have all AYE's in the Trust undertaken (or be in a position to undertake) the minimum required 10 development days?**

Yes [x] No [ ]

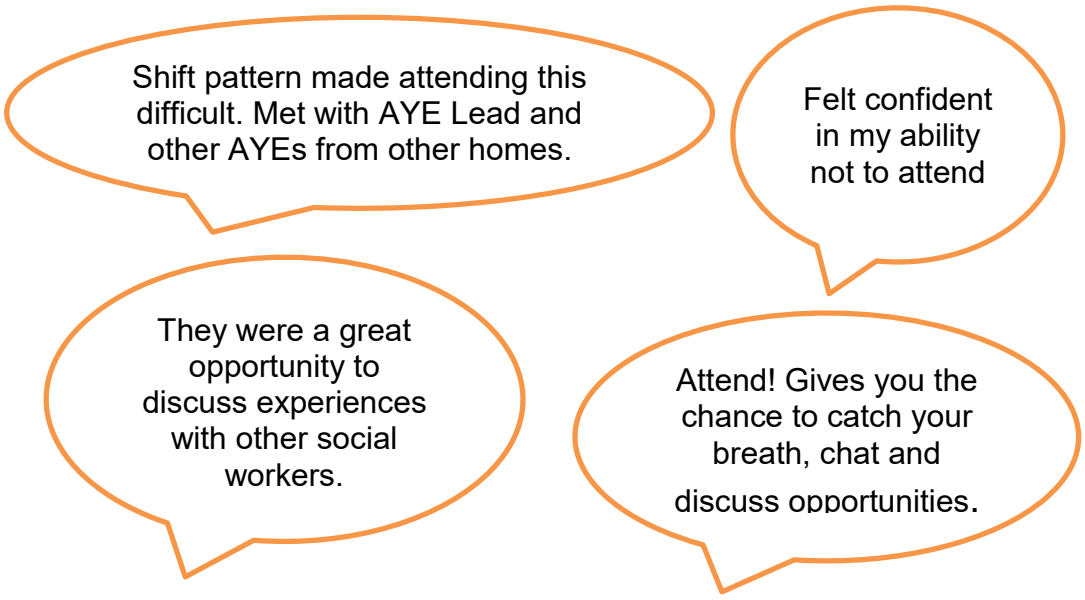
Please provide details of what arrangements are in place to ensure that this requirement (Standard 4) is met.

- The Trust's audit of AYE 2018/19 sampled the records of 15 (30%) registrants. All records complied with this standard.
- Exit questionnaires with AYE registrants confirmed compliance with this standard. Albeit the return was 39%. The returns were evenly spread over permanent, temporary and agency staff.
- AYE Registrants are invited to attend a monthly AYE Forum. This Provides an opportunity for the AYE Lead in the L&D Team to '*check-in'* with staff.

Additional Comments on the AYE Forums:

- The numbers in the AYE cohort will vary each month as this is a fluid Group. Therefore the statistical analysis is difficult. However, in a review of attendance in the last 6months 70% attended 0 or 1 group. Of the 30% who did attend the majority attended between 3-5 Forums.

Quotes:



8. Have all AYEs received a formal Social Work Induction as per the NISCC guidance?

Yes [ ] No [x]

See explanatory note.

Please provide details of the Induction Procedure (Standard 2).

Explanatory Note:
Audit:

- 6 files in the audit of 15 files did not evidence induction by completing an Induction Booklet provided to all AYE Registrants.

This 60% compliance is an improvement from last year's 50%. The Trust interpret

this data as staff not evidencing their induction as opposed to it not happening. The questionnaire returns indicate that induction does take place.

Questionnaire Return:

- 95% stated that they received induction into their role and
- 95% said that it prepared them for their post.
- 90% said they had completed the Induction Booklet.

Summary Comment: Evidencing this standard is tricky as the AYE's definition of Induction will vary. The Trust are satisfied that in triangulation of the audit, Questionnaire and no issues being raised with the AYE Forum that staff are receiving adequate action.

Action:

- In 19/20 continue to reinforce the importance of induction with managers and encourage staff to evidence via the Induction Booklet.

- Have a conversation with the AYE Forum on their experience of Induction.

Induction Procedure:

Induction is a three way process.

- **Corporate Welcome.** This is a half- day corporate induction to welcome staff to the organisation. It explains the Trust's structures, values and provides information for example on Infection Control and Safeguarding. In 2019 this '*Welcome'* will extend to a one day event where all staff will exit having completed all the core statutory and mandatory training requirements.
- **Local Induction.** This will consist of Team/Departmental orientation arrangements to detail job role, processes, procedures and policies. This is lead by the Team Leader, Senior Practitioner and/or professional lead.
- **Induction to Assessed Year in Employment.** A Learning and Development Consultant who leads on AYE meets new staff within three weeks of appointment and will also meet Line Managers as required.

9. Please answer Yes or No for each of the following systems that are required to be in place and available for all AYEs. Provide a separate explanation for each instance that 'No' has been ticked.

Table 4	**Systems required**	**Yes**	**No**
1	Human Resource system to track AYE progress	x	
2	Performance appraisal for AYEs 6 monthly	x	
	Year end	x	
3	25% Sample of AYE performance	x	
4	Management of AYE workload **The Exit Questionnaire asks:** *''In general my workload is about right'' and ''I can keep a reasonable balance between work and personal life'' Both answers received*	x	

	the same response. 7 staff strongly agreed, 11 staff agreed and 2 neither agreed/disagreed. This is an encoura position.		

10. Please report on the frequency of professional supervision afforded to the AYEs in post at 31st March (Standard 3).

Table 5 **Job setting**	**Number of AYE receiving supervision:**		
	Fortnightly	**Monthly**	**Other**
Children's (1 to 10 from Table 1)	6	26	
Hospital (11 from Table 1)	1	3	
Adults (12 to 18 from Table 1)	10	10	

How many of those shown above as 'Fortnightly' have been in post for more than 6 months @ 31st March?

0

How many of those shown above as 'Monthly' have been in post for more than 6 months @ 31st March?

39

Trust should provide details and explanations of situations where professional supervision of AYEs is less than the minimum requirement in Standard 3, and what steps are being taken to achieve full compliance.

The Trust seeks to identify non-compliance by reporting by exception those situations in which supervision does not comply with the expected standard.

100% of the questionnaire returns confirmed that supervision took place.

The Trust acknowledges that in some services there have been particular workforce issues but considerable efforts have been made to comply with this requirement.

Comments from staff indicate that supervisors strived to provide a supportive lear environment,

My managers encourages my development at work.
Strongly Agree: 16
Agree: 4

My manager has recently told me I've done a good job.
Strongly Agree: 16
Agree 4

11. What proportion of staff who provide professional social work supervision to AYEs have undertaken relevant training in 'professional supervision and appraisal'? (Number of staff with supervision/appraisal training as a percentage of the Total number of staff who supervise AYE).

The Trust is unable to answer this question with a numerical reply as it is not possible to interrogate training data via HRPTS. The Trust has previously raised this matter with HSCB.
On the 31st March 2019 there were 41 professional supervisors. On reviewing the list the Learning and Development Manager believes they all have completed supervison training. See comment below that provides assurance of compliance.

What arrangements are in place within the Trust to ensure that all such supervising Social Workers have undertaken the appropriate training?
(Narrative)

All newly appointed managers or professional social work leads complete a 3 Day Regional Supervision Course and refresher training is available for all.
In the Data 7 Report 31/12/18 the Trust evidenced 100% compliance with the following DHSSPS Target:
From 2010, all newly appointed Senior Social Workers/Team Leaders will undertake relevant training in professional supervision and appraisal within two years of appointment.
The Trust usually meets this standard within six months of appointment.

In addition, the Learning and Development Consultant for AYE meets all Managers new to AYE and other managers by request to ensure that they have been apprised of their roles and responsibilities. This is supported by Learning an Development Team guidance notes for managers new to post/AYE.

12. Please provide an account of how the Trust assess practice against the six key roles as set out in the Northern Ireland Social Care Council (NISCC) guidance (The Assessed Year in Employment (AYE) for Newly Qualified Social Workers in NI, NISCC)

- The individual AYE registrant provides evidence to the Line Manager who assesses competence against the six key roles. This occurs within the supervisory process and is recorded on a pro-forma designed by the agency.
- At the mid-point the registrant submits a 750-word reflective summary of learning needs, progress in evidencing the six key roles and identifies any gaps in learning which require to be addressed during the remaining period of the AYE.
- The Line Manager assesses the registrant's performance at six months against the six key roles, recording the outcomes in the supervision file.
- The final appraisal follows a similar process as the mid-point review with the Line Manager beginning to identify how the registrant will continue their journey post-AYE via the Professional in Practice accreditation pathway.
- The audit process and exit questionnaire provide opportunities to benchmark the AYE Registrants' experience.

- The audit reviewed the AYE Registrants' reflective summaries and they conveyed a sense of growth in confidence and competence.
- Equally the documentation that managers were required to complete met the necessary standard.

This process mirrors the requirement that is detailed in the *NISCC (2015) Assessed Year in Employment.*

Additional Comments from AYE Exit Questionnaires:

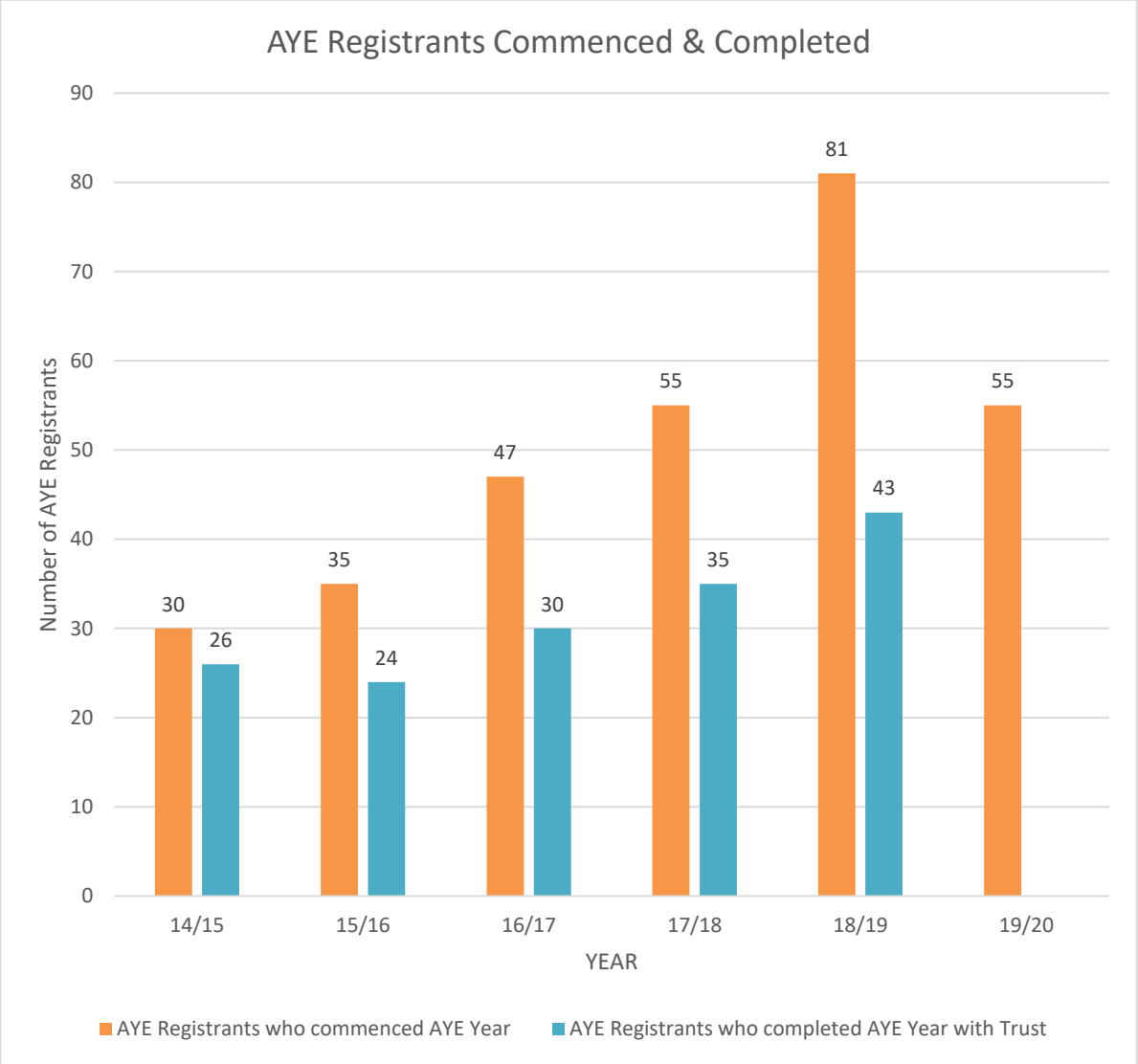
(The AYE Lead).. was very helpful throughout and I could not thank him enough.

Very helpful meeting at the beginning of AYE. I used notes from this meeting when I was putting together my folder and to write up the 6 month and final reviews.

I really appreciated the support and advice from colleagues, manager and the AYE Lead. It helped me a lot through the journey

Do not be afraid to ask for more training opportunities. You are not expected to come from university knowing everything.

Summary Comment: The Assessed Year in Employment is now embedded into practice. The responses to some of these questions are a repeat of what was reported in previous years as we are now reporting on established systems. At this point it would be useful to review and streamline this reporting template.


AYE Registrants Commenced & Completed
Number of AYE Registrants
90
80
70
60
50
40
30
20
10
0
30
26
35
24
47
30
55
35
81
43
55
14/15
15/16
16/17
17/18
18/19
19/20
YEAR
AYE Registrants who commenced AYE Year
AYE Registrants who completed AYE Year with Trust

APPENDIX B

DATA RETURN 11 – PoC / Directorate ALL

Please Note: Information for this section will inform the Annual Accountability Report to the Department of Health, Social Services and Public Safety

11 Accountability Report
Personal Social Services Development and Training Strategy 2006-2016

11.1 Regional Social Work Trainees		
11.1.1	Regional Social Work Trainee Investment 01.04.18 - 31.03.19	**Accountability 18-19**
11.1.2	How many Regional Social Work Trainees were employed within the Trust as at 1st April 2018?	**0**
11.1.3	Total Number of Trainees completed within 2018 -19	
11.1.4	How many Regional Social Work Trainees were employed within the Trust as at 31st March 2019?	**0**
11.1.5	***Narrative****. Trust must detail any students which have deviated from expected pathways to include reasons for deviation, current salary point and expected graduation date.* The Regional Social work Scheme ceased approximately five years ago. This section of the report is redundant.	
11.2 Practice Learning Opportunities		
11.2.1	PLO Investment 01.04.18 - 31.03.19	**Accountability 18-19**
11.2.2	How many PLOs have been provided by the Trust during the period?	**Accountability 18-19**
11.2.3	How many Children's PLOs have been provided during the period? (Trust must specify the numbers of level I, II and III placements)	**Level 2—23** **Level 3- 20**
11.2.4	How many Adult's PLO have been provided during the period? (Trust must specify the numbers of level I, II and III placements)	**Level 2- 22** **Level 3--22**
11.2.5	*Commentary. Trust must highlight and provide explanations for any deviations from the expected PLO provision. Processes which have been implemented to ensure high quality Adult's and Children's PLO should be included in addition to specific demands on resources and achievements in year.* *Commentary. Trust must highlight and provide explanations for any deviations from the expected PLO provision. Processes which have been implemented to ensure high quality Adult's and Children's PLO should be included in addition to specific demands on resources and achievements in year.* **Deviation from PLO Provision:** The Trust are contracted to provide 91 PLO's and while 91 were presented 87 commenced. This small shortfall arose as students did not commence PLO due to personal circumstances or the PLO was reallocated to another agency to meet the meet the needs of the student.	

Processes to ensure high quality PLO's: The Trust is approved by NISCC as Designated Practice Learning Provider (DPLP). This requires the Trust to meet the *'The Standards for Practice Learning for the Degree in Social Work'.* Compliance with these Standards is monitored by NISCC.

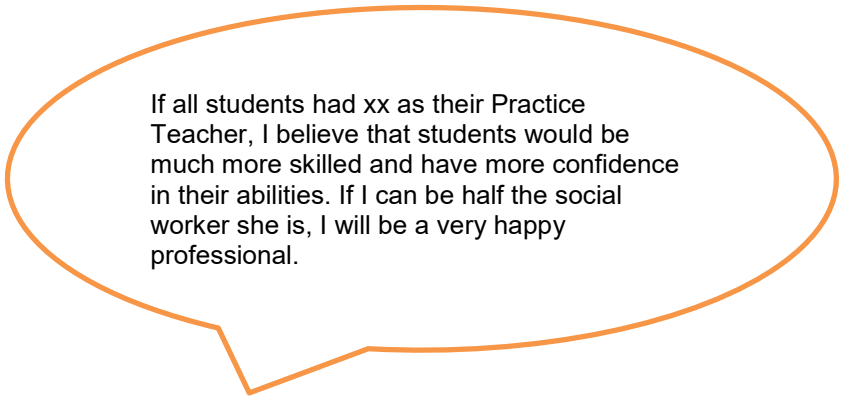
The NISCC Standards provide a framework for ongoing evaluation and continuous improvement. This includes:

- An audit of student supervision records and evidence files that provides an insight into the teaching and assessment that the Practice Teacher has provided.
- Universities provide feedback on their experience of provision of PLO's.
- Students complete an evaluation of Corporate Induction and an Exit Interview. In addition, the Degree Provider also asks students to complete an evaluation of the PLO. This all contributes to providing an overview of the student's experience.
- Active Practice Teachers and On-sites are required to attend an annual workshop where they receive feedback from the audit, updates on changes to the PLO assessment and space to reflect on their practice.
- Newly qualified Practice Teachers and Practice Teachers returning to the role receive mentoring and support through the PLO.

Focus of the 18/19 Audit: In 18/19, the BHSCT fully implemented the introduction of electronic files that contain the student's PLO Meetings, supervision records and evidence files. The electronic file was reviewed to establish how practice teachers were adapting to this new arrangement and the appropriateness of student evidence. (Previously too much evidence was being presented.)
Outcome: There were inconsistencies in how practice teachers had organized the electronic files. Those presented in sub sections were more accessible.
Action: Create an electronic file with subsections to harmonise how all store and present information.

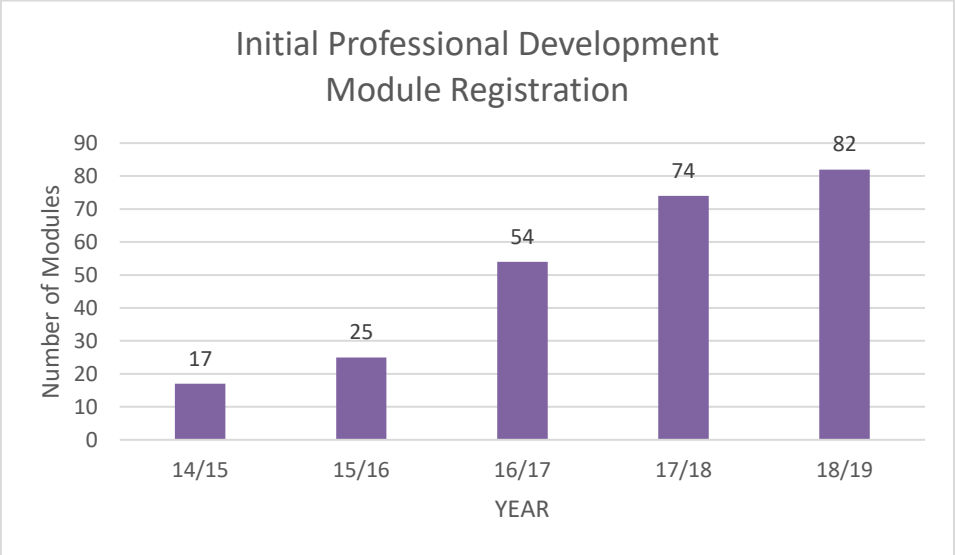
Focus of the Audit 19/20. This year universities stated the standard of practice teaching reports is variable. This will be the focus of the next audit.

Feedback forwarded by the University on one Practice Teacher.



Specific Demands on Resources:

	Collaborative Working: The provision of the BSc Social Work is dependent on collaborative arrangements with many agencies**.** This includes for example, membership of Boards, Committees, Practice Assessment Panels, Recruitment Panels, Teaching and contributing to the achieving the NI Social Work Degree Business Plan. The latter is a significant time commitment that often remains invisible. **Identification of PLO's:** Change is a consistent theme and it can often seem that the workplace is in one continual change process. This year a high level of staff turnover, sickness and vacancies continue to augment the stresses and difficulties experienced by teams and individuals. In this context, it is a challenge to engage practice teachers and teams to host PLOs. The consequences are: • The Learning and Development Team spend considerable time and effort in gaining commitment to 91 PLO's. Often the strength of personal relationships/goodwill is a key factor in meeting the target. • A fast changing workplace means that PLO's that are agreed four to five months before the start date can be unavailable and time is required to rearrange and accommodate students. This augments the work of the PLO Coordinator and detracts from the student experience. In January, some PLO's were only being confirmed on the start date. **Individual Circumstances of Students:** Students can identify individual circumstances that the Trust are required to consider and accommodate these in keeping with legislation, policy and procedure. In the August –December PLO, five of the thirty- five students PLO end due to mental health/stress. The experience of the Trust and other employers is that this is an increasing issue. The '*duty'* to accommodate these needs, to support the student and practice teacher plus the responsibility to ensure that the management of the PLO meets the requisite legislation requires time and attention to governance. **Non- Car Drivers.** The number of students who have no access to a car has increased. This is a challenge in allocating of PLO's, as this is essential criteria for the majority of social work posts. **Opportunities for social care staff to pursue a career in social work.** As already alluded, the Trust and other employers are struggling to fill vacant posts. There a small number of employees who wish to pursue a career in social work. Due to financial commitments, however they cannot participate in the fulltime degree. These staff are exploring how they can continue their studies through the Open University by making a commitment to self- fund if the Trust supported them by providing a practice teacher/PLO. This in itself is a cost to the agency. In light of our present vacancy, rate and decline in social work applications there could be merits in the DoH, HSCB and employers exploring a sponsored scheme for staff to complete a social work qualification.	
11.2.6	*This has been left blank intentionally*	
11.2.7	*This has been left blank intentionally*	
11.3 Post Qualifying Training		
11.3.1	Post Qualifying Training for Social Workers Investment	**Accountability 18-19**
11.3.2	Post Qualifying Training for Social Workers Activity	**Accountability 18-19**

11.3.3	*Commentary. Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce.* This section of the report must be read in conjunction with the Excel Accountability Report Section 11.3 as this includes the detail of the course fee expenditure, the achievement of candidates and work of the Learning and Development Team. **Consolidation Award:** Newly qualified staff within their first three- year period of registration with NISCC must complete a minimum of two requirements in the Consolidation Award. While this requirement was introduced in 2010, there was a lead-in period and it was not until 2014 that eligible staff were re-registering with NISCC. The number of staff availing of Initial Professional Development (IPD) Modules has continued to rise over the last five years.  ***Success of staff meeting NISCC meeting mandatory requirements with their period of registration.*** This previous graph indicates that staff, managers and the Learning and Development Team have heavily invested in achieving this target. As staff exit the Assessed Year in Employment, they are encouraged to move seamlessly into the Professional in Practice Framework. The majority of staff will quickly engage in the taught modules of the IPD Course at Ulster University. In 2018, all staff met the NISCC requirement In 2019 there are 36 staff due to meet the NISCC Requirement and already 33 staff have already achieved what is required. This illustrates that the Trust proactively work with staff to meet their registration requirements ahead of time. In 2018/19, all staff chose to meet the NISCC Requirements via the taught Initial Professional Development (IPD) Course at University of Ulster. The lack of uptake of Individual Assessment Route and Credit Accumulation will be discussed later in this section. ***Agency staff joining from the voluntary sector who delay in PiP*:** Staff who struggle to achieve this target are usually Agency Staff or staff joining from	

the voluntary sector (whose fees are not funded) who have chosen to delay their studies in hope of gaining a permanent post and thus avoid self- funding.

Encouraging Staff to complete the Consolidation Award: The DoH ambition for newly qualified staff is that they complete all of the Consolidation Award. Of 124 staff eligible staff, 21% achieved the entire Award while 79% chose to meet the NISCC Requirements, which are two requirements out of a possible six.

Impact of the increase in uptake of Initial Professional Development Modules: The uptake of IPD Modules has increased by 20% over the last five years.

- **Financial Impact:** A module costs £252 and a 20% increase in the uptake of these modules has increased monetary expenditure. The fees are a 60% reduction in normal fees. This reduction is premised on the employer via the Learning and Development Teams co-producing and delivering these modules. The arrangement with the Ulster University provides a real opportunity for the employer and university to collaborate in the education of employees. This brings real synergy.
- **Increase on workload for Learning and Development Teams.** The work of the Learning and Development Team in the delivery of the IPD Modules is invisible to many who are unfamiliar with the delivery of university courses. Particularly in this situation when the Learning and Development Team are delivering 60% of the course for example through teaching, assessing, mentoring and marking. The impact of 20% growth in IPD Modules has consequently meant that the work of Learning and Development Teams in supporting this course has also increased by 20%. Each year the Trust has realigned resources to respond to this growth however when the data is reviewed over a five year period alongside the Assessed Year in Employment (Data 8 that confirms a growing number of new staff entering the workforce) it is evident that the demand for IDP will continue to increase.

Specialist and Strategic & Leadership Award Accredited Courses:
The Trust offer a range of courses for both these Awards. These include the Practice Teachers Award, Adult Safeguarding, Community Development, the Approved Social Work Award and Diploma and Certificates in Cognitive Behaviour Therapy and Systemic Practice. The Trust usually support 40 candidates on these courses and this number is consistent over the last number of years. The staff who apply for these one-year courses at Masters Level are motivated to progress with academic studies and professional development.

The funding for these courses varies between payment of full fees to a 60% reduction in lieu of the Trust Learning and Development Teams working in partnership to co-deliver the course. This is the same arrangements as described for the Initial Professional Development Course. At present, the five Trusts are engaged in the delivery of the Adult Safeguarding Programme, Community Development, Approved Social Work and the Practice Teacher's Award. As already indicated this is invisible work that is often not apparent to those unfamiliar with the Learning and Development Service.

The Strength of the Partnership Arrangement: The partnership arrangements between employers and education provides the opportunity to have a taught

	course that can quickly respond to the changing needs of social workers. This an integrated way of working that maintains links between academia and the employer. ***Is the financial allocation sufficient?*** Social Work Education and employers have a long history of collaborating to meet the learning needs of the workforce. Trusts have engaged in this partnership model (60% reduction in fees in lieu of work) probably thirty years ago when there were fewer courses and a very small number of candidates. As the PiP Framework has grown an staff participation has grown the Trust believe that we have not paid sufficient attention to the Learning and Development staff costs/ time that are required to support and deliver these courses. It is the Trust's opinion that costs quoted in the excel expenditure sheet do not reflect the level of activity of the L&D Teams. A scoping of the time required to support PiP Courses commenced in 18/19 and will provide a benchmark to negotiate more realistic costs in 19/20/ **Action:** • Trusts alongside the HSCB will work together to agree realistic costs to reflect the significant and hidden work of Learning and Development Teams and to build them into the budget allocation. • Future proposal to develop PiP Courses must include the 60% costs to Learning and Development Team as a way of highlighting the required resources. (The Trust representative can raise this at NISCC PiP Partnership Board.) **Funding for the Diploma in Practice Teacher, Approved Social Work and Adult Safeguarding:** The BHSCT host the management of these three courses that includes the oversight of Course Co-ordinators, a Band 3 Administrative. This will be discussed in 11.13 Additional Allocations as this funding is managed on behalf of the five Trusts. **Credit Accumulation and Individual Assessment Route:** PiP Credit Accumulation and Individual Assessment Route allows social workers to earn professional credits for a broad range of learning and development that can be gained through taught or self-directed study. This model endeavours to capture and encourage *'learning and reflection in the workplace'* and reinforces the complimentary nature of formal and informal learning. The evolution of the framework set out to make the PiP Framework accessible to all social workers as opposed to the few who completed accredited academic learning. In the last four year the Trust have expended time on raising awareness of PiP Credits as a way to maintain Post Registration and Learning Requirements (PRTL) and how achieve Requirements within the Professional Awards. The Excel Activity Report indicates that this year we have continued to provide these awareness sessions with 148 in attendance. This mirrors the investment of previous years. **Outcomes of the above work**: The Trust and other Trusts are not gaining traction with this route. In • **17/18:** 100 staff registered credits for learning • **18/19:** 40 staff registered credits for learning.

- **18/19:** No staff in BHSCT sought professional Requirements/part Awards (21staff from the voluntary and the statutory sector submitted for requirements with a 66%sucess rate. This is a small uptake.)

In reviewing the Credit Accumulation Report, the pattern is that staff attend an Awareness Session/seek individual advice and they will register credits however, they do not continue to embed this into their practice. The L&D Team have also targeted longer in-house courses such as 3 Day Supervision Course, Solihull Foundation Couse (3day), Achieving Best Evidence (8day) and Therapeutic Crisis Intervention Foundation (5day), TCI Refresher by integrating an input into credit accumulation as a means to encourage success but almost no success.

In reviewing the staff who registered for credits in the previous year 17/18 only four of these staff returned to register credits in 18/19 and three of these staff were in the Learning and Development Team. This is disappointing. The volume of training provided to social work staff is evident in the Excel Report with in an excess of xxxxx training places and only 40 staff chose to register for PiP credits.

As yet, the social work profession have not yet embraced a commitment to evidencing continued learning. Indeed a motivator for many staff to engage in the PIP Framework is to avoid the NISCC PRTL Audit.

Action:

- The Trust will table the low uptake with the NISCC Partnership Board.
- The Trust will continue to promote all models of learning within the PiP Framework.

Work based/Course Based Learning: There are a small number (Regional Quality Improvement, Risk Assessment of Sexual and Domestic Violence and Stroger Together Leadership Course) of 'pilot' courses
overseen by NISCC that are linked to the PiP Awards but not academic accreditation. The Trust participate in these courses with good candidate feedback. The strength of this approach is that the coursework generates the evidence, assessment is 'built- in' and a course leader can endorse practice as being at the requisite level.

Action:

- This is a pilot with good outcomes. Staff achieve Awards and social work practice is greatly enhanced. There is some disquiet that while practice is at a specialist/leadership level the academic aspect of the course may not be evidenced at Masters Level that is stipulated..

Signs Of Safety: The SoS Implementation Plan sets the objective of enabling staff to achieve appropriate PiP Awards. Staff will at a minimum attend a two day Foundation Course and others like Practice Leaders will attend in excess of 10days training that will be supplemented by '*learning in practice'* through completion of group supervision and leading their staff team through the implementation. There will be at least 60 Practice Leaders within each Trust plus all child care social workers will complete the 2 day Foundation Course. The Signs of Safety Training Sub Group have NISCC involvement and a professional officer is mapping how staff can avail of Awards.

	Action: • As indicated in the action point above it will be important that this route is explored and endorsed by NISCC/Employers through the PiP Partnership Board if appropriate. • At this point the detail of how the assessment for the Awards is still under discussion but consideration is being given to this been undertaken by Resolutions (who lead on SoS). The financial cost of this must be explicit in any proposal. **Summary Comments on PiP:** • The partnership model of delivering on PiP Course has many strengths in addition, in the context of the Learning and Improvement Strategy 2019-27 this model of working meets strategic priorities of working in partnership. • Insufficient attention has not been given to making explicit the financial costs of providing a 60% input into these courses. The HSCB/Trusts should collectively agree the true costs of these courses. **Is the funding adequate:** There is an overspend in this category. This year a number staff progressed to the Diploma in Systemic Therapy and this increased out usual PiP Costs. As already indicated this is likely an under estimation as the Trust are not capturing the extent of the partnership work (60% fee reduction to equate to 60% course input) within Learning and Development Teams. Discussions with other Trusts indicate a similar position.	
11.3.4	Describe the process by which the Trust selects suitable candidates for PQ training **(Narrative)** **PiP Accredited Courses:** • Courses are advertised across all of the social work population to ensure equity of opportunity to express an interest. • Staff who are required to complete two Specific Requirements as part of their registration and newly Senior Practitioners required to complete three Specialist Requirements are identified through an information system and they receive individual emails to apply for appropriate courses. • Staff must complete a Trust PiP application form endorsed by their Line Manager. • The Learning and Development Manager reviews the appropriateness and to benchmarks the applications. The course must compliment/develop a core part of the applicant's job role. • Recruitment for the Approved Social Work Course is led by operational managers who wish to target teams/services where this role needs developed. Staff are interviewed to establish their suitability for the course and to act in a Band 7 role on completion of the course. • High demand courses like the Practice Teacher Award have additional criteria to help priorities applications. • Courses for example the Masters in Systemic Practice/CBT are not routinely offered as the level of knowledge/skills is beyond the usual social work role. These courses will be offered in exceptional circumstances for example the development of a new service.	
11.3.5	*This has been left blank intentionally*	
11.4 Learning and Development in Children's Services		
11.4.1	Investment in Learning and Development in Children's Services	**Accountability 18-19**

11.4.2	Learning and Development in Children's Services Training Activity	**Accountability 18-19**
11.4.3	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce.*	

Strategic Direction:
The Children Services Learning and Development Programme in 2018-19 was shaped by the following:

- The Children Services Improvement Board (CSIB)
- PHA, Infant Mental Health Strategy
- BHSCT Corporate and Children Services Management Plan.
- Signs of Safety Implementation Plan.
- SBNI Learning and Development Priorities & Strategic Plan.
- Transformational Funding to support various projects.

The importance of synergy: It is important that Children's' Services focus on continuous improvement and development of services and at present there are a number of transformational initiatives that are led by Children Services Improvement Board, Health and Social Care Board, Public Health Agency and the Safeguarding Board NI. The initiatives such as Signs of Safety, Adverse Childhood Experiences, Infant Mental Health, Building Better Futures Outcomes Based Accountability, Quality Improvement and electronic records (PARIS) are in themselves important developments. There needs to be a synergy across all of these developments.

Challenges for the Children's Social Work:

- The above initiatives bring significant changes within Children's Services.
- In BHSCT, this is within the context of significant staff vacancies.
- Promotion/Staff changes means that there is a significant cohort of newly qualified staff in social work roles plus Team Leaders and Principal Social Workers also new to post.
- The possibility of '*change fatigue'* is conceivable and this can create a barrier to embedding change.

Challenges for Learning and Development: The challenge for the Trust Learning and Development Service is to merge these many themes into existing training provision and to create the connections for staff.

Learning and Development Provision: Section 11.4.1 of the Excel Accountability Report details the range of training provision that was provided by the Social Services Learning and Development Team. The majority of these courses are provided by the Team and reflects the knowledge and expertise within the service.

An overview of key areas of learning and development:

Signs of Safety: Signs of Safety is an integrated framework introduced across Northern Ireland to shape intervention with children and families. It is predicated on families and agencies building a meaningful relationship that enables child

	welfare interventions to be the catalyst for change that will empower families to change behaviours. **SoS Volume of Training Activity:** The first year of the Regional SoS Implementation Plan placed a heavy emphasis on provision of training. • Foundation Course (2day) 240 staff in attended and 35 voluntary sector • Advanced Course (5 day). 33 staff. The Learning and Development Team took a key role in the recruitment, management of these courses. The exit evaluations were all very positive with staff showing eagerness and a willingness to engage with the Signs Of Safety process. Staff also identified the challenges of implementing SoS in an environment that is struggling to manage workloads and that were experiencing staff shortages. The comments reflect the challenges for implementation of a whole system complex change. **SoS Implementation & Learning and Development.** ***Delivery of Course/Supporting Learning after March 2020.*** Unlike other training initiatives, the capacity to deliver SoS Courses after March 2020 will be placed with experienced practitioners who can anchor their teaching/learning in current SoS practice experience. The Trust are in the process of identifying appropriate staff for this role. **Action:** There is no resource to continue specifically fund or provide workload easement for the implementation of SoS in 20/21. This is a reality and likely a deficit in the implementation plan. In a year, the Trust and others will still be in the early stage of implementation. The funding of a post or even a part-time post/job share with Learning and Development could provide a platform to provide training but more importantly space to continue to mentor and coach practice '*in practice'*. Opportunities for funding often quickly emerge and we need to be mindful of this unmet need. ***Involvement of Learning and Development Teams in SoS:*** The Trust Learning and Development Manager has been involved in the Trust's Implementation Plan and Regional Leadership Days. This has assisted in connecting practice and the Learning and Development Team. SoS will influence the delivery of Child Care Services in the next five years or longer and it is important that Learning and Development Staff are fully engaged in practice. The Child Care Learning and Development Staff attended the Foundation Course and are involved in the Practice Leader's Workshop. Involvement in the Practice Leader's Workshop brings them alongside Team Leaders and Senior Practitioners. This is further extended by the The Learning and Development staff have become involved in assisting with group supervision as a means of enhancing their practice. **Innovate Idea:** The Practice Learning Co-ordinator that oversees the placements of 91 students each year has worked alongside the SoS Implementation Officer to provide group supervision for students as a means of exposing them to elements of SoS. Practice teachers are also working with students to incorporate 'the three houses' plus Danger/Safety Statements in casework. **Integrating/Linking SoS with key knowledge and skills.** SoS is a process of working that still depends on staff having knowledge, for example of child

	development, attachment, and impact of trauma, domestic violence plus the skills of appreciative inquiry, analysis and working with reluctance. **Action:** • The Learning and Development Team will continue to attend Practice Leaders' Workshops and negotiate way of observing and become involved in practice opportunities. • The Learning and Development Team will strive to create links to SoS through other core training. **Summary Comment**: Early research indicates that there can be improvement in assessments, management of risk and a more focused approach to goals. The DoH (July 2017) Evaluation of Signs of Safety in 10 Pilots reaffirms that improvements are possible however they also note that there must be a necessary commitment of trust in their staff plus increased resources and time to spend with families. It concludes that Signs of Safety is *'not a magic bullet'.* We need to be mindful that we are now entering the challenging phase of *'landing SoS'* across the organisation. **Trauma Informed Practice/Adverse Childhood Experiences (ACE):** The SBNI through ETIP are taking forward a strategy *'Developing Trauma Informed Practice In NI'.* The Strategy sets out to interrupt the cycle of generational adversities that can cause repeat trauma in families. Trauma Informed Practice provides a framework to consider the systemic changes that are necessary in planning and delivering children services. The Learning and Development Manager is a member of the Regional Steering Group. Trauma Informed Care is a based on the understanding that many service users have experienced previous trauma and social workers must cognisant of this fact. Many of the in-house training courses such as Therapeutic Crisis Intervention already reference Trauma Informed Care and the task of Learning and Development is to make the theory and connections more explicit. **Action:** • The SBNI Trauma Informed Lead will provide a one-day workshop for Learning and Development Team to assist and support staff to consider how to expand and develop existing training courses. • The Trauma Informed Care will also provide opportunities for the delivery of discrete training to social services staff plus the opportunity to Train Trainers to continue to cascade learning. • Adoption and Fostering staff who deliver group work to carers/adoptive parents may be well placed to incorporate this into their existing work. • To link Trauma Informed Care and SoS practice **Trauma Informed Care for Staff:** Managing vicarious trauma among practitioners and the importance of self- care is also within the remit of this Project. BASW's Report Insult to Injury and the DoH's commitment to produce a framework to promote consistent approaches to safe and supportive work environments. Transformational Funding led by Inspire within residential services also explores promotion of staff wellbeing. These all combine to create a continued impetus to consider how aspects of self- care is integrated into social work tasks such as Team Meetings and Supervision.

Action:

- The Learning and Development Team will continue work with the residential workforce through TCI, the pilot with Inspire and other project work to continue to explore how supports for staff in a challenging environment.
- Two QI Project are exploring the supports for staff in residential care. A Learning and Development Consultant is mentoring one of the Projects and a member of the Steering Group for the second.
- To promote and respond to the DoH Framework.
- To engage with the DoH or the Trust to provide information/learning on self- care/protection for social workers within a digital world.

Building Better Futures for Children (ETIP): This Project is in the final year and set out to improve children's outcomes by providing an evidence-based model of social work assessment and interventions. Unfortunately, for a myriad of reasons in BHSCT the Implementation of this Project is not on schedule. The Project Plan has an expectation of a continued '*roll-out'* of this approach across all Teams. Staff who have availed of training and implemented the assessment speak very positively about the development in their own practice and the improved assessment and understanding of the family.

Action:

- The Trust is committed to continuing with the Project. A lead Snr Practitioner and a Learning and Development Consultant have further training planned and a commitment to continue to support staff. The BHSCT Implementation Plan for the Signs of Safety will need to consider how these two Projects interface and consider how we can support staff to engage with both methods of work in a timely and appropriate manner.

Graded Care Profile (GCP) Assessment Tool: This assessment tool provides a framework to assess and to intervene with families were neglect is prevalent. The Trust have engaged in two pieces of national research with NSPCC dating back to 2013 to develop and to evaluate the tool. The Learning and Development Consultants and the Safeguarding Nurse continue to take an active approach to implementation by provision mentoring on the tool in practice. The focus on neglect is in tandem with the SBNI Strategic Priorities 2018-22. Similar to Building Better Futures the focus on SoS has diluted the capacity to promote GCP. The model can also interface with SoS and can assist in naming and scaling problems with family.

Action:

- The impact of neglect is core learning for social staff and is part of the Trauma Informed Practice. In the next year, the Learning and development Team need to connect all these strands so that staff receive integrated knowledge as opposed to silo teaching.

Summary Comments: The discussion of SoS, Trauma Informed Care, Graded Care Profile and Building Better Futures illustrates that recent developments have not always taken account of each other.

Assessment/Analysis: Critical analysis in social work assessments and interventions is a continued development need.

Community Teams: This year to promote the transfer of learning into practice the Learning and Development Consultant worked with one service comprising 15 social workers. He read and reviewed a Court Report from each member of staff providing individual feedback and feedback to the Team as how they could improve as a team by agreeing standards and formats for Court Reports. In addition, Team Leaders seek one to one coaching for staff who are having particular issues with written records.

Action:

- Continue to work with this service to develop analysis within assessments.
- Provide coaching/mentoring for staff who wish to improve written records.

Residential Services: The service has worked alongside Therapeutic Support Services (TSS) to create an assessment format for residential services and the Principal Practitioner and TSS are in the process of introducing this to homes. It is '*well bedded'* into the short-term homes. In the long- term homes the focus is to assist practitioners to think about assessment, care planning and outcome based practice at a micro and macro level. Interventions need to identify how to best support the young person's health and well -being, through short and long-term goals that can evidence progress for the young person and others.

Infant Mental Health: The PHA (2016) Infant Mental Health Framework for NI continues to inform the work of the Learning and Development Service. The Learning and Development Manager is a member of Belfast Infant Mental Health Steering Group. The focus of our work is collaborating with others to deliver the 2-day Solihull Foundation Course (focus is on attachment, containment, reciprocity and behaviour management), follow up Practice Sessions to integrate learning into practice plus delivery of Solihull Master classes (Brain Development/Attachment and Trauma).

Action:

- The Learning and Development Service will continue to deliver this programme and explore how we can create reflective space for participants who have completed the course over a year or more to continue to refresh and explore their work using this conceptual model.

Think Family

Family: Focused Practice- Champions: This is the third year of the revitalisation of the Champion Support Group with membership of approximately 60 staff. An annual review workshop took place in June 2018 provides the opportunity to review and to agree a work plan for the coming year. The larger group is split into four groups bringing staff from same practice areas/geographical area together. In 18/19 Forums have addressed the following:

- Awareness and Information sessions arising from issues raised by Champions around the interface between adult mental health and children's services
- Sharing of information on resources to support parents and children living with parental mental ill health

- Supporting Champions to apply the Family Model in respect of their casework
- Discussion of practice issues arising across the interface
- Sharing of developments in collaborative working- for example, Champions from Children's Hospital Team and CAIT (CAMHS) have been spent time shadowing each other to build understanding of roles and responsibilities and to improve relationships and communication

Achievement: At the Think Family Symposium in May 2018, the Family Focused Champions Project was submitted and won the Poster Section.

In-house Courses: The Learning and Development Service provide a range of mental health courses to develop the knowledge of staff. This includes a two-day course, *Working with Parents who have mental health problems*. Many Services mandate this course for their staff and it is the foundation course for those who are Champions.

Think Family E Learning-Collaboration with the HSCB: The Learning and Development Consultant has also worked with the HSCB to review E-learning modules that have been developed through international partnerships.

Action:

- Continue to led and sustain the Family Focused Champions.
- Support HSCB to develop an e-learning module to demonstrate to supervisors how to integrate the Think Family Model into supervision.

Children moved across borders including those at risk of trafficking and modern slavery: Belfast as a centre of large population with hubs for various transport routes need to be mindful of the risks to these children. The Learning and Development Manager is a member of a Regional Network (Members are senior staff in DoH/HSCB/Trusts/Border Control/PSNI etc.) and work with others to maximise learning opportunities for a small cohort of staff who need to be experts in this area of complex work. The Network ask as a learning forum for key agencies where research, news article, legal judgements are shared.

In July 2017, a similar Network for practitioners was set up however the momentum of this has not been sustained. There is an opportunity for rich learning between these Band 7 staff but in retrospect asking the group to self-manage by appointing a Chair with administration did not work as in a busy front line post it is difficult to maintain a priority/focus on learning groups.

Action: In 2019/ 20 we will return to how we can better support these networks. It may be more prudent to delegate the management of the group to a Learning and Development Consultant as a way of encouraging/supporting learning.

An Achievement: The NSPCC and HSCB hosted a European Conference on the 16thMay 2018 that will brought together 100+ experts from the UK and Europe. The Belfast Learning and Development Team made a significant contribution to the organisation of this event.

The social workers involved in the work with these young people have developed expert knowledge in legislation, policy and practice that underpins work with

	those seeking asylum or who have trafficked. This year HSCB centrally funded staff to attend Age Assessment Courses. **Action:** • The DoH have indicated that this year they will progress on a product on what cultural competence means for the Social Workers in Northern Ireland. The Trust and the Learning and Development Team will engage in whatever work comes forward. The population of our city is rapidly changing. • Reconsider how we can re-energise the Practitioner's Network • Organise a workshop with the Refugee Support Service/Independent Guardian Service to share learning on the first year in practice. **Residential Child Care:** Residential care is a challenging work environment. Young people who have trauma related experiences have a myriad of needs and often the frustration and anger of the young people can manifest in verbal and/or physical assault. The DoH and Trust through Transformational Funding are taking forward a project with Inspire. • Inspire have commenced work with staff in one residential home to consider how staff are supported to work with trauma, manage their own emotions and to build team and self- care networks. **Action:** • The Trust will support this project and work towards embedding and spreading the learning. This Project must be connected to the DoH's plan to produce a framework to promote consistent approaches to safe and supportive environments, the work of the SBNI's Trauma Informed Practice that is discussed earlier and the existing work of the Trust's Therapeutic Support Services. **Building the capacity of Residential Managers**: The Trust has also initiated a number of strategies focused on enhancing the capacity of the service to provide the best possible care for children and young people. This included the recruitment of Deputies within the homes. Using examples from international contexts a Learning and Development Consultant alongside managers developed a job description that clearly informed the applicant about the personal and professional skills and ethical perspective required for this role. The staff development of all managers/deputies within residential childcare then focused on leadership, management and supervision. There are a number of strands to this including a two-day workshop (x 2) on leadership and supervision. To further embed and support learning a Learning and Development Consultant co-facilitated a Deputies' forum, which seeks to develop their specific role, to give space for reflective learning and to consider how they balance their management responsibilities including governance, supervision, staff care alongside supporting therapeutic care for the young people. **Social Pedagogical and Restorative Approaches:** The Trust in 2018 have reflected on the models of care to underpin residential practice. It was recognised that while there are many models of work within the service it is important to have common unifying approaches that have common language that will support team work. It was agreed to continue to commit to existing

models of Social Pedagogy and. Restorative Practice. Both approaches fit well with TCI.

This work was underway prior to the DoH's plan to work towards a one model of residential care across Northern Ireland. The Trust understand that the latter work is an overarching framework that will accommodate all of the various models.

Action:

- Workshops to revisit these long- standing practices of Restorative Practice and Social Pedagogy are planned for 2019.

Therapeutic Crisis Intervention: The purpose of TCI is to provide a crisis prevention and intervention model for residential childcare that will prevent crisis from occurring, de-escalating potential crisis and managing acute crisis. Reflective Practice, Post Crisis Debriefing and agreeing Individual Crisis Management Plans are all key to the model. Cornell University will soon release Edition 7 of TCI. There will be a stronger emphasis on Trauma Informed Care. This is welcomed as it will reinforce the ethos within residential care and make links to other areas of practice.

This year the Trust have continued to:

- Delivered Refresher training to over 100 staff.
- Delivered a 5 day Foundation TCI Course to Bank/Agency Staff.
- Addressed operational issues on whether staff are 'fit' to participate in physical aspects of the course.
- Continue to emphasise that TCI is essentially about prevention, de-escalation, and the use of relationship skills to respond to trauma.
- Support and Mentor TCI Trainers.
- Trained new TCI Trainers.
- Provided workshops for managers and deputies on Post Crisis Response and how best to support staff.

Action:

- Continue to provide TCI Courses.
- Support and mentor practice through workshops or mentoring managers with a post crisis response.
- Introduce TCI Edition 7.

Children with Disabilities Residential Care:
This Service uses Positive Behaviour Support (PBS), a person centred approach to supporting people who display or a risk of display behaviour that challenges. To continue to embed the model staff who are identified as 'coaches/leaders' undertook refresher training.

Action:

- To continue to support the residential service through reflective practice opportunities to embed PBS.

	Summary Comments: As indicated in the opening statement of this section many new initiatives were introduced over the last two year. This year the task is to make sense as to how they integrate and interface.	
11.5 Learning and Development in Adult's Services		
11.5.1	Investment in Learning and Development in Adult's Services	**Accountability 18-19**
11.5.2	Learning and Development in Adult's Services Training Activity	**Accountability 18-19**
11.5.3	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce.* The Learning and Development Team aims to meet the diverse range of training need of approximately 2500 staff from Band 2 to 8d. The Adult Services Learning and Development Programme in 2018–2019 was shaped by the following • A Learning and Improvement Strategy for Social workers and Social Care Workers 2019 - 2027 (DoH) • Bengoa Report 2016 "Delivering Together – Health and Well-being 2026 • Power to People – Expert Advisory Panel 2017 • Making Life Better – a whole system framework for public health2013-2022 • HSC Collective Leadership Strategy 2017 • Adult Safeguarding Policy 2015 • Self-Directed Support – Phase 2 • Co-Production • Dementia Strategy 2011 and The Dementia Learning and Development Framework 2016 • Improving and Safeguarding Social Wellbeing a Strategy for Social Work 2012-2022 • Mental Health • Capacity and Consent • RQIA Training Requirements • Trust Statutory/Mandatory Training Requirements **Adult Social Care Forum:** Adult Social Care is in the process of significant reform driven by a drive to deliver more centred care, a greater demand for care and the challenges retaining social care staff. To assist staff linking policy and plans within the Trust to redesign services the Adult Learning and Development Manager worked with the Director of Adult Services to host this one- day forum to engage with staff and to gain ownership. **Action:** • A further forum will occur in the autumn. **Transforming the Delivery of Home Care:** The Adult L&D Manager is a member of the Trust Steering Group to deliver on the reform of home care services and Chairs the Learning and Development Sub- Workstream. This is a significant commitment with monthly meeting and associated tasks. This reform brings opportunities to improve service delivery and to develop career pathways for the social care workforce. All of these staff are mandated to register with the NISCC and are required to meet the NISCC post registration and learning requirements. This in itself can create opportunities to develop new career pathways for social care staff. **Challenges/Areas to Explore:** • In BHSCT, the Homecare Workforce is in excess of 750 staff and 28% of these are over 60. This statistic may well indicate that these staff will exit the workforce in coming years. • 47% of these staff have already attained Level 2 NVQ/QCF/RQF and this % will likely decrease as staff retire.	

Action:

- The Learning and Development Manager in conjunction with others will develop a Learning and Development plan detailing what learning is key to delivering on this planned reform. This will highlight financial resources including '*staff back fill'.*
- There is a target that 60% of these staff will have achieved RQF Level 2 in three years. Existing L&D resources are insufficient to meet this target. Trusts and HSCB need to consider this funding deficit.

(Refer also to commentary in next section, Vocational Qualifications.)

Trust Joint Negotiation and Consultation Forum- Learning and Development Sub Committee: Trade Unions will be involved in the workstream considering the Home Care Staffs' learning needs. In addition, the Adult Learning and Development Manager represents Social Services Learning and Development in the Trust's Meeting with the Unions. This is an opportunity for both parties to identify emerging workforce themes.

I**n House Courses:** There were 121 learning and development events with 2564 staff trained. Many of these events were delivered by the Learning and Development Team. These are detailed in the appended Excel Sheet

Commentary is provided on key aspects of the Adult Learning and Development Provision.

Meeting the NISCC Learning Requirements of the social care workforce: The social care learning needs are met through this category, 11.6 Qualification Credit Framework and 11.9 Safeguarding Adults. As already indicated the focus on the social care population is greater due the employers' responsibilities to support their NISCC Registration, the recognition of their importance in delivering future services and the high level of accountability through RQIA. In the Spring of 2018, NISCC piloted an audit of Social Care Staff whose re-registration was due. The Learning and Development Team supported managers/staff to submit for audit and have provided raising awareness session on the NISCC Requirements. Compulsory Registration for residential staff occurred in 2015 thus by 2020, many of these staff will be re-registering and a % will be audited. The re-registration of this staff group will soon be a constant flow and as employers, we will need to support these staff to re-register and to comply with audit.

Self-Directed Support – SDS: The Learning and development Manager is a member of the Trust SDS Steering Group and two members of the Learning and Development teamwork in collaboration with Service Users/Carers and SDS Project Manager to deliver the Self-Directed Support Strategy across the Trust. The strategy has been underway since 2015 and is now entering Phase 2 of Implementation. During the period 2018-2019, 297 staff participated in a range of learning opportunities creating a total of 1924 social care and social work staff who have engaged in this learning since 2015.

Learning and Development Opportunities

- Level 1 – SDS Awareness ½ day programme
- Level 2 – SDS Process ½ day programme
- Level 2 – SDS Direct Payments ½ day programme
- Level 3 – SDS Support Planning - full day programme
- SDS Reflective Practice Groups – 2½ hour session

	During the course of the year, the learning and development opportunities have been reviewed and co-designed in collaboration with service users/carers, the current provision for this year has been: **Black and Minority Ethnic Communities access to Self-Directed Support Project** The Learning and Development team contributes to an on-going project aimed at supporting Black and Minority Ethnic communities to access Self-Directed Support. This is a collaborative project, involving community and statutory services. In April 2018 BHSCT launched their report *'Black and Minority Ethnic Communities: The Health and Wellbeing of Older People in Belfast'* to help map the needs of the growing older BME population in Belfast and help influence the design and delivery of high quality and culturally appropriate health and wellbeing services for BME older people **.** The report has a number of recommendations that highlight need for all health and social care services to be more equitable in terms of access and cultural appropriateness. The Learning and Development Team work with the SDS Project Manager in sharing information to encourage uptake of the options under SDS. **SDS Co-production Activities** The Learning and Development Team continue to deliver on the SDS strategy using a co-production approach, working collaboratively with service users, carers, practitioners and the SDS implementation officer on the development and delivery of regional, standardised learning and development opportunities. The team provide continuous support to a group of service users and carers with a view to building capacity, competence and confidence in the design and delivery of training. The service user group are representative of carers and service users who receive support from learning and physical health and disability services. There are currently 4 service users and 3 members of staff who actively participate in this group. Overall, progress has been excellent and the group are becoming increasingly confident as co-facilitators, delivering training, developing training materials and sharing their personal stories. **Co-Production Study** A member of the Learning Development Team is currently carrying out a research study. The title of the study is *"Getting co-production off the ground: The perspectives of social work practitioners and service users/carers who have tried".* **The Objectives are:** 1. To explore service user/carer and social work student/practitioner perspectives or experience of the implementation of service user involvement or co-production both in social work practice and social work education 2. To identify examples of good practice, opportunities and outcomes that this way of working presents 3. To explore the challenges and barriers faced by those who have tried to work in this way **The Methodology:** Between 12-15 semi-structured interviews with service users/carers and social workers. There has been a good response to the study and interviews have

commenced. The interview phase will cease at the end of May. Service users/carers are involved in design and analysis of study. A final report and presentation will be available in September 2019.

SDS & Recovery College
Collaborative work is on going with the Recovery College. One session was delivered during this period that was aimed at raising awareness of self-directed support, principles, ethos and how to access practical assessment and support if it is needed. .

Phase 2 Self-Directed Support - Review of Training Provision. Self-Directed Support is entering Phase 2 of implementation and there is significant work underway in terms of reflecting on learning from phase 1 and planning for the next phase.

Action:

- Learning and Development provision will be reviewed and influenced by the evaluation and feedback from participants.
- Reflective Practice Sessions and bespoke Awareness Sessions. The SDS Project Manager and a Learning and Development Co-Ordinator will facilitate these sessions in-house for teams across Adult and Children with Disability Services.
- Self-Directed Support Process training and Support Planning sessions will merge into one full day and the programme is currently being co-designed with service user/carer group.

Dementia:
A programme of learning and development activities is provided cognisant of the Dementia Strategy 2011 and the Dementia Learning and Development Framework 2016. This includes:

- Dementia Awareness – for all staff in Adult Services with the aim to develop staffs understanding of dementia; consider the impact this can have on the individual and to begin to develop skills and person centred practice in supporting the person living with dementia.
- Specific Dementia Awareness Training for Home Care staff – a number of sessions were facilitated at the request of this service.
- 2-day Dementia Awareness - People with a Learning Disability – Doctor Diana Kerr continues to provide one session a year. This focuses on the particular needs of people with a learning disability and considers the challenges for early diagnosis, highlights the need for a supportive and conducive environment as dementia progresses and enables staff to consider their values and how best to support those living with dementia.
- Following the success of The Virtual dementia bus experience we provided a further 15 sessions this year. This was extremely well evaluated. It provided an environment for staff to experience what it might be like for people living with dementia on a daily basis. Staff reported this was an extremely effective method of training, it produced real feelings and emotions of fear and confusion and the debrief afterwards provided an opportunity for staff to discuss their learning and how this can be applied in every day practice.

Action:

- Adult Services Learning and Development will continue to provide a rolling programme of activities to meet the needs of as staff described in Tier 1 of the Dementia Learning and Development Framework.
- Provision of further training provided by the Virtual Dementia Bus.
- Doctor Diana Kerr is retiring and we will need to source another facilitator to meet the needs of staff supporting adults with a learning disability and dementia.

Mental Health:
Staff training needs in this area remain consistent.

Changes within the staff team, primarily the retirement of the lead Learning and Development Coordinator reduced the range/volume of training provided this year as a new member of staff needed to develop their knowledge/skills to lead on this work.

Mental Health Awareness is a tailored course to meet the varied needs and experiences of the social work/ social care workforce and allied health professionals. As this training is generic, there is an acknowledgment that a lot of information is covered in 3-hour training session.

Successes include; positive feedback meeting the learning expectations of attendees, requests for more in depth training for staff in new posts within mental health teams.

Attendees have requested more in depth training on mental illnesses. Requests particularly from staff who have moved into new posts within mental health teams.

New legislation: The future provision of Mental Health Training continues to be challenging given the implementation of the Mental Capacity Act. It is still not determined the impact this will have on the training needs of social care/social work staff. Issues of '*capacity and consent'* and '*deprivation of liberty'* continue to be highlighted by staff at training and the legal "*vacuum"* created by legislation and policy keeping pace with case law and judicial reviews.

Other aspects of mental health courses/developments are referenced in 11.4.3 (Think Family Champions & a two- day course *Working with Parents with a Mental Health Problem*.)

Action:

- Changes to legislation will generate learning and development needs within social work/care and other professions. It is critical that Trusts are involved in planning how meeting these needs. It is likely that additional Learning and Development resources will be required.
- Scope the need for a course that will meet the needs of staff who require a more in depth knowledge.
- The Learning and Development Service will continue to provide support to the Mental Health Recovery Services Directorate in terms of co-ordinating

the ASW Re-approval training yearly (in partnership with South Eastern Trust) and ongoing facilitation of mental health social work forums.

Human Rights Awareness training

A half day programme is delivered alternate months. There is a rise in the demand for this course and perhaps the Commissioner of Older People's Report that highlighted the need for an increased attention to Human Rights as prompted this response.

Challenges have include tailoring this training to the varied needs and experiences of social work/ social care workforce and allied health professionals across adult and children's services ensuring appropriate up to date referencing to recent case law and rulings.

There has been a good response to this training with feedback being very positive.

Action:

- Review of current provision as demand is currently outweighing capacity. This could include developing courses that will focus on Human Rights and areas of practice. For example Human Rights and Children Services, Human Rights and Older People.

Anti-Poverty Event (While reported in this section it was open Adult and Children Services.)
On 7th March 2019, the Learning and Development Team hosted an event to raise awareness of the Anti-Poverty Practice Framework. This was attended by social work and social care staff across the Belfast Trust. Aine Morrison, Professional Officer from OSS set out the key themes of the Anti-Poverty Framework. Keynote speakers, Pam Borland (Principal Social Worker for Community) and, Gerry Largey (Senior Social Worker) stressed the importance of working together to combat social inequalities and the cruelty of poverty. The event was interactive in nature and a number of representatives from the voluntary and community sectors, facilitated round table discussions. Feedback from participants was that this was both valuable and productive. The majority of participants highlighted the need for more collaborative work and ways in which to connect with our community and voluntary partners in combating poverty and social inequalities.

Specialist training for Rehabilitation Workers
In previous years, additional funding of £12.5k was provided to support 2 Trainee Rehab Workers to undertake the BCU FdSc Rehab Work at Birmingham University. The HSCB chose not to fund the final year fees and associated costs. Funding was accessed from this allocation.

Concluding Remarks:
The Learning and Development team in Adult Services responds to identified staff training needs, meets RQIA mandatory training requirements and takes account of social care governance, service user specific needs, service change and redesign of an increasingly changing and diverse social work and social care workforce.

	It has been a challenging year due to staff changes. This has resulted not only in the reduced capacity of the team but also the loss of a wealth of knowledge and experience from the service. This year the Trust have successfully recruited 2 permanent L&D positions and have appointed a temporary full-time L&D Coordinator. This has been a challenging and transitory time that has focused on induction and developing the capacity of new team members. It has also been extremely positive in terms of what this brings to the team and has given us the opportunity to build on strengths, review existing practices and move forward together in meeting the demands of the social work and social care workforce.	
11.6 Qualifications and Credit Framework Training		
11.6.1	Investment in Qualifications and Credit Framework Training	**Accountability 18-19**
11.6.2	Qualifications and Credit Framework Training Activity	**Accountability 18-19**
11.6.3	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce*. The Springvale Community Learning Centre has responsibility for the delivery and the overall management of the Regulated Qualification Framework (RQF) (QCF) qualifications for social care staff within the Trust. City and Guilds the External Awarding Body inspected the Assessment Centre in May 2018. The External Quality Assurer commended the Centre for providing records of the highest quality. Whilst there were areas of improvement, she had *"no hesitation in awarding a low level risk status.'.* At present, the Team are preparing for an External Quality Assurance assessment from City and Guilds on 22nd May 2019. The Centre also ensures consistent and quality assurance in the delivery of vocational qualifications by attendance at Regional Vocational Meetings. These are key to collating a Northern Ireland perspective as often England influence/drive changes. The Trust also work alongside NISCC who oversee the development of standards. The Centre has undergone significant changes to the staff team in 2018–2019: • One of the full-time Vocational Advisors has now completed the TAQA 3 and is near completion of the TAQA 4. • One of the new full-time Vocational Advisors resigned and a part-time Vocational Advisor is retiring at the end of April. Interviews are scheduled for the beginning of May for these positions. The reduced capacity in terms of staffing quota and experience has been challenging in terms of new course intakes, course progression and course planning. The team have been focusing on supporting current learners to complete units. **A new Vocational Manager:** The Trust are increasingly aware of the need to increase development opportunities for the social care workforce. When a Band 7 vacancy arose with the Learning and Development the post was re-evaluated and a Vocational Team Leader Post created. The manager will lead/supervise the Team and there	

is an expectation that the manager will take an increased strategic and developmental lead in responding to the emerging needs of the social care workforce.

A new pilot. Developing Career Pathways. (This interfaces with the review of Home Care and the need to develop Career Pathways in Social Care.)
The L&D Team have introduced a pilot for Band 3 staff to complete a Level 3 Diploma. The pilot in Mental Health Older People's services aims to provide a career pathway for existing Band 3 staff to gain further knowledge and skills that would enable them to apply for a Band 5 post. These staff are unable to make the move from Band 3 to Band 5 as there are no Band 4 posts and they do not meet the essential criteria for Band 5. This pilot was originally anticipated to take twelve to eighteen months for completion. However, on review we perceive it may take sixteen to twenty-four months for all of the learners to complete the course.
The challenge: There is a significant knowledge and competence jump from a Band 3 to a Band 5. While the Service have been innovative in wishing to pursue this staff development opportunity, the unintended consequence is that the staff undertaking the Diploma require staff release from their current duties to have space to learn, observe the practice of others and to be mentored within work. This staff release brings financial implications plus logistically problems of managing staff rotas.

Action:

- Resources are at a premium however, as all Trusts move forward to up skill and develop staff the hidden costs of learning and development must be made explicit and the potential for *'back fill'* sought.

The Assessment Centre currently delivers the RQF qualification at Levels 2, 3 and 5. Completion of the qualification can take up to 18 months to 2 years to complete according to the Level to be obtained and therefore the frequency of the courses delivered varies every year and is dependent on the demands for the qualification and the capacity within the team. This year the Centre commissioned Belfast Met to deliver RQF Level 2 qualification to a group of 12 learners from the Home Care Service.

RQF Level 5 Diploma Health and Social Care Leadership
There continues to be high demand for this qualification as it is a recognised requirement by RQIA for Band 7 positions within the social care workforce. A new cohort of 8 commenced training in 2018 and are expected to receive their qualification within 24 months.

The increase in demand outweighs the capacity of the vocational learning and development team. As career opportunities and pathways are developed there needs to be consideration given how we can meet this increasing needs without further discussion and strategic planning at local and regional levels.

Cross- Reference to 11.10 Leadership and Management, for discussion on ILM Level 4 Certificate in the Principles of Leadership and Management for Adult Social Care in 2018.

	Action: • Discussion with Trust, Board and NISCC to consider how the learning and development needs of the increasing social care workforce can be facilitated and to agree an action plan. • To implement recommendations from the External Quality Assurance Assessor and a as a team to review systems and processes and ensure quality assurance with standardisation as per the Centre's Sampling Strategy. • To support new team members to achieve their Assessor Qualifications and IQA qualifications as necessary. • To continue to work closely with City and Guilds in the review of current levels of training and ensure a standardised regional approach to the RQF qualifications. • Continue to prepare and implement the City and Guilds new standards for each of the levels in RQF in the second half of 2019 and early 2020. • To progress from a paperwork system to an electronic system. • To continue to work closely with managers in Mental Health for Older Peoples Services regarding the pilot for Band 3 staff to complete a Level 3 qualification. To review regularly and complete an overall evaluation of the Pilot on completion.
11.6.4	What measures has the Trust taken to ensure QCF training is embedded across the workforce? *Trusts should comment specifically on any difficulties within this area and evaluation of any pilots if applicable* (*Narrative)* The Centre has established good working relationships with service managers throughout the Trust. It ensures the range of qualifications available are appropriate to the needs of the workforce and communicated to relevant managers across the Adult Social Care Workforce and welcomes expression of interest; all requests are screened against eligibility criteria. **Challenges:** A constant challenge facing vocational training is that of capacity. The review of Adult Social Care including the report from the Expert Panel "Power to People" refers to the changing demands of an increasingly ageing population with increasing complexity of needs. Personal social services is provided via Self Directed Support ensuring that those in need of support have more control, choice and flexibility in how this is provided. This increasing demand requires us to be more creative and person centered in our delivery of care and support. NISCC has highlighted this in their corporate plan and highlights the demands this places on the social care workforce and on learning and development in a workforce that is primarily female and where there are significant issues with retention of staff. As already referenced in 11.5 the Trust are reviewing the Home care Service. This includes ensuring that the workforce have the necessary skills, knowledge and qualifications to ensure quality provision. Such transformation will challenge the capacity of the learning and development service in terms of supporting a range of vocational qualifications across a career pathway for social care workers. This is a very exciting time for the vocational training team and social care workforce but at the same time extremely challenging in terms of meeting this demand without increased resources/capacity.

	We need to address this workforce issue in terms of all Trusts, the HSCB and NISCC collectively considering an immediate and long- term action plan that will continue to shape the development of accredited learning for the social care workforce.	
	11.7 Quality and Safety Issues	
11.7.1	Investment in Quality and Safety Issues	**Accountability 18-19**
11.7.2	Quality and Safety is the cornerstone of good practice throughout social care services and demands a high level of investment from the Learning and Development Service. The key areas identified are central to social care governance and are identified as RQIA training requirements. All regulated services are inspected on staff attendance at the following training programmes: • First Aid • Food Safety • Food Safety Refresher • Medicine Management for Care Workers • Medicine Management for Managers There were 88 training events with 1384 staff trained. These learning and development programmes are offered on a planned basis, circulated by a training calendar and staff attendance recorded on HRPTS. There is a high attendance rate at all sessions. **First Aid Training:** Emergency First Aid at Work Training is a one-day programme. It is HSCENI approved and is a comprehensive First Aid course designed to deliver training in basic lifesaving priorities and skills. **Food Safety Training:** Food Safety Training is a 1-day programme. The key learning outcomes include:- • Firm understanding of the importance of food safety and knowledge of the systems, techniques and procedures involved. • Understanding of how to control food safety risks [personal hygiene, food storage, cooking and handling. • Confidence and expertise to safely deliver quality food to service users. **Medicines Management:** Medicines Management Training for Care Workers is a 5-hour programme. It includes the following areas:- • Introduction to medicines and prescriptions. • Understanding direction and types of medicines. • Usage, procedures and techniques. • Administration, storage and disposal of medication.	**Accountability 18-19**

	Medicines Management for Social Care Manager places emphasis on the manager's responsibility to develop and implement safe practice, to have robust governance systems and to support staff to implement safe practice. **Action:** • To provide appropriate training opportunities to meet RQIA requirements. • To enhance the skills and knowledge of the Social Care Workforce in the areas of Medicines Management, First Aid and Food Safety.	
11.7.3	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet requirements from RQIA visits (announced or unannounced) or failure to comply notices*. **Funding:** The allocated funding for this category remains inadequate to meet the mandatory and RQIA requirements for a large social care workforce.	
	11.8 Child Protection	
11.8.1	Investment in Child Protection Training	**Accountability 18-19**
11.8.2	Investment in Child Protection Training Activity	**Accountability 18-19**
11.8.3	Of those who attended Child Protection Training, how many staff were from other disciplines or sectors? *(Narrative)* Safeguarding Children is '*everyone's business'* and this is reinforced by the SBNI Child Safeguarding Learning and Development Strategy 2015-18 that states that '*all staff and volunteers in the organisation must avail of Safeguarding Level 1'* and on a three-yearly basis *access learning and development that enables them to deliver on their responsibilities'*. In a Trust of 22,000 staff, this generates huge logistical, capacity and resource challenges. The following challenge has been highlighted in previous years and it remains a problem. Social Services Learning, Development, and Safeguarding Nurses are the only staff providing Safeguarding Courses. Others do not know nor understand social services ring fenced funding and there is a perception that it is the task of this limited resource to meet the learning needs of all 22,000 staff. There are large cohorts of staff, for example, administration, psychology, psychiatry that have no allocated funding for a Safeguarding Children Course. The Social Services Learning and Development Service are not in a position to deliver mandatory safeguarding training within its current workforce and funding base. The challenge is also replicated in Adult Protection. It is unfortunate given the known success of multi-disciplinary/agency training that within Northern Ireland that we have been unable to negotiate central funding for this activity. At	

	present, there is no central focus to take this work forward as the SBNI Education Committee stood down a few years ago. **Action:** • BHSCT Safeguarding Children Committee have asked the Learning and development Manager to scope this resource. Learning and Development have now created an Information Booklet (via Page Tiger that supports video clips) that is sent to all new employees. It is Level 1 Awareness meeting the learning needs of staff that have no direct role with children parents and/or carers. In addition to this the Learning and Development Service hosts a Safeguarding Children Information Page on the Trust Intranet. **How many staff trained from other disciplines:** These figures are an approximate number. The Information Management System (HRPTS) is unable to generate this data. **Action:** • HSCB and Trusts to explore the purpose of collating this data and if required agree how all Trusts can capture.	
11.8.4	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce*. ***This section must be read in conjunction with the ACPC Section 11.12.3 to gain an overview of all of safeguarding children training activity within the community and voluntary sector.*** The SBNI, Safeguarding Learning and Development Strategy 2015-2018 and the SBNI Strategic Plan 2018-2022 continues to shape and inform the activity of this category. As already highlighted in 11.4 there are many initiatives within Children's Services and it is important that priorities be taken forward in a cohesive and consistent fashion. **SBNI Priorities and the Trust's response:** **<u>Sexual Violence:</u>** **Child Sexual Exploitation (CSE):** NEXUS continue to provide Level 1 and Level 2 courses. In the contract Year 2 and 3 was to see the development of CSE Level 1 e-learning programme. It is also envisaged that CSE Conferences, Seminars, and other supporting materials would be uploaded onto a bespoke safeguarding site. The Trust are unaware as to how these plans are progressing. The Senior Practitioner for CSE continues to play a key role in the Trust by providing bespoke awareness sessions on CSE and risk assessment.	

The Missing Children Protocol (June 2015): A review of this document is still in process with an expected completion date in the autumn of 2019.
Action:

- A review of this document may well identify further opportunities to host workshops for PSNI/Social Work and other relevant staff to share learning and to increase understanding of role and responsibilities.

Children who pose a risk to others: The SEHSCT manage this specialised service and they deliver a one-day course each year.

Domestic Violence:
Belfast Domestic Violence Partnership. The Learning and development Manager is the Chair of the multi-agency Belfast Domestic and Sexual Violence Partnership (BDVP).The Trust alongside BDVP continues to facilitate multi-agency Raising Awareness of Domestic Violence (half-day) and Domestic Violence the Impact on Parenting and Children (1-day) programmes. This year the BDVP received funding from the Policing and Community Safety Partnership and by the Trust funding venue and catering Trust and other multi-agency staff were able to attend the following workshops.

- Domestic Violence and Mental Health.
- Domestic Violence and Addiction
- Domestic Violence and Physical Health.
- Coercive Control.
- Domestic Violence and the Digital World
- Prostitution.

Action:

- The BHSCT PPANI Co-ordinator had led the development of an Information Leaflet on Adult Child to Parent Violence. This will be launched in May with workshops to raise awareness of this issue.

SBNI, Domestic Violence and Sexual Violence Sub Group: The Trust have contributed to SBNI's Training Needs Analysis/Scoping Exercise to seek assurances that professionals working with children/young people have adequate training.

Action:

- The SBNI are collating the findings and the Trust await the outcome.

The SBNI Sub Group have also funded '*'Working With Young People's Violence in Close Relationships"* a five day course provided by RESPECT for SEHSCT and two staff from BHSCT.

SBNI will also fund Non Violent Resistance-Child to Parent Violence a two-day course in 19/20.

These are high cost programmes and it is important that nominated staff have the opportunity and scope to implement their learning.

Domestic Violence – Risk Assessment: QUB and Barnardos developed risk assessment tools/interventions for social work staff that are widely used across the UK.

Action:

- This is important work and in the context of Signs of Safety, we need to revisit how/if this work will progress.

Parental Mental Health and Safeguarding: Please see 11.4.3. Think Family and 11.5 Mental Health.

Action:

- Provide a workshop on peri-natal mental ill health.

Mental Health of Young People:

Staff avail of a range of courses/conferences including Applied Suicide and Intervention Skills. Young People can present with a myriad of problems that will not be addressed through training. Teams like the Therapeutic Support Services offer Consultation Clinics and also visit residential homes to discuss and reflect on particular issues presented by the young people.

Action:

- Re-establish the Young People and Self-Harm Course. Work with CAMHS to develop an awareness course for fieldwork staff.

Chronic Neglect:

Refer to 11.4.3 for discussion on the implementation of the Graded Care Profile**.** The SBNI Multi Agency Neglect Strategy 2017-19 continues to reaffirm the importance of childhood neglect and has a sub-group with members from a range of agencies including Trust Learning and Development Teams to develop resources to support trainers to deliver a range of learning events for single and multi-agency audiences.

Action:

- The Trust will continue to embed the use of the Graded Care Profile.
- Continue work with SBNI to implement to develop course materials at Level 1.
- Implement the Trust's Neglect Multi-Disciplinary Action Plan

E-Safety: The Team continue to offer a 1-day course and bespoke workshops. It is a challenge, however to remain up to date and current with this fast moving world. Residential Child Care staff all received an update on this theme in their annual Safeguarding Children Refresher.

Female Genital Mutilation: A Safeguarding Nurse and a Social Services Learning and Development Consultant deliver a course designed by Female Genital Mutilation (FGM) National Centre, England. The DoH free e-learning course is hosted on the Trust Intranet for staff.

Outcomes of Case Management Reviews: The SBNI CMR Panel with support from the Trust hosted a workshop that identified key learning from CMRs.

Action:

- The Trust will continue to profile, cascade and promote learning from CMRs, SAIs and other processes to improve safeguarding practice across all service delivery settings.

<u>Co-operating to Safeguard Children and the SBNI Policy and Procedures:</u>
Working Together/Understanding Roles and Responsibilities is key to Safeguarding Children. A range of multi-disciplinary training provides staff with the opportunity to learn together and to explore their role in safeguarding. This includes Safeguarding Level 1,2,and 3 plus *Safeguarding Children*, *Making a Good Referral and Care Pathways* provide information for other professionals on their roles in child protection and family support.

Action:

- The Trust continues to raise awareness of these procedures through the various Safeguarding Children Level 1, 2 and 3.
- The Trust have significant vacancies and it is likely that newly qualified staff will be appointed to these posts. The Trust will consider how these new staff can be mentored in these early stages of practice, as while 'ready for a career in social work' they will need space to consolidate their practice.
- The management of Child Protection Case Conferences will change by January 2020 and alongside the Signs of Safety Lead, the Trust will consider how to prepare other disciplines to engage in this new process within the meeting.

Joint Protocol for Investigating Cases of Suspected or Confirmed Child Abuse: The Trust equip staff to implement this protocol via Awareness Sessions, trained to complete Pre-Interview Assessments (3-day course) and to complete interviews in accordance with ABE processes and standards (8-day course).

The initial training and subsequent refresher training require substantial investment through staff release plus the Learning and Development Service. A proposal to explore each Trust in co-locating one staff with PSNI, as a means to centralising this work, reducing the volume of staff involved did not receive regional support.

In 18/19 through staff, promotion/new posts the cohort of available staff have reduced. There are 69 PIA staff and 19 ABE who are available for this work with further staff leaving in 19/20.

A DoJ Action Plan in 2015 advocated inter-agency meetings between PSNI and Trusts. These are in place since 2016 and have a small number of attendees with Social Services being the key driver. In 18/19, issues on Information Sharing have arisen in joint working and this will be a theme for a workshop in the coming year.

The Learning and Development Manager is a member of the Regional Core Group and a regional conference may be planned for the autumn.

	Public Protection Arrangements in NI: The Learning and Development Manager (Children) is a member of the Regional Steering Group. The PPANI Officer works with the Learning and Development Service to deliver multi-agency training courses to profile the operationalising of PPANI structures, statutory remit and interfaces with Trust services. PPANI Officers and those in Forensic Services receive specialised training under the umbrella of PPANI. **Action:** • Continue with Raising Awareness of PPANI.	
11.9 Adult Protection		
11.9.1	Investment in Adult Protection Training	**Accountability 18-19**
11.9.2	Investment in Adult Protection Training Activity	**Accountability 18-19**
11.9.3	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce*. **Safeguarding Adults Learning and Development Framework:** The BHSCT delivers the 5 levels of Adult Safeguarding training as outlined in the NIASP Training Strategy and Framework (revised 2016). These 5 levels are designed to equip staff of different bands develop the knowledge and skills commensurate with their job role and experience to support adults in need of protection and to promote staff confidence and competence in effectively carrying out their adult safeguarding role. The Training Strategy is compatible with the Adult Safeguarding Policy 2015, Regional Operational Procedures, 2016 and the Joint Protocol, and all training materials are designed to raise standards, promote best practice and ensure consistent and proportionate responses to safeguarding issues. Training is provided for all levels and our specialist Investigating Officer/Designated Adult Protection Officer and Joint Protocol Trained staff are supported through quarterly support group workshops. **Safeguarding Adults in Children Services:** In the policy/procedure the term '*safeguarding adult'* is used in its widest sense, that is, to encompass both activity, which prevents harm from occurring in the first place, and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention. By virtue of this definition, it is likely that Children Services Staff are working with parents/carers/adults who are in need of safeguarding. For example • A Kinship Carer subject to physical/financial abuse from a young person. Particularly if the person is older/mental health issues etc. • Parents of Looked After Children who have chosen to have a minimal role with their child/social services due to the nature of the placement. • Domestic Violence and Modern Slavery are also defined apart of Safeguarding Adults. **Action:** • In May 2019 the Learning and Development Team will pilot a bespoke course on Safeguarding Adults for those whose primary role is working with parents/carers /young people.	

Deficit in Funding:
The profile of Adult Safeguarding has been at the forefront this year with the publication of the Commissioner of Older People's NI Report and ongoing investigations into Muckamore Abbey Hospital. Adult Safeguarding is now a multi-disciplinary/multi-agency concern that continues to increase demands on our learning and development service.

As already discussed in Safeguarding Children there is a deficit in funding to meet the need for Safeguarding Learning. This is '*everyone's business',* it is mandatory training for a large cohort of staff however within other professional groups and other supports services there is no dedicated funding to support the training need.

The demand and lack of capacity to deliver Safeguarding Adults is even greater than Safeguarding Children as this mandatory training for a greater number of staff.

Inadequate training places for other professionals/services: To accommodate other professionals a small number of places are offered for other Trust employees whose primary role is work with adults. There however continues to be requests from many different service areas and we have delivered some bespoke training to try to meet these demands. Lifeline staff became Belfast Trust employees, Estates and Palliative Care received bespoke Level 1 Adult Safeguarding Course. There however, remains a concern that we continually have to turn down requests and in this last year, in particular from medical staff including staff from the GUM clinic, Geriatric services, psychiatry, nursing and OT services. This problem was further exacerbated when an Inspection of Out Patients Departments raised these very concerns.

This in turn highlights the potential that the implementation of the Regional Operational Procedures and Joint Protocol is not standardised across these different service areas.

Responding to the unmet training needs. The Learning and Development Manager alongside other key staff will scope the training needs of all Trust staff for both Safeguarding Children and Adults**.**

Learning for Social Work/Social Care Staff: In the social work/social care, population there continues to be a high demand for Level 1 Adult Safeguarding awareness raising and mandatory refresher courses. The RQIA requirement for the social care workforce to attend Level 1 and Refresher training is the primary driver supporting compliance. The requests for bespoke training for these service areas is considerable. For example, this year we delivered bespoke awareness raising training to new staff in the Mental Health Assessment teams and a two- day bespoke training for both investigating officers and designated adult protection officers within the mental health POC. A further example was 2 sessions in Muckamore Abbey regarding quality recording in the Adult Protection referral forms.

While it is unfortunate the L&D cannot meet the needs of others our priority is to meet the needs of social work and social care staff.

Modern Slavery/Human Trafficking: The DoJ, were tasked to take forward a training needs analysis and creating a response to this training need for health and social care staff. DoJ initial contact was made via the Trust CEO and similar to the delivery of Safeguarding Adults/Children the matter was referred to the Social Services Learning and Development Team. Considerable time was spent directing the DoJ to the variety of other training providers like Centre for Clinical Education, NI Medical and Dental Training Agency. This is another example of the complexity on raising awareness/training on generic issues that cross all social care and health care staff. The Social Services Learning and Development Team have agreed:

- To integrate information on trafficking into existing courses like Safeguarding Children/Adults
- Advanced knowledge likely only applies to those in Gateway Child Care, Gateway Adults Regional SW Emergency Service. These staff will complete the National Referral Mechanism forms. As these forms will soon be electronic and this new process and a refresher on trafficking will be delivered.
- Training for Trainers: The Trust will avail of this training when offered by DoJ. This is for all disciplines and provides information/resources to deliver anything from a video awareness to a Lunch and Learn Sessions (45mins).

Action:

- To ensure that all training material is contemporary and compatible with 2015 and 2016 Policy & Procedures to ensure staff are knowledgeable about roles and responsibilities in adherence to regional requirements.

- To continue to support staff through the quarterly facilitation of practice support groups for staff undertaking the roles of IO, DAPO and Achieving Best Evidence interviews. This ensures that staff are cognisant of the current NIASP strategy and that issues from a staff perspective are understood. It also involves inviting speakers and sharing relevant adult safeguarding research to ensure staff are aware of up-to-date developments related to adult safeguarding.

- To continue to sustain and develop effective relationships with PSNI and Regional Adult Safeguarding trainers in the delivery of the NIASP training strategy.

- To continue to be committed to meet workforce needs in working towards full implementation of the regional policy and procedures. It has been emphasised that these documents are ‘live’ documents’ and therefore it is imperative that staff are kept updated in relation to on-going changes.

- To deliver bespoke training to reorganized POC’s to ensure confidence / competence in relation to screening and thresholds that are compliant with the 2016 Regional Policy and that recording of required forms are of a high quality.

- Several service reorganisations are underway and it is anticipated that these programmes of care will require additional training to develop confidence and

	competence in relation to screening referrals at ASC/Line management level and in relation to quality recording in all APP forms. • Progress raising awareness of Modern Slavery/Human Trafficking. **PREVENTION** **LASP Prevention Group** The focus of the LASP prevention group continues to be compatible with the NIASP strategic plan 2013 -2018. The group meets on a quarterly basis and membership of is derived from voluntary and statutory sectors. The group continues to increase awareness of adult safeguarding to communities through the well-established projects that have been developed and sustained. A review of the Keeping You Safe project was completed in July 2018 and the outcome was that while large numbers received the training the number of active staff delivering the training was low due to a variety of reasons including staff moving to new posts, retiring or leaving the trust. Existing staff attended an update session in July and this was well received and achieved the aim of ensuing that Adult Safeguarding messages are standardised and consistent with current policy. The programme was evaluated positively and is viewed as a very useful resource for service users. This will continue to be delivered across a range of regulated facilities and in all service groups. There continues to be an additional session for new staff who want to deliver this training and this was likewise well attended and evaluated. This is a very important project as it is designed to empower service users to recognize abuse and know who to talk to if concerned. It is imperative that the current staff trained to deliver this programme to service users are supported and encouraged to continue to remain involved. It is equally important that new staff be recruited on a yearly basis to ensure that key adult safeguarding messages are far reaching and that service users are involved as co-facilitators. Towards the end of the last year, the group considered developing a DVD to assist in the delivery of adult safeguarding messages but subsequently decided against this project as a regional one was being developed and there was a risk of duplication. This may be revisited, as the thought process was a DVD to be shown to service users as opposed to staff. The group continues to meet on a quarterly basis and will focus on organizing workshops for ASC's in commissioned services who are now required to complete a yearly return position report. The aim of these workshops will be to establish the level of confidence in relation to completing these forms and will assess understanding of commissioned services understanding of the position report, what are the expectations and what support will they require going forward.
11.9.4	Of those who attended Adult Protection Training, how many staff were from other disciplines or sectors? *(Narrative)* Raising Awareness of abuse amongst staff is one of the most important single measures towards prevention of abuse. During 2018/2019, 20 Level 1 Awareness courses were delivered with 424 staff attending of which 120 were from other disciplines.

	43 Level 1 refresher courses were delivered with 671 staff attending of which 110 were from other disciplines.	
11.10 Leadership and Management Protection		
11.10.1	Investment in Leadership and Management Training	**Accountability 18-19**
11.10.2	Leadership and Management Training Activity	**Accountability 18-19**
11.10.3	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce*. Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the service specific needs of the workforce*. The BHSCT Leadership and Management Framework 2016-19 outlines the ethos and the objectives of the Trust in the next three years. The principles of the Berwick Report (outlined below) provide the platform for the Trust's future direction. ➢ Safety and quality. ➢ Engaging and empowering service users. ➢ Growing and developing staff. ➢ Transparency and accountability. There are a range of learning opportunities for all social services staff including both corporate and bespoke social services courses. For example, ➢ Service Improvement-Change Management; Managing Conflict; Managing People; Coaching Skills for Managers. ➢ Organisational Development. ➢ Leadership and Management-ILM 3 Leadership and Management; ILM 5 Managing for Success; and Living Leadership with Care (a modular 7-day programme over 10months for all Trust Senior Managers). ➢ An in-house 3 days First Line Management Programme for Social Services Managers. ➢ NISCC accredited Diploma in Health Services Management, Managing Effective Practice and Stronger Together. **Action:** Integrating learning and practice: • Three Coaching Sessions are already offered to all newly appointed Team Leaders • In recognition of the support needs of a group of newly appointed Team Managers, the Principal Practitioner is facilitating reflective workshops with the input of the Learning and Development Team. This will continue in 19/20. • The Learning and Development Team will work with Human Resources to consider how best support newly appointed Principal/8a Managers. **ILM Level 4 Certificate in the Principles of Leadership and Management** From the success of last year's pilot a new cohort of 12 learners commenced this level 4 certificate in January 2019. They are due to complete in June 2019. This	

extremely well evaluated programme addresses a gap in a career pathway for Band 5 staff.

Supervision:
Regional Social Work Supervision Course: This course is well established in addition, feedback indicates that learners are reporting increased confidence and knowledge.

The DoH set the following target:
From 2010 all newly, appointed Senior Social Workers/Team Leaders will undertake relevant training in professional supervision and appraisal within two years of appointment.

Year of Appointment	Target date	Number	Achieved
2010-2016	2018	26	26
2017	2019	9	9
2018	2020	11	11

It is apparent that this course is given a priority within the Trust and that newly appointed social work staff are motivated to attend.

Action:
- Continued development and delivery of this course**.**
- The Learning and Development Manager alongside other Trust staff are members of a Regional Supervision Group that is contributing to the review of the Regional Supervision Policies.

Coaching:
Coaching plays a key role in the Trust Leadership and Management Strategy, is integral to '*Putting Improvement at the Heart of Social Work'* and is acknowledged as a key component in non-formal learning. Two of the Learning and Development Team accredited at ILM 5 Coaching continue to offer coaching to all newly appointed managers and other staff who make a particular request. Those avail of the service provide positive feedback and it is an additional support to staff when they are transitioning to a new role.

Action:
- The DoH have funded an eight-day Coaching Course for six residential staff. It commenced in March and will continue until May. This compliments work with Deputies and Managers that was referenced in 11.3 that encourages these staff to use supervision, Post Crisis Response and other opportunities to embed learning into practice.

Co-Production Learning & Development Team:
The team continues to support the development of the Co-production Learning and Development Team to build capacity, competence and confidence in the design and delivery of training in Adult Services. The group are becoming increasingly confident as co-designers and co-facilitators, delivering on course content and developing initiatives namely:-
- continued input into SDS, Recovery College sessions, vocational training
- input into the Regional Social Work and Communities programme

- Participation in local and regional implementation and planning groups (Belfast LEP, SDS Implementation Group and SDS Project Board).

Action for 2019-2020:
- Continued input into learning and development programmes (SDS, Recovery College, Quality Improvement Awareness).
- Continued support from learning and development staff – bi-monthly meetings
- Participation in a "Learning and Development PATH to explore the vision for Co-production within Adults and Children's Services and agree an action plan – June 2019.

Improving and Safeguarding Social Wellbeing a Strategy for Social Work 2012-2022 – Belfast Local Engagement Partnership:
The Learning and Development Service continues to provide ongoing support to the Belfast Local Engagement Partnership (LEP) and Stage 2 of the Social Work Strategy, with the focus on "*Putting Improvement at the Heart of Social Work"* with key priorities: Leadership; Improvement; Outcomes and Co-production. Membership of the LEP has been "*open"* and widely drawn from the BHSCT, voluntary, and community sectors including education and criminal justice. This has included Social Work reps, PPI representation, Service Users and Carers.

The Belfast LEP has 2 Co-chairs, Dave Milliken, person with lived experience and Avery Bowser, Action for Children.

The LEP activity has included:
- Participation in the Regional review of Local Engagement Partnerships and stage 2 of the SW Strategy
- Bi-monthly LEP steering group meetings
- Organisation and facilitation of a series of LEP events including; Co-production Café; Power to People and social care reform event; Outcomes in social work event.

Action 2019-2020:
- Organisation of a series of events on the theme; "Dust of your documents", to showcase policy/practice for Social Work this will include; an event on the report; *'Black and Minority Ethnic Communities: The Health and Wellbeing of Older People in Belfast' and will include input from a project to increase the uptake of SDS in the Chinese Community and an event of the OSS "Anti-Poverty Framework linking this with community development for social work.*
- The LEP recognises the need to get more front line Social Workers at Trust level involved in the group and need to promote on Belfast Trust HUB; Social Work Forums, etc.

Quality and Social Work/Social Care:
The Social Work Strategy has identified improvement and quality as the template for social work professional development. It has outlined a vision and related goals and outcomes that profile the pivotal importance of innovation, co-production and a relentless pursuit of improvement and quality as the foundations for service delivery.

	The Learning and Development Manager is a member of the Steering Group for the Regional Social Work QI Course and 5the BHSCT QI Training Sub Group. At present social work/care staff can access: • Quality Improvement Level 1 via E-Learning or a Corporate Course. • Quality Improvement Level 1 for Social Work/Social Care delivered by the Learning and development Team • Quality Improvement Level 2: The Regional Social Work Quality Improvement Course alongside a similar BHSCT Quality Improvement course provides the relevant learning opportunities.. • The QI Staying Connected Forum also provides a vehicle for QI Level 2 students to continue their learning. • The Regional Social Work QI Group continues to provide support and education for those who are mentoring staff on the Level 2 Course. It is recognizes that they are also at the beginning of their learning journey and that they need additional teaching on improvement science and coaching skills specific to QI. **Achievements**: • In June 2018, the Regional Social Work QI Steering Group collaborated to host a QI Conference that focused on improvement within social work and social care. This launched the SCIE QI Webpage. • The Trust have funded one manager for a short duration to lead on QI across the Adult and Children's Directorate. The initial focus is develop thinking and systems on data collation and measurement. • The Level 1 Course that is for social care/work staff only was enhanced this year by working with a service user who has an interest in QI. The course is now co- produced with practice and discussions relevant to the audience's daily work. • The Trust have sponsored three social work staff to complete the Scottish Leadership and QI Course **Action:** • In 19/20, the DoH have funded six places on the Scottish Leadership and QI Course for residential services. This is an opportunity for social work to continue to build on existing QI foundations. • The Learning and Development Team will continue to mentor and support candidates on the Regional Social Work Course. There is increasing engagement in social work/social care with Quality Improvement but the ownership and integration of Quality Improvement is still at an early stage. While this role *'is everyone's business'* there needs to be space and time to focus on service improvement. **Research:** The Trust strive to implement the Social Work Research and Continuous Improvement Strategy 2015-20 by promoting a culture of evidence informed practice to enhance outcomes for service users. **Achievements:** The Trust promote research under the banner of Resilience Through Evidence Informed Practice. The concept is to share the wealth of research and projects generated by candidate participation across the spectrum of programmes within the PiP Framework. This is a collaborative venture,

	working in partnership with SEHSCT and QUB. Three events were hosted with 175 social workers and social work students in attendance. In November, in partnership with SEHSCT and UU, a workshop was hosted with Professor Jill Manthorpe, Kings College London. Twenty practitioners attended, exploring current Adult Safeguarding practice. **Dissemination of Research via PiP Courses:** The HSC Library participate in workshops to raise awareness of PiP and staff are encouraged to join the library. While undertaking PiP Accredited Courses candidates are required to demonstrate competence in understanding research, and to facilitate a presentation to their team. This ensures the dissemination of learning. For example in the Adult Safeguarding Course, participants presented to eighty-four social work staff. The presenters then went on to deliver these presentations to a wider audience in Social Work and Adult Safeguarding Forums. **Evidence Informed Practice and Research Methods:** The Trust continue to recruit very small number of staff to this course. The Learning and Development support and mentor a Service User's participation in the course. **Challenges:** The Assistant Director for Governance and Learning and Development work with the HSCB to identify appropriate research that will support the work of social workers. This is a challenge as often the interests of the researcher and the employer are not in tandem. It is, acknowledged that other health colleagues have been more research minded and that social work/care needed to be more research active in the workplace. The ethos of social work/care leading research in their own field is an important goal but it may not be achieved unless there is specific funding that can periodically release staff. The final year of the strategy will provide an opportunity to reflect on our journey. **Action:** • The Trust plan to continue with the above work in 19/20. . **Concluding Remarks:** An emerging theme is that this category is increasingly being utilised to resource developments emerging from the Social Work Strategy. Research, coaching and quality improvement are examples of practice developments which have been resourced through funding for this section. **Funding:** The funding in this category has a slight overspend.	
11.11 Programme Support		
11.11.1	Programme Support Expenditure	**Accountability 18-19**
11.11.2	Commentary. *Trust should include reasons for over or under spend within the financial year and specifically comment on whether the proposed expenditure was adequate to meet the demands of training provision for the workforce*. The expenditure in this section funds administration costs of the Learning and development Service.	

11.12 ACPC		
11.12.1	Investment in ACPC Training	**Accountability 18-19**
11.12.2	ACPC Training Activity	**Accountability 18-19**
11.12.3	Commentary. *Trust should include reasons for over or under spend within the financial year and include any training activity undertaken in addition to other support activity such as an ACPC trainer*. Commentary. *Trust should include reasons for over or under spend within the financial year and include any training activity undertaken in addition to other support activity such as an ACPC trainer*. The Belfast Keeping Safe Initiative is a partnership of key voluntary, community, statutory and public sector organisations in Belfast, which all have a remit and responsibility for safeguarding children and training. The Initiative was set up in 1999 to meet the increasing demand for training on good practice in safeguarding children and young people. **Keeping Children Safe training** is a suite of modules which gives participants the opportunity to explore the current and relevant issues in safeguarding children including legislation, statistics and good practice. Participants will learn through a variety of methods-presentations, group work, scenarios and case studies. The importance of creating safe spaces for children and young people remain a key safeguarding priority. Volunteer Now continues to play a central role in supporting the initiative by producing standardised training materials, provide '*Training Trainers'* programmes and quality assurance.. This year 38 accredited trainers delivered a range of 64 Keeping Safe Courses to 997 volunteers/staff. The organisations are wide and varied including Sure Starts, Church Groups, Brass/Flute Bands, Community Forums/Centres and the Donkey Sanctuary. Training sessions are becoming more diverse in terms of ethnicity of participants, including Belfast Islamic Community, Indian Women's Group, Polish Education and Cultural Association, Chinese Welfare Community Association, NI Nigerian Community Association and Polish Cultural Association (POLCA). Many of these sessions rely on the support of the Interpreting Service. This activity is based on agencies and volunteers gifting this training time. The Trainer's Group are keen to meet and continue to develop their knowledge and there are now quarterly meetings that will enhance their development. The Trainer's practice is monitored/quality assured annually by reviewing course evaluations and every three years by an observation of a training course. This year the Trust supported three staff from the community/voluntary sector to complete a Trainers For Trainer Course thus continuing to build capacity to deliver this Project.	

	The Keeping Safe training courses remain in high demand and are positively evaluated by participants. **Challenges:** Volunteer Now continues to face ongoing financial challenges and due to ministerial changes and no local government, their funding is not guaranteed. This is precarious for a small organisation. **Action:** • The Trust will continue to support this worthwhile project.	
11.13 Additional Allocations		
11.13.1	Investment in other Training Activity/Initiatives	**Accountability 18-19**
11.13.2	Other Training Activity	**Accountability 18-19**
11.13.3	Commentary. *Trust should include comment on each additional allocation individually including those allocations for regional initiatives or schemes and in-year additional allocations*. The Belfast Trust manage three PiP Courses on behalf of the five Trusts and there were challenges in managing this budget in 18/19 with an overspend. As already indicated in discussions on PiP in 11.3.3 there are concerns about the accuracy of PiP funding. **Action:** • The HSCB and Trusts will need to review this allocation. • Review and benchmark the costs allocated to Course Co-ordinators. **<u>Approved Social Work Course</u>:** The primary purpose of the NI Approved Social Work Training Programme is to ensure the competence of social workers being considered for appointment as Approved Social Workers (ASWs) by their employing Health and Social Care Trust. • Funding allocation of £100,000. • Actual Expenditure £117,519. Fees to QUB are approximately £65,000 and costs of a Residential at £4,860 account for the majority of the expenditure. While QUB provide a small discount on fees, it is not equal to the 60% reduction provided by UU. **ASW Training Programme Activity:-** 22 candidates commenced training in September 2018 **Action 2019–2020:** - The ASW Coordinator has given her intention to step down from this position. Given the uncertain nature of the Programme with the implementation of the Mental Capacity Act the Joint Management Group have reviewed the Job Specification for this role and intend to recruit this position on a temporary basis for one year and then review. - With the impending introduction of the Mental Capacity Act consideration needs to be given to the training needs of the ASW staff group and the wider social care workforce to ensure they are competent and prepared for implementing the new legislation and codes of practice	

Practice Teacher Award:

- Allocation: 40,000
- Actual Expenditure: £40,306

There are 34 candidates currently on the programme.

Adult Safeguarding Programme:

- Allocation £30,000
- Actual Expenditure: £30,000

The Adult Safeguarding Programme was delivered through 3 taught modules in June and September 2018 and January 2019. There are currently 41 candidates registered with the programme.

The programme continues to attract Regional applications with staff at varying stages of completing the Full Award.

The Programme Co-ordinator has invested a huge amount of personal time and commitment in the programme and has been instrumental in its growth and development.

The Adult Safeguarding Programme continues to be positively evaluated by candidates and external verifiers
There are many additional challenges facing the safeguarding agenda at this time. This year two large-scale investigations have placed a renewed focus on how we all safeguard adults. In addition, social work staff must be mindful of other aspects of safeguarding such as modern slavery, trafficking and forced marriage and domestic violence. Safeguarding Adults involves nuanced judgements and often many aspects of safeguarding are both intractable and enduring. This modular course provides an opportunity for staff to build on their existing strong practice to further build on their knowledge and skills to respond to the complexity of this work. Those who complete the programme comment on how it has increased their confidence in their work.

Course Applications: This is a modular course providing the opportunity for busy practitioners to pace their study commitments. The following provides an overview of the uptake of the course in the last three years.

- 2016/17 ----41 Modules
- 2017/18-----41 Modules
- 2018/19-----53 Modules (BHSCT 25 modules, NHSCT 11 modules, SEHSCT 13 modules and SHSCT 3 modules.)

While the above data indicates that this course is viable and that there is a market. An analysis of this data shows that there is a variation between Trusts in the numbers of staff that they sponsor. This year the variation is quite stark with BHSCT having significant participation level than other Trusts. This may well be explained by the dedication and enthusiasm of the Adult Safeguarding Co-ordinator who works within BHSCT however, this is an opportune time to remind other Trusts of how this course can contribute to developing a highly skilled and confident workforce.

Safeguarding Adult Programme contributing to quality assurance and governance. The course provides a benchmark for employers to develop effective and competent workforce with the arena of Adult Safeguarding. Employers can promote this course among staff where this is their core business and perhaps an expectation that those in Senior Practitioners complete the programme.

Action: HSCB, the Directors of Social Work and the Directors of Adult Services consider the merits in this course as providing a platform to continue to develop evidence based and skilled practice within Adult Safeguarding.

REGIONAL ALLOCATION FOR SENSORY SERVICES TRAINING

The Social Services Regional Training Managers identified Ann Purse, Belfast Trust to link with the Regional Sensory Network to manage these additional monies on behalf of the region. The Sensory Network identified their training priorities and Belfast Trust has coordinated learning and development opportunities and managed this funding in conjunction with the Regional Sensory Networks Training sub-group. Belfast Trust has also provided administration support in respect of the organisation of venues, catering, and travel and accommodation costs. Belfast Trust has regularly provided updates on this learning and development activity at the Regional Training Managers Meetings.

Funding allocation: £4,592

This funding enabled Trusts to support qualified visual rehabilitation staff to complete an online single module offered by Birmingham University on Dementia and Mental Health. Funding secured 7 places on this course, which ran over 12 weeks.

Outcomes: 5 staff who completed this course have reported an improved understanding, and new strategies to engage people with mental health or dementia within the role or rehabilitation.

Funding allocation: £15,340

This funding met the following training priorities/requests:

• University of Birmingham Mentor Training Day	£ 900
• Regional Sensory Support Team Training Day	£1,300
• Group Work Training – facilitated by Jarleth Benson	£3,000
• BSL Level 2	£4,140
• Macular Society – Skills for Seeing	£6,000
TOTAL	**£15,340**

Outcomes:

University of Birmingham Mentor Training Day :

2 Rehabilitation workers attended this training in Birmingham. This enabled them to act as mentors to trainee rehabilitation workers, to help them understand their role and responsibilities in supporting them to achieve their qualification and to practice safely and to the required standard.

Regional Sensory Support Team Training Day:

To provide regional training to staff from all 5 Trusts regarding CVI process, audiology, auditory implant centre and round table reflective discussion. 90 multi-disciplinary staff attended this full day training and addressed the workforce

	training needs of the Regional Strategy building the capacity and skills of the workforce. Group Work Training – facilitated by Jarleth Benson: This 2 day training plus follow up supervision was designed to meet the specific needs of sensory support staff. A total of 15 places were available. Macular Society – Skills for Seeing: To teach and further develop the skills of eccentric viewing for visually impaired people. 21 staff attended this training – there were numerous practical sessions to demonstrate the learning that was achieved. Participants were provided with a Toolkit. BSL Level 2: Funding has enabled 8 staff to attend a 32-week course that was interactive, used modern teaching techniques to support staff to learn vital communication skills and expand their vocabulary to work directly with the deaf community in their own language at a more advanced communication level. **Action 2019/2020:** The Regional Sensory Network training sub-group have identified training priorities for 2019/2020. It has been agreed by the Regional Training Managers that Belfast Trust will continue to coordinate and manage any funding working closely with the training sub-group. A training plan is currently being finalised and a proposal will be submitted for funding for next financial year. **PHYSICAL & SENSORY DISABILITY AWARENESS TRAINING** **Funding allocation £7,000 – in year allocation to BHSCT** To meet the workforce training needs in relation to the Regional Strategy Provision of a range of training included: • BSL Level 1& Level 1 Refresher Training • Virtual Dementia Bus Training This funding has increased the workforce capacity in terms of qualification attainment and the development of specialist skills. **BELFAST LOCAL ENGAGEMENT PARTNERSHIP** **Funding allocation - £1,150** To cover cost of venue, catering and facilitator for a LEP event on 8th March focusing on Outcomes in Social Work. Facilitated by Dr Helga Sneddon of Outcomes Imps.
General	
11.14	This has been left blank intentionally
11.15	How many attendees at in-service training were from other disciples within Trust or from external providers? (including voluntary, community and commercial organizations) Where does this most commonly occur? ***(Narrative)***

	The multi-disciplinary and other sector attendance has already been addressed within the main body of the report. Safeguarding Adults and Safeguarding Children are the two courses, which are in high demand from other disciplines and agencies. As already highlighted the Social Services Learning and Development Service resource cannot respond to the demand for mandatory training for 22,000 staff plus external requests.
11.16	Describe the mechanism(s) by which the Trust ensures staff attendance at Training courses and; how appropriate staff can meet the PRTL requirements set by the Northern Ireland Social Care Council. *(**Narrative**)* **Staff Attendance at Courses:** Essentially ensuring that we have the '*right staff*' on the '*right course'* is one way of ensuring that the Service effectively use of resources. In relation to short courses the Administration Team pay attention to whether applicants meet the criteria and the Service has adopted an over booking approach as inevitably there will be a percentage of Did Not Attend (DNAs). Staff vacancies/workload pressures have contributed to a high DNAs and the cancellation of some courses.. Courses that require a more significant period of study, for example the accredited PIP Courses will have a more rigorous application process where written Line Management Support is sought or interviews to establish suitability of candidates are held. Notwithstanding these processes, candidates may have to defer or withdraw from these commitments. Work demands can escalate within a Team. There are currently significant workforce pressures across all service delivery settings. Within a largely female workforce, the demands of childcare and other caring roles generate significant additional pressures for those staff engaged in both accredited and one-off training courses. **Mechanisms to ensure staff meet their NISCC PRTL requirements:** The Trust's Staff Development Review Framework provides an organisational vehicle to deliver annual appraisal and learning and development reviews. On an annual basis with a mid-point review, staff and line manager identify how they will contribute to the Trust's strategic objectives as outlined in the Corporate Plan and the local Service and Team Plans including PRTL requirements for registrants. The Learning and Development Service provide bespoke supports to staff identified by NISCC for inclusion in their randomised audit of PRTL compliance. The opportunity to evidence compliance via the PiP Credit Accumulation route has been a welcome innovation reinforcing in a practical sense the value of engaging in accredited learning.
11.17	Identify key achievements or awards within the Trust, which specifically support the delivery of the PSS Training and Development Strategy 2006-16. *(**Narrative**)* See Analysis of Data 7 Report that outlines the Trust's achievement in the identified DOH targets in Appendix 1.

11.18	Describe any activities, which have been undertaken in the reporting period to evaluate the impact of training on service delivery and improvement within the Trust. Trusts should comment on outcomes of such activities where applicable. *(**Narrative**). Examples may include audits and evaluations undertaken* The Trust has an Evaluation Framework for Learning and Development based on Kirkpatrick's Model of Evaluation. • **Reaction:** Exit Questionnaires are completed. • **Learning:** Monitored/Evaluated for example through feedback from managers, outcomes of accredited courses participation in audit of casework. • **Behaviour:** Staff completing AYE, RQF and other accredited courses requires live observation of practice and reflection in practice. • **Return on Investment:** This is always more of a challenge to identify however; the Keeping Safe Project is undoubtedly a good example of efficient use of resources that builds capacity in the Trust/Voluntary and Community Sector. **Challenges:** Evaluating the Effectiveness of learning is a challenge. In a complex organisations change is constant and multi-faceted and it is difficult to draw direct correlations between training and outcomes. In addition, it is difficult to measure the non- formal methods of learning purported by the 70-20-10 model. Another drawback is that focusing on the changes in behavior/results is the most useful information and this is time consuming, resource intensive and expensive to implement. **Action:** • The Learning and Improvement Strategy for Social Work and Social Care 2019-27 identifies the importance of evaluating the impact of learning and commits to designing new methods. The Trust will work with the DoH and HSCB to achieve this priority.
11.19	*This has been left blank intentionally*

APPENDIX C

Belfast Health and Social Care Trust
caring supporting improving together

Belfast Local Adult Safeguarding Partnership (LASP)

Annual Report 2018/2019

CONTENTS

SECTION 1: Overview

The Belfast Health and Social Care Trust is committed to promoting the health, well-being and protection of all adults in receipt of its services across the spectrum of its universal and specialist provision including domicilliary and day care services, 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 annual LASP work plan is reviewed under the three core themes contained in Adult Safeguarding Prevention and Protection in Partnership (2015).

The report includes an update from each Trust service area in relation to adult safeguarding, with each service area detailing challenges, achievements and activity levels.

LASP partner organisations are also provided with an opportunity to detail adult safeguarding work undertaken within their organisation during the reporting year.

SECTION 2: Work plan for Reporting Period

Achievements and Challenges

PROTECTION

Adult Safeguarding Structures within the Belfast Trust

Currently within the Belfast Trust each service area have their own separate arrangements in place for delivery of adult safeguarding. While these service area arrangements have been effectively delivering on adult safeguarding work for a number of years, it had been agreed that the current structures would be amended to reflect the requirements of the Prevention and Protection in Partnership Policy 2015. The Department of Health (DOH) Policy details the structures required within Trusts in terms of a single Adult Protection Gateway Service.

The Trust took the decision to develop a single Adult Protection Gateway Service and
remains committed to delivering on this objective. This work has been delayed due to other operational priorities but the Trust remain committed to developing a Trust wide Adult Protection Gateway Service.

Work in relation to the development of this new Adult Protection Gateway Service will be progressed by the Trust Adult Safeguarding Specialist (TASS) and the three divisional social workers for each service area.

<u>Adult at Risk of Harm work</u>

The Trust recognise the importance of ensuring that there are robust arrangements in place in response to adults at risk of harm when the threshold for an adult protection investigation has not been met. The need for professional risk assessment/risk management strategies and alternative safeguarding responses is recognised as pivotal to the safety and welfare of this group of service users. There is also a need to ensure that effective governance and monitoring arrangements are in place for adults at risk of harm. As detailed in the Older Peoples Core team service area report, work is currently underway to develop the necessary tools to ensure that this important area of work is appropriately and effectively addressed.

<u>Role of the Adult Safeguarding Champion (ASC)</u>

The Belfast Trust ASC is accountable to the Executive Director of Social Work for the discharge of their role. Given the size of the Trust, the ASC role has been delegated down through the current reporting structures, with first line managers being responsible for the operational delivery of the role. Within social work, many of these line managers are already trained DAPOs and are therefore very familiar with the ASC role and where this fits within the wider adult safeguarding structures and reporting arrangements.

Adult safeguarding training for line managers has been amended to ensure staff are fully briefed on the ASC role and responsibilities. There is a need for widespread training of line managers to ensure that they are fully briefed on their role as ASCs but given limited resources this is currently being managed on a phased basis. In the interim any adult safeguarding referrals received by a DAPO not meeting the threshold for an adult protection investigation will result in advice being given regarding the need for a professional assessment and alternative safeguarding response.

RQIA inspection in Hospital Outpatient Departments across the region

An RQIA inspection of Outpatient Departments in hospital settings identified a lack of knowledge among staff (medical and nursing) in relation to adult and child safeguarding. The Belfast Trust drafted an action plan in response to issues identified. This action plan included a number of actions. Of particular note are proposals to develop a new Adult Safeguarding Nurse Specialist post similar to the current Specialist Nurse Child Protection posts. It is anticipated that this will help ensure adult safeguarding is embedded in the acute sector. Job descriptions are currently being drafted

Regional Joint Protocol

The primary aim of the regional Joint Protocol 2016 is to ensure that adults at risk of harm who have experienced harm which constitutes a criminal offence have equal access to the justice system. The Protocol further seeks to promote a rights based approach in relation to the individual's views and wishes. In this reporting period Trust adult safeguarding staff continue to view as positive the limited discretion within the Protocol which facilitates a sensitive and proportionate response. Trust staff have, however, also continued to report instances when there are differences between PSNI and Trust in relation to the interpretation and scope of the Protocol. The Protocol includes a process of escalation where there is a difference of opinion between Trust and PSNI and this has been used appropriately and effectively.

A review of the Joint protocol is ongoing and practice issues identified are being addressed within the review process. The working group taking forward this review includes representatives from Trusts and PSNI. RQIA, as co-signatories to the Joint Protocol, have also provided an input into this review. The review had been put on temporary hold at PSNI's request and was further delayed as a result of the Belfast TASS sick leave. The working group have reconvened and held a two-day workshop in Garnerville. It is hoped that a first draft of the revised Joint Protocol will be available for consultation in June/July 2019.

Scamwise

Scamwise Northern Ireland Partnership have produced the fourth edition of the 'Little Book of Big Scams' and have shared these books with Trusts for onward circulation. The Trust welcomes the opportunity to assist with this very significant area of financial abuse.

PSNI are also in their second year of a rolling programme to raise awareness of financial abuse and in particular scams. Year one focused on training Trust domiciliary care workers in order to heighten their awareness of potential scams, so that they could assist vulnerable service users in early identification and scam avoidance. Now in year two the Trust are working with relevant PSNI scam prevention officers to facilitate training of independent sector domiciliary care staff. Feedback from Trust staff in year one was very positive and it is anticipated that this success will be mirrored in year two.

COPNI Report and Independent Review commissioned by Department of Health

The COPNI report Home Truths and the issues of concern highlighted within this report have formed the basis of an action plan at regional and local Belfast Trust level. Belfast Trust have participated fully in regional meetings to discuss and address issues raised and have also been looking at Trust practice at a local level.

The Trust have welcomed the independent review commissioned by DOH and have met with the Independent Review Panel to discuss its role in relation to Dunmurry Manor.

More recently DOH notified each Trust to submit an anonymised list of all adult safeguarding referrals commenced in nursing homes during the period 01.03.17.-28.02.19. They subsequently clarified that this list should include nursing, residential and supported living. Trusts were advised that CPEA would be conducting an audit in relation to 50 files which would be randomly selected from the list submitted. Belfast Trust have submitted lists as per DOH requirement and await clarification on files submitted for audit.
In addition, on 12 March 2019 the CPEA independent review team held a working session for social work practitioners involved in adult safeguarding cases in Dunmurry Manor Nursing Home. Each Trust was asked to nominate 8 practitioner staff to attend this event. Belfast Trust practitioners in attendance at this session reported that it provided a useful opportunity to reflect on practice and consider areas for improvement.

The current culture is one of openness, reflection and learning and the Belfast Trust have embraced opportunities to reflect on current practice.

Belfast Trust Learning and Reflection Workshop

The Trust Adult Safeguarding Champion organised a Belfast Trust adult safeguarding workshop with a focus on reflection and learning. Margaret Flynn facilitated this workshop, which was well attended by adult safeguarding staff across all programmes of care. Members of the Trust collective leadership teams also attended, as did senior consultants and senior nurse colleagues. Margaret Flynn shared with the group the themes and issues that had emerged from her extensive portfolio of conducting high-profile reviews such as Winterbourne View and Operation Jasmine. The themes and initial learning from her review in relation to Muckamore Abbey Hospital were also discussed and she touched on some of the initial learning from the COPNI and DOH

independent review in relation to Dunmurry Manor. The workshop was very interactive and allowed for a reflective discussion on adult safeguarding experience and practice within the Belfast Trust. The work from this session will inform Belfast Trust adult safeguarding practice going forward.

Pressure Ulcers within an Adult Safeguarding Context

HSCB and PHA gave a commitment to develop a regional Safeguarding Adults Protocol in relation to the interface between pressure ulcers and adult safeguarding. A regional working group was established and the Belfast TASS contributed to this by convening a regional meeting to look specifically at the threshold/criteria for referral of pressure ulcers into an adult protection process. Specifically the group were tasked with looking at the Department of Health (DOH) England 'Safeguarding Adults Protocol - Pressure Ulcers and the Interface with a Safeguarding Enquiry' (January 2018), to consider whether this would meet the needs in a Northern Ireland context. This group drafted initial views and this work helped inform a regional workshop on 10th October 2018. HSCB and PHA have since drafted a guidance document in relation to the management of pressure ulcers and this is currently out for consultation.

The Belfast Trust Adult Protection Gateway Team have previously made referrals to police under Article 121 of the Mental Health Act in relation to potential wilful neglect. As noted in the APGT service area report, the Public Prosecution Service have taken the decision in one case to refer to PHA. The Belfast Trust welcomes plans to reach a regionally agreed position in terms of the interface between adult safeguarding and pressure ulcers.

Capacity Assessments

In April 2019 the Trust received confirmation from the Royal College of Psychiatrists NI that a decision had been taken that Financial Capacity Assessments would not form part of core NHS work for Consultant Psychiatrists. The view taken was that financial capacity assessments can often be complex, requiring the obtaining and assimilation of much information in addition to detailed clinical assessments. The decision to deem a Patient incapable of managing their financial affairs can have far reaching consequences. In addition, there may be a perceived conflict of interest in cases where the Trust has asked for a Financial Capacity Assessment and a Psychiatrist is acting as an officer of that Trust.

The consensus view from the Royal College of Psychiatrists is that Financial Capacity Assessments are not part of core NHS work for Consultant Psychiatrists; rather they are special medico legal or category 2 work. As such, our opinion is that Consultant Psychiatrists are not obliged to carry out this work as part of their job plans. The only exception to this is when a Patient is detained as an inpatient under the Mental Health (NI) Order 1986, when a Consultant acting as RMO may carry out a Financial Capacity Assessment if necessary as part of that Patient's care. There may be other exceptional clinical circumstances when a Consultant may conduct a Financial Capacity Assessment in cases of immediate clinical need.

Trusts were advised of the need to make alternative provisions for these assessments. This will have significant implications for the Trust and for Adult Safeguarding in terms of financial abuse allegations. While the number of Trust assessments privately funded is currently quite low, it is anticipated as a result of this notification there will be a need for the Trust and Adult Safeguarding to be clear regarding arrangements in place going forward.

The issue of capacity to consent to and/or contribute to a police investigation is an important element of Adult Protection work and Joint Protocol. To date the Trust have provided these assessments when required and occasionally have needed to fund these privately. Police are of the view that Trusts are best placed to provide these assessments. In light of the Royal College of Psychiatrists' position in relation to financial capacity assessments, there will be a need to clarify their position in relation to capacity assessments for Joint Protocol.

Complex Investigations

Central to the work of Adult Protection is the management and co-ordination of complex investigations, many of which relate to large scale investigations in regulated services. These investigation are resource and time intensive and are managed within the context of competing priorities. The multi-agency nature of many of these large scale investigations, along with issues associated with working across Trust boundaries, can be challenging. For the agencies who have staff subject to investigation, protection plans can also be resource intensive. As detailed in the Learning Disability service area report, the Muckamore Abbey Hospital adult protection investigation is ongoing. The work involved in this investigation is critical to the safety and welfare of the patients and is a key priority for the Belfast Trust.

Adult Safeguarding / Adult Protection Funding

The Trust welcomes the additional funding provided in relation to adult safeguarding work.

The non-recurrent funding of £39,400 was utilised to help fund the Muckamore Abbey Hospital adult protection investigation. It is important to note that this investigation is very time and resource intensive. Funding of this investigation and any subsequent investigations of this scale will require ring-fenced funding from DOH.

The recurrent funding of £112,000 is also welcomed and the Trust are currently considering how best to utilise this additional funding. There are competing priorities for this funding, as each service area could benefit from additional DAPOs to support their work in complex adult protection investigations.

The Trust had in previous reports highlighted the need for additional funding in relation to adult safeguarding training and delivery of adult safeguarding training continues to be a challenge for the Trust.

Data Returns

The Belfast Trust continue to collate HSCB monthly data returns manually and as in previous years this has proved challenging. Priority is understandably given to casework and this has resulted in collation of information being a secondary consideration. The Trust continue to struggle to ensure accuracy in collation of information and to avoid duplication in terms of statistical returns. The new HSCB reporting template was implemented in October 2018 and is currently subject to regional review. It continues to be the aim of Belfast Trust to ensure that the new Adult Safeguarding Module on Paris will provide the necessary statistical collation. Work in relation to this is ongoing.

PARTNERSHIP

Belfast LASP

The Belfast LASP normally meet quarterly but due to TASS extended sick leave, only three meetings were held within this reporting period. Attendance at LASP meetings has fluctuated this year, in part due to changes in named LASP representatives for partner organisations.

The LASP work plan for 2018-19 has also been impacted by TASS sick leave and TASS operational pressures associated with work in Muckamore and back-fill in the Adult Protection Gateway Team. There is a need to re-energise Belfast LASP in terms of membership, focus and an achievable work plan for 2019-20, which is inclusive of the aims and objectives set by NIASP and by LASP members.

Policing & Community Safety Partnership (PCSP)

The TASS continues to represent adult safeguarding on the South Belfast PCSP. Adult safeguarding continues to be an established area of work in terms of the PCSP Action Plan. There is currently a project in South Belfast - Growing Older Growing Safer, which aims to increase the safety of older people in South Belfast with access to prevention, early intervention and protection. The project supports community guardians who will provide support and information to organisations and individuals with regard to keeping themselves safe.

On 7 March 2019 the PCSP held a community event for seniors in the Finaghy Road area of Belfast. A local councillor and the Lord Mayor were in attendance. This event included a number of information stalls, one of which was a Trust-manned stall providing information on adult safeguarding, local Trust services and self-directed support. The event was well-attended and feedback received on the day was positive.

NIASP

The TASS continues to represent Belfast Trust at a regional level on NIASP. TASS attendance at NIASP facilitates the sharing of information from NIASP to LASP. LASP members view this as a key positive as it ensures they are kept updated on regional issues and regional developments.

Human Trafficking

In November 2018 Trusts were issued with an updated version of the Working Arrangements for the Welfare and Protection of Adult Victims and Potential Victims of Human Trafficking & Modern Slavery. This guidance document was jointly issued by DOJ, Police and HSCB and had been developed in discussion with DOH. As the NIASP representative on the DOJ Engagement Group, the Belfast TASS has been working with the Modern Slavery Strategic Training & Data Coordinator in the Protection & Organised Crime Division / Modern Slavery & Human Trafficking Unit, to look at raising awareness of the guidance document and the role of Trusts. An initial information session has taken place

with the regional TASSs and work is planned with the regional training group. It is anticipated that bespoke training for key staff will be devised. The conduit for taking forward this work is that it will fall within the remit of adult safeguarding. The Belfast TASS and the South Eastern Trust TASS are currently working on a proposal in relation to a Trust internal referral pathway.

Domestic & Sexual Violence and Abuse Partnership / MARAC

Trust Adult Safeguarding are represented on the Belfast Area Domestic & Sexual Violence & Abuse Partnership by the TASS. Attendance at meetings has been problematic due to sick leave and competing operational priorities. That said, there is relevant communication with the Chair of the Partnership. The TASS had chaired the MARAC work-stream but this had been put on hold following changes at regional level, which included the MARAC Operational Group being disbanded. It is understood that a new strategic MARAC Operational Board has been established with Terms of Reference and objectives set. The Belfast MARAC will reconvene to ensure delivery of regionally agreed objectives.

<u>Domestic Violence & Abuse Disclosure Scheme</u>

The Domestic Violence & Abuse Disclosure Scheme, launched in March 2018, continues to function following MARAC meetings. Issues around information sharing and the decision making forum continue to present challenges.

PREVENTION

Adult Safeguarding Training

The BHSCT delivers the 5 levels of Adult Safeguarding training as outlined in the NIASP Training Strategy and Framework (revised 2016). These 5 levels are designed to equip staff of different bands develop the knowledge and skills commensurate with their job role and experience to support adults in need of protection and to promote staff confidence and competence in effectively carrying out their adult safeguarding role. The Training Strategy is compatible with the Adult Safeguarding Policy 2015, Regional Operational Procedures, 2016 and the Joint Protocol, and all training materials are designed to raise standards, promote best practice and ensure consistent and proportionate responses to safeguarding issues. Training is provided for all levels and our specialist Investigating Officer/Designated Adult Protection Officer and Joint Protocol Trained staff are supported through quarterly support group workshops.

This year the Learning & Development service has continued to deliver to social work and social care staff and due to the high level of demand from other programmes of care, we reserve a number of places for any Belfast Trust employee whose primary role is work with adults. There continues to be requests from many different service areas and we have delivered some bespoke training to try to meet these demands. Lifeline staff became Belfast Trust employees and they received bespoke level 1 adult safeguarding training. Other examples include Estate services and Palliative Care staff. However, there remains concern that we continually have to turn down requests and in this last year, in particular from medical staff including staff from the GUM clinic, Geriatric services, psychiatry, nursing and OT services. While they access a limited number of places on the awareness raising courses concern remains that they do not appear to have access to Adult safeguarding training for the numbers required. This in turn highlights the potential that the implementation of the Regional Operational Procedures and Joint Protocol is not standardised across these different service areas.

There continues to be a high demand for Level 1 Adult Safeguarding awareness raising and mandatory refresher courses. The RQIA requirement for the social care workforce to attend Awareness Raising training is the primary driver supporting compliance. The requests for bespoke training for these service areas is considerable. The Learning & Development team continue to respond to requests for bespoke training. For example, this year we delivered bespoke awareness raising training to new staff in the Mental Health Assessment teams and a 2 day bespoke training for both investigating officers and designated adult protection officers within the mental health POC. A further example was 2 sessions in Muckamore Abbey regarding quality recording in the Adult Protection referral forms.

Several programmes of care are continuing to undergo reorganisation and it is anticipated that these programmes of care will require additional training to develop confidence and competence in relation to screening referrals at

ASC/Line management level and in relation to quality recording in all APP forms. This will have an impact on resources within the training team.

Action 2019 – 2020:

- To ensure that all training material is contemporary and compatible with 2015 and 2016 Policy & Procedures to ensure staff are knowledgeable about roles and responsibilities in adherence to regional requirements.

- To continue to support staff through the quarterly facilitation of practice support groups for staff undertaking the roles of IO, DAPO and Achieving Best Evidence interviews. This ensures that staff are cognisant of the current NIASP strategy and that issues from a staff perspective are understood. It also involves inviting speakers and sharing relevant adult safeguarding research to ensure staff are aware of up-to-date developments related to adult safeguarding.

- To continue to sustain and develop effective relationships with PSNI and Regional Adult Safeguarding trainers in the delivery of the NIASP training strategy.

- Continue to be committed to meet workforce needs in working towards full implementation of the regional policy and procedures. It has been emphasized that these documents are 'live' documents' and therefore it is imperative that staff are kept updated in relation to on-going changes.

- To deliver bespoke training to reorganized POC's to ensure confidence / competence in relation to screening and thresholds that are compliant with the 2016 Regional Policy and that recording of required forms are of a high quality.

LASP Prevention Group

The focus of the LASP prevention group continues to be compatible with the NIASP strategic plan 2013 -2018. The group meets on a quarterly basis and membership of is derived from voluntary and statutory sectors. The group continues to increase awareness of adult safeguarding to communities through the well-established projects that have been developed and sustained.

A review of the Keeping You Safe project was completed in July 2018 and the outcome was that while large numbers received the training the number of active staff delivering the training was low due to a variety of reasons including staff moving to new posts, retiring or leaving the trust. Existing staff attended an update session in July and this was well received and achieved the aim of ensuing that Adult Safeguarding messages are standardized and consistent with current policy. The programme was evaluated positively and is viewed as a very useful resource for service users. This will continue to be delivered across a range of regulated facilities and in all service groups. There continues to be an additional session for new staff who want to deliver this training and this was likewise well attended and evaluated. This is a very important project as it is designed to empower service users to recognize abuse and know who to talk to if concerned. It is imperative that the current staff trained to deliver this programme to service users are supported and encouraged to continue to remain involved. It is equally important that new staff are recruited on a yearly basis to ensure that key adult safeguarding messages are far reaching and that service users are involved as co-facilitators.

Towards the end of the last year the group considered developing a DVD to assist in the delivery of adult safeguarding messages but subsequently decided against this project as a more regional one was being developed and there was a risk of duplication. This may be revisited, as the thought process was a DVD to be shown to service users as opposed to staff.

The group continues to meet on a quarterly basis and will focus on organizing workshops for ASC's in commissioned services who are now required to complete a yearly return position report. The aim of these workshops will be to establish the level of confidence in relation to completing these forms and will assess understanding of commissioned services understanding of the position report, what are the expectations and what support will they require going forward.

Adult Safeguarding Training Activity	No. of candidates attended	No. of courses held during the reporting period
ABE 5 Day	16	1
ABE 7 Day	2	1
ABE Practice Support Group	24	3
ABE Refresher	8	3
Adult Safeguarding Level 1 Awareness	424	20
Adult Safeguarding Level 1 Refresher	671	43
Adult Safeguarding Level 2	52	3
Adult Safeguarding Level 3 Investigating & Designated Officers	61	3
Adult Safeguarding Level 4 Joint Protocol	24	1
Chairing Skills for Designated Officers	22	3
Court Skills (IO/DAPO)	14	1
Designated Officers Practice Support Group	49	4
Investigating Officers Practice Support Group	181	4

Keeping You Safe for Facilitators	31	2
Keeping You Safe Review	12	1
LASP Prevention Group	26	4
MARAC	29	2

Period – 1st April 2018 – 31st March 2019

SECTION 3: Belfast Trust Adult Safeguarding Activity Returns

Chart 1: Belfast Trust Safeguarding Referral Rates April 2011 - March 2019

Chart 2: Belfast Trust Monthly Safeguarding Referral Rates by Service Area
April 2018 – March 2019

Chart 3: Belfast Trust breakdown of Adult Safeguarding Activity by Service Area

Chart 4: Table of Percentage Increase / Decrease in Adult Safeguarding Activity

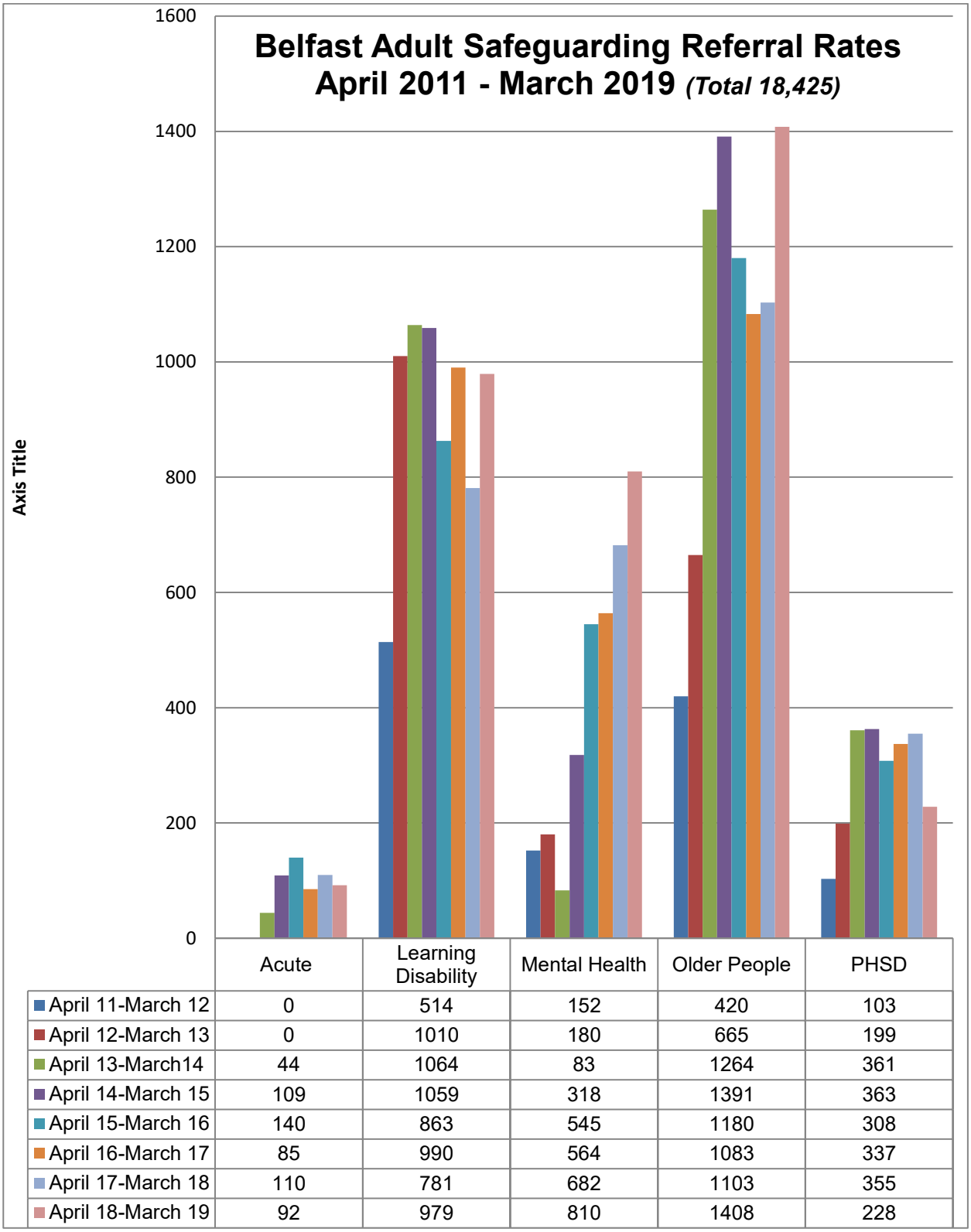
Data Returns

Analysis of data returns is included in each service area report. This section therefore focuses on the overall position in relation to the Belfast Trust statistical returns.

As detailed earlier in the report, the Belfast Trust continue to find the current system of manual collation challenging. The Trust are working with Paris developers to set up a system where in future this information can be collated directly from Paris.

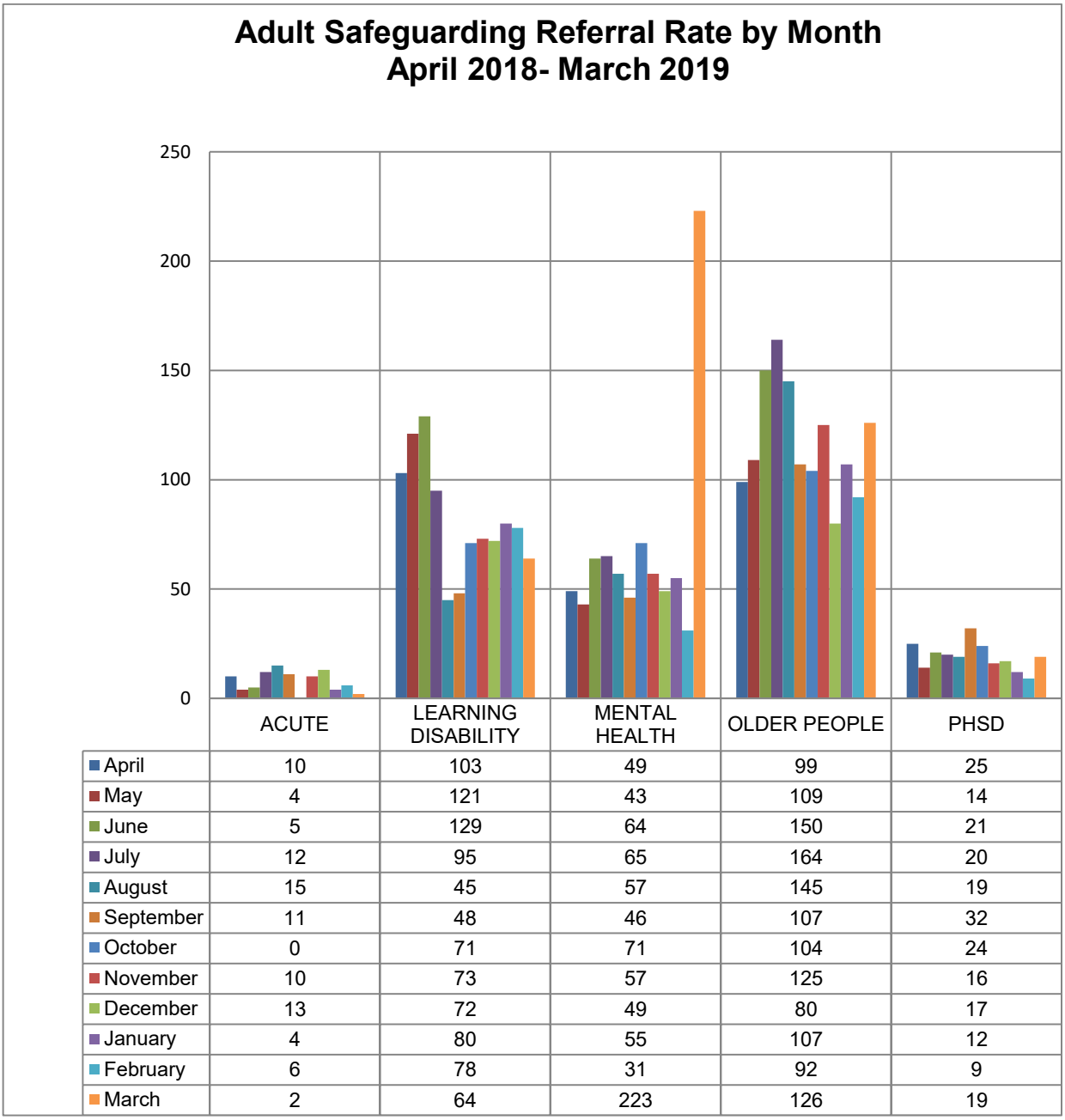
In this reporting period April 2018 to March 2019 the Belfast Trust received a total of 3,517 referrals. 1,723 of these referrals resulted in an adult protection investigation. There is clearly significant work to be done to ensure more accurate reporting of adult protection cases. This will be a key piece of work for Belfast Trust in the coming year.

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
April 16-March 17	85	990	564	1083	337
April 17-March 18	110	781	682	1103	355
April 18-March 19	92	979	810	1408	228

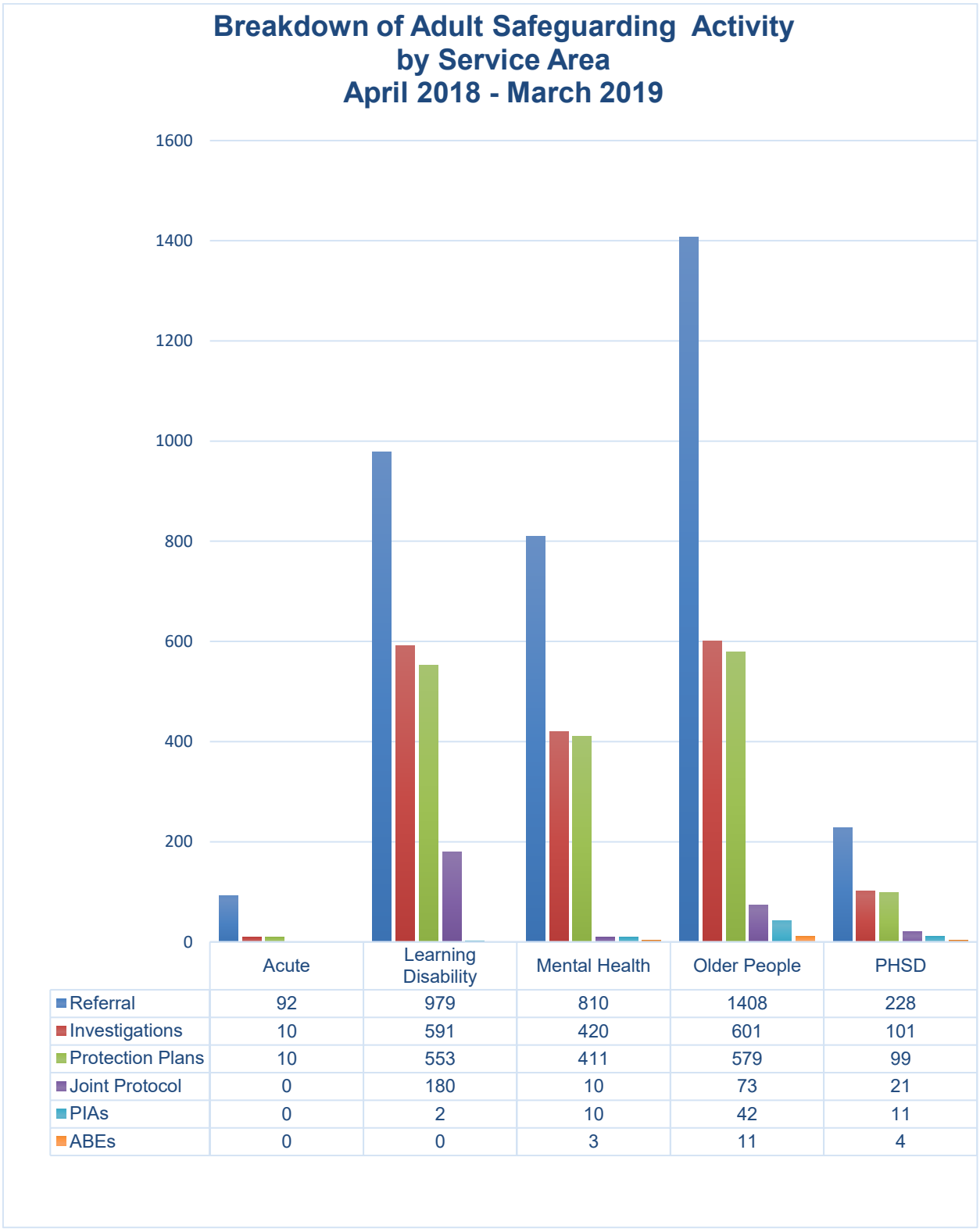
Referral rates have continued to rise year on year.



	ACUTE	LEARNING DISABILITY	MENTAL HEALTH	OLDER PEOPLE	PHSD
April	10	103	49	99	25
May	4	121	43	109	14
June	5	129	64	150	21
July	12	95	65	164	20
August	15	45	57	145	19
September	11	48	46	107	32
October	0	71	71	104	24
November	10	73	57	125	16
December	13	72	49	80	17
January	4	80	55	107	12
February	6	78	31	92	9
March	2	64	223	126	19

Note: astronomical data point for MH, March 2019 is due to non-reporting of data by specific teams during the year, then reporting in a cumulative manner for March 2019. Unable to separate into individual months.

CHART 3



	Acute	Learning Disability	Mental Health	Older People	PHSD
Referral	92	979	810	1408	228
Investigations	10	591	420	601	101
Protection Plans	10	553	411	579	99
Joint Protocol	0	180	10	73	21
PIAs	0	2	10	42	11
ABEs	0	0	3	11	4

The differential between referrals and investigations across each of the service areas highlights that, in real terms, the numbers of adult protection investigations is significantly less than would first be perceived, e.g. Older People 1408 referrals, only 610 resulted in an adult protection investigation, meaning that less than 50% resulted in an adult protection investigation.

CHART 4

Table Of Percentage Increase/Decrease In Adult Safeguarding Activity Years 17/18 to 18/19												
Service Area	**Referrals**		**Investigations**		**Protection Plans**		**Joint Protocol**		**PIAs**		**ABE Interviews**	
Years	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %	17/18	18/19 +/- %
Acute Sector	110	92 -16%	6	10 +67%	4	10 +150%	0	0 NC	0	0 NC	0	0 NC
Learning Disability	781	979 +25%	352	591 +68%	343	553 +61%	34	180 +429%	0	2 *	1	0 -100%
Mental Health	682	810 +19%	364	420 +15%	362	411 +41%	21	10 -52%	12 -	10 -17%	9	3 -67%
Older People	1103	1408 +28%	448	601 +34%	444	579 +30%	58	73 +26%	24	42 +75%	12	11 -8%
PSD	355	228 -36%	131	101 -23%	129	99 -23%	14	21 +50%	10	11 +10%	2	4 +100%

SECTION 4: Service Area Reports

PHYSICAL & SENSORY DISABILITY

Within the reporting period there have been 144 Adult Safeguarding referrals. 26% of this activity was assessed as not appropriate for the safeguarding frameworks. 43% were assessed and considered as level three activity and were subsequently managed by the Adult Protection Gateway Team with protection plans being implemented by that team. The remaining 31% were subject to investigation and protection planning from within the service area.

There has been a continued appropriate reporting of quality concerns with 33 referrals within the reporting period. This reflects the pattern in the previous reporting period and would suggest that professional staff continue to correctly utilise alternative safeguarding response processes.

All relevant staff in the community teams are trained to Designated Adult Protection Officer or Investigative Officer level. The updated Adult Safeguarding Operational Procedures were implemented in the service area in June 2017 and the Belfast Trust Training Team provided additional training to all relevant staff. Staff have continued to embed the Operational Procedures into practice.

The implementation of the Operational Procedures and the Designated Adult Protection Officer role has been positive within the service area. The Designated Adult Protection Officers in the service area make decisions upon the thresholds for all referrals and are responsible for activity relevant to situations involving adults at risk of harm, including the consideration of alternate safeguarding responses and the investigation of adult safeguarding concerns. Therefore, there are no referrals/consultation with the Adult Protection Gateway Team in relation to those adults as defined within the Operational Procedures as being ‘at risk of harm’. The service area continues to find the transition positive for service users; it has reduced delay in decision-making, by eliminating the transfer of cases to the Adult Protection Gateway Team to await their decision-making and has improved service user experience by ensuring that the core team staff maintain involvement without interruption. However administrative demands continue, the service area has a limited number of minute takers and discussions continue regarding how this pressure can be relieved.

Across the reporting period, interface challenges with the Adult Protection Gateway Team remain. This primarily relates to consistency and clarity in decision making within referrals involving suspected criminal activity, wherein the Protocol for Joint Investigation is required; and cases being accepted for investigation involving ‘adults in need of protection’. It is apparent that challenges remain regarding differences in operational understanding of this Protocol between the Belfast Trust and the PSNI. Such instances have caused delay, and it has been necessary for a small number of cases to be re-referred to the Adult Protection Gateway Team for further strategic discussion with colleagues in PSNI. The service area includes a number of trained Achieving

Best Evidence interviewers; however, there are insufficient opportunities to embed this learning in practice and to meet NIASP requirements, given the lack of demand. This reduction on the demands of specially trained practitioners has been consistent with a rise in decision making within Joint Protocol strategy discussions between the Adult Protection Gateway Team and PSNI which have resulted in single agency, PSNI only Achieving Best Evidence interviews. Staff within Physical & Sensory Disability service area continue to advocate on the behalf of those service users who may benefit in achieving equity to justice from the support available via 'special measures'. Additionally the levels of complexity of these cases being returned to core teams for investigation is very significant in terms of implementation of safety plans and responses to any emerging concerns.

With regard to user engagement within the safeguarding process, it is critical that we continue to ensure and demonstrate that individuals are fully involved in the interventions that bring about their desired outcomes. The 10,000 Voices project has provided a vehicle for important discussions and critical reflection upon the investigative process. The service area has continued to promote and encourage user participation within the survey.

The service area continues to utilise internal networks in terms of practice development. Furthermore, staff participate in the designated and investigating officer forums facilitated by the Training Team. Staff report positively on these opportunities.

The core teams continue to employ the community information system to record all activity. Unfortunately, the Regional Operational Procedures documentation is not yet available on PARIS, and availability of the updated administrative tools to record the investigative process will be welcome.

Throughout this reporting period the service area continues to foster a climate within which the implementation of the Adult Safeguarding Prevention and Protection Regional Policy (2015) and attendant regional procedures and joint protocol occurs. It continues to be essential that service users are equipped with the knowledge regarding what constitutes abuse and know the basic care standards. The Keeping You Safe programme is a priority for the service area and continues to be delivered to groups and individual service users by trained staff. This will enable and empower service users to assess risk, ensure quality and thwart detrimental behaviours developing. This labour intensive activity will increase demand upon the workforce but it is critical in assuring the prevention of harm. The Keeping You Safe programme recognises service users as experts in their own lives and provides the means to achieve contact with the right professionals if they so require it. It is vital in the effort to work preventatively regarding adult abuse and is a key objective for the service area. Work to continue the provision of this service user training programme is planned within the Day Centre forum.

ADULT PROTECTION GATEWAY TEAM

The Adult Protection Gateway Team (APGT), is now in its sixth operational year and continues to provide a gateway / protection response for the Older People (OP) service area and Physical and Sensory Disability (PSD) service area. In the APGT this two tier function acts to provide a central point of contact for external referrals, for all internal safeguarding referrals for OP and for protection referrals forwarded by PSD. For referrals that require a protection response cases are allocated to APGT DAPOs and IOs for investigation. To provide this service the APGT has the following compliment of staff: 1 B8A Assistance Service Manager, 4 B7 DAPOs, 6 B6 IOs and 1 B6 Nurse Specialist. During this reporting period the rate of referrals, screened out, protection investigations and joint protocol investigations were as follows:-

	Older People Service		**Physical Health & Sensory Disability Service**	
	2017/2018	**2018/2019**	**2017/2018**	**2018/2019**
Total Referrals received	1103	1408	355	228
Total Level 3 Adult Protection Investigations	190	323	48	58
Total Screened Out referrals	351	429	135	84
Total Joint Protocol Investigations	58	73	14	21

Looking at a comparison from 2017/18 to 2018/19 there is an evident increase in Adult Protection L3 investigations and an increase in Joint Protocol Investigations over this period.

The task of screening referrals on duty continues to require a daily resource of one DAPO and one IO to manage. As noted above, the number of referrals forwarded to APGT continues to remain high in comparison to investigation figures. The level 3 adult protection investigations account for approximately 23% of the total number of referrals received by the APGT. However, the task of receiving and recording information, conducting screening processes and allocating referrals requires one quarter of the B7 resource within the team.

As reflected in previous reporting years, there remains a high number of inappropriate referrals sent to APGT for screening. Over the period of 2018/2019, approximately 32% of referrals were screened out of the adult safeguarding process. The APGT continue to receive a high number of

inappropriate referrals from Care Homes and external agencies which include resident on resident incidents, quality issues, explained injuries, medication errors etc. APGT have also noted a continuing trend whereby Care Homes report incidents to the Belfast Trust keyworkers, however they are then redirected to APGT to make a referral under Adult Safeguarding Policy and Procedures. This creates duplication for care homes who have referred the incident to RESWS or Community Teams/CReST and then directed to contact APGT, when on occasions many referrals are inappropriate and do not meet the Safeguarding Threshold.

Last year's report envisaged the requirement to work with Care homes to focus on thresholds for reporting adult safeguarding concerns. This action will be carried forward with the intention over the next few months to work with Care Homes which will focus on ensuring that the thresholds for reporting concerns are being applied appropriately and that the reporting pathways are clear.

This action is timely, as the statistical breakdown for OPS over the period of 2018/2019 reflected a significant increase in referrals to APGT for screening for Older Peoples Programme of Care. The statistics highlight a significant increase of 28% in referrals made to APGT for screening. The increase in referrals is most evident over the months of June 2018-August 2018 with referrals peaking at 164 in July 2018. The increase in referrals over this period can be linked to the release of the COPNI report mid-June 2018 which seen an increase in Adult Safeguarding referrals referred to APGT by Care Homes and external agencies.

Within the Belfast Trust there has been a phased approach to implementing the regional Safeguarding Policy & Procedures, with Older People service area being the last to be implemented. Significant organisational change and workforce challenges have resulted in delays in full implementation. Now that the CReST service is established it is anticipated that work with Care Homes and CReST will be carried out concurrently to ensure that there is further clarity regarding thresholds, reporting arrangements and referral pathways.

PSD implemented the new Procedures in June 2017. The ability for core services to screen their own referrals and to forward only protection referrals to APGT has been welcome and demonstrates a more appropriate use of the APGT gateway function. As both service areas are working within different safeguarding frameworks, APGT's ability to straddle two processes and pathways has been challenging. It is expected that current pressures will be alleviated when service areas are working within the same framework.

Followed on from the previous year, the Director of Adult Services determined that the Belfast Trust would move to one Trust wide Adult Protection Gateway service. This will require one team to act as a single point of contact and manage all adult protection cases. Given the current arrangements within the Trust, it is anticipated that Mental Health and Learning Disability services will join with the existing APGT. There has been some initial work in relation to the structure, function, role and remit of the new Trust wide protection team but further discussion and consideration of the remit of the team is required.

In addition to the gateway function, it is proposed that the APGT will also act as a central point of contact for all Human Trafficking, Female Genital Mutilation, Forced Marriage, No Recourse to Public Funds, Domestic Abuse and MARAC referrals. Within the framework of the new Trust-wide team the APGT will continue to hold responsibility for these areas of practice, additional to this the development of audit and governance arrangements for both APGT and Core services will also be required.

The development of a Trust-wide team will require Core services to provide a screening and safeguarding response for those referrals that do not require a protection response.

Casework that requires a joint protocol, multi-professional or institutional investigation continues to be challenging, resource driven and time consuming. This is evident when regulated facilities particularly Nursing Homes are involved. The referral rates relating to abuse, exploitation and neglect in regulated facilities have remained consistently high with figures outlined highlighting a significant increase from the previous year. With the implementation of the new Policy and Procedures it has become evident that at times there has been a level of ambiguity in relation to the interpretation of cross Trust arrangements and the roles and responsibilities of host and placing Trusts. At times there also appears to be some variation in the role, function and remit of the Strategic Management Group across Trusts. This has been flagged with the NIASP Protection work-stream who are currently reviewing the Procedures. It is anticipated that the update of the regional Procedures will address the practice issues identified. In the interim, the Trust continues to work in partnership with other Trusts to ensure the safety and well-being of residents. This includes ensuring that investigations and protection plans are in place. In moving forward, further clarification regarding what is defined as an institutional investigation would also be helpful.

Over the reporting period of 2018/19 referrals and adult protection investigations vastly increased resulting in additional pressure on the staff within APGT. As a result, APGT were placed on the Risk Register in relation to an identified back log of case closure and recordings which fell outside the expected standards. This was subject to close monitoring and review by management of APGT.

In the last quarter of this period, APGT were subject to significant staffing changes with three senior members of the team, two DAPOS and the ASM/Team Manager, leaving the team to pursue temporary Expression of Interest Posts within the Trust. Additionally, APGT experienced the departure of Investigating Officers who left the team or moved into senior positions. The staff situation experienced by APGT has had a consequential impact on the team, APGT were placed on the Risk Register due to the staff shortages, however the void in the staff team remains ongoing despite actions from Senior Management to recruit and stabilise the service.

APGT were successful in recruiting B7 Social Workers/DAPOs, and partially successful in recruiting two B6 social workers, however the recruitment process is ongoing, with the pressing need to fill the empty posts. Due to the nature of

the service delivered and the impact of recent staff changes within the team, APGT are now functioning with an inexperienced staff team, which requires enhanced monitoring and support from senior management for the foreseeable future.

Despite the practical challenges identified, APGT continue to function as the central point of contact for external agencies and continue to screen adult safeguarding referrals for OPS and investigate level 3 Adult Protection investigations for PSD and OPS. Additional challenges faced by APGT over this reporting period include APGT experiencing an increase in information requests from professional bodies such as NISCC & NMC. This is in addition to Freedom of Information (FOI) requests, subject access requests and Data Protection requests from external managers, relatives and staff members subject to investigation. APGT continue to liaise with Data Protection and DLS when required to meet the requests outlined.

This has also highlighted the interface issues between Adult Protection Investigations and HR/Management Internal Investigations and the challenge faced when agencies attempt to use safeguarding reports as evidence during internal investigations. Responding to such information requests within specified timeframes places additional pressures on the team, this was evident over the past 12 months when APGT received numerous statistical data requests following the release of the COPNI report in June 2018. The collation of data and producing of reports exceeded the current staffing resource and created significant pressures within the team.

Over this reporting period, APGT experienced an increase in referrals from for OPS resulting in an increase in level 3 adult protection investigation in care home settings. The impact on the team resulted in an increase number of complex investigations with multiple incidents of abuse subject to investigation at any one time. As a result, the b6 specialist nurse was subject to a change in case work allocation and activity, such as removal from duty and allocation of specialist case work due to the increased volume of investigations and activity within Care Home settings. The specialist nurse role continues to remain a vital component within APGT due to the complexity of care home and nursing/ care related investigations referred into the Trust. A fundamental service provided by the nurse specialist is the facilitation of bespoke education sessions with care homes, service providers and agencies in relation to the Role of APGT and function of Adult Protection investigations within the Belfast Health and Social Care Trust.

There has been an increase in the requests and demand for the education sessions by agencies in an attempt to increase the awareness within care settings in relation to Adult Protection and Adult Safeguarding. Additionally, the specialist nurse attends and contributes to the review of regional strategic developments for example the development of the NIPEC guidance on safeguarding training in the nursing profession, developments relating to investigating pressure damage and chairing of quarterly Regional NIPEC meetings attended by specialist nurses across the region.
Due to the expert clinical area of work undertaken by the specialist nurse in complex investigations which include Article 121 of the Mental Health Order,

Pressure Damage and Institutional Abuse, APGT senior management have conducted a review of the skill mix within the team and has proposed the appointment of a temporary B7 Specialist Nurse within the APGT. There is the intention to pilot this post for a 6 month period and review it in relation to role, responsibility and outcomes.

It continues to be the case that none of the Joint Protocol investigations conducted by APGT with police under Article 121 of the Mental Health Order have reached the threshold for prosecution as determined by the Public Prosecution Service (PPS). What is of note is that investigation processes in this area of work are elongated and protracted with outcomes for the most part of no prosecution. It would be beneficial and informative if the PPS could provide a clearer understanding of what constitutes a criminal threshold for wilful neglect and provide guidance around investigations and threshold for referral to police. Currently it would appear that police are seeking advice from PPS about thresholds for prosecution before investigations are concluded. While this is welcomed, it would be preferable if PPS and police could agree thresholds for wilful neglect. The review of the Joint Protocol will consider in detail the use of Article 121. Following the regional review of pressure damage investigations, APGT conducted an investigation under Adult safeguarding and Joint protocol policy and procedures with a recommendation by the PPS for prosecution under Health and Safety Legislation, this is the first of its kind in the Belfast Trust area, with the process and outcome eagerly anticipated.

The number of investigations agreed as Joint Protocol by police increased by 26% for OPS and 50% for PSD over the reporting period of 2018/19. This is a substantial increase, however the number of ABE interviews conducted for OPS decreased by 8% over this period, with PSD ABE interviews increasing from 2 to 4 demonstrating a 100% increase over this reporting period. Approximately only one third of referrals made to CRU are agreed as Joint Protocol. It is generally acknowledged that the new Joint Protocol is being interpreted very differently by respective agencies, hence resulting in a high percentage of referrals made by DAPOs not meeting Joint Protocol as determined by police. Given outcomes APGT find themselves querying decisions made by police and have on a number of occasions challenged decisions in support of vulnerable service users. APGT staff are experienced practitioners who frequently negotiate decision making with the police and use the escalation process as detailed in the Joint Protocol. Again, it is anticipated that the review of the Joint Protocol currently underway will address the concerns identified and will reach a consensus position in terms of definition and application of the Joint Protocol.

The reduced number of investigations agreed by police has had a substantial impact on the number of PIA and ABE interviews conducted. Aside from the implication of this on vulnerable service user groups, there has also been a significant impact on social work ABE interviewers who are unable to meet their practice requirements as outlined in the protocol. APGT note that police have advised DAPOs that referrals are being passed to uniformed Police Officers and Registered Intermediaries are being used as an alternative to ABE trained social workers. The review of the Joint Protocol will consider this and all related issues.

CORE TEAMS - Older People's Service Community Social Work Teams

The Adult Safeguarding Protection Team still retain the responsibility for receiving and screening all adult safeguarding referrals in Older People's Services. During this reporting period the Older People's Social Work Service continues to move ahead with structural and organisational change. The professional oversight has been strengthened with four 8a Team Leader posts across all Community Social Work and the service is pleased to report that this management structure is now stable. However, during this reporting period a vacancy of rate of 50- 75% in team leaders in Community Social Work has prevented the full implementation of the Regional Policy. Adult Safeguarding referrals continue to be screened and thresholded by the Gateway Team. It is the view of the service area that this was the only way that we could ensure a consistent response and thresholding during this very unstable period. Whilst the service area intends to move forward with full implementation of the policy, we remain concerned that further work needs to be developed in relation to identifying standards and processes for managing adults at risk of harm and developing alternative pathways. This is a priority for the service area in the forthcoming year

The management of safeguarding concerns raised in the care home sector continue to present significant demands. The development of a preventative CREST model has ensured that early warning signs of a change in standards in a care home setting are identified with earlier interventions. The issues raised through the Dunmurry Manor investigation Home Truths Report continues to be a focus in the broader discussion of how risk is identified and managed across the Service Area. Staff have been involved in DOH and Trust facilitated workshop sessions reflecting on particularly how our current thresholds of risk and risk management plans are a critical to our broader responsibilities under Safeguarding.

The CREST model has been significant in ensuring the development of strategies which deliver timely reviews, responsive supports and prevention work in Residential and Care Home sector. The ASCOT tool along with the guidance and mentoring of Kent University is being introduced to the CREST team as a methodology to support and assure. Further training and development in this area is anticipated. This outcomes tool will both support the care homes in identifying particular areas for improvement and provide a mechanism to work together on improvements. Also it will bring a rigour to the work carried out by our Social Work staff in observations, monitoring and reviewing within the sector to prevent safeguarding concerns arising.

Quality Improvement methodology has been applied to reviewing and improving the understanding of how older people and/or their family can feel safe in raising concerns or complaints within the care home setting. This again has at its core service improvement and also supports the prevention of concerns being raised later or not at all and escalating to the need for protection.

Staff have also benefited from being able to attend training and events held by partner agencies such as Women's Aid and Action on Elder Abuse.

Challenges

The service area is training staff to be able to bring a range of tools to the protection of our older citizens through a range of methodologies. Community Services have made use of the High Court to ensure the protection of those who lack the capacity to make decisions to protect themselves. This work will inevitably change as aspects of the Capacity Legislation is enacted. As a Service Area we are working to remain flexible and creative in how we respond to the circumstances of individuals to ensure their safety.

At present the Service Area is taking an action to the High Court in respect of a service user who has been subject to harm through the actions and interference by another. The service user lacks capacity to recognise and manage these harmful actions. The Trust are asking that the Court would make an order on behalf of the person, in the absence of their mental capacity, to exclude the perpetrator from interfering in the service user's property and care. This is a new approach and could be critical in shaping case law. This is a significant piece of work for staff both in terms of understanding and managing the day to day complexity but also in the number of reports and consultations ahead of any court appearance.

The importance of a competent and confident workforce who are well versed in early identification and intervention is essential.

Strategic Direction

We are confident that within the Care Home Sector the ASCOT methodology represents a welcome focus on quality of care and a supportive system of bring further strength to the prevention work which is ongoing. Within the Community Social Work Teams we have appointed a governance post which will bring further assurances in the form of regular auditing of our safeguarding work to highlight areas of good practice through peer support initiatives. It will also help to identify areas of variance in practice. A Principal Social Work has been permanently recruited in the Community Teams and a temporary equivalent post in our Hospital setting. This will bring a renewed focus to the training and development of our staff and the governance arrangements related.

As we progress to integrate the Regional Policy in the service we will have a renewed focus on the feedback from people who are supported through our safeguarding processes and look at how we improve the lived experience of safeguarding. Feedback from 10,000 Voices will help inform this work going forward.

HOSPITAL SOCIAL WORK

Processes and staff resources are in place to provide a response to Adult Safeguarding queries and referrals across the hospital sites in Belfast Health and Social Care Trust. These include: Royal Victoria Hospital, Belfast City Hospital, NI Cancer Centre, Mater Infirmorum, Musgrave Park Hospital and Meadowlands. Monthly returns are provided to the Adult Protection Gateway Team (BHSCT) by way of collection and monitoring of referrals for BHSCT referrals.

We have Designated Adult Protection Officers and Investigating Officers trained and available on each of the hospital sites and cover arrangements in place if required.

There have been a number of instances of residents from other Trust areas coming into regional hospital facilities in the BHSCT area (e.g. Royal Victoria Hospital or Musgrave Park Hospital) for care and treatment and disclosing Adult Safeguarding issues. We have worked with the Gateway Teams from other Trusts to ensure referrals are made to the appropriate area and immediate protection planning is done. We have initiated a new reporting process for 2019/20 to capture the number of referrals to other Trust Adult Protection Teams.

One of the challenges we have is that service users can often have short admissions to hospital were Safeguarding disclosures are made. This can often be a vulnerable time for people due to injury and/or ill-health. Social Work staff in the Safeguarding roles provide a sensitive and professional response in these situations taking cognisance of issues such as capacity to engage in the investigatory process, what immediate protection response is required and how Adult Safeguarding issues may impact on discharge planning.

A recent RQIA inspection report highlighted the issue of awareness of Adult Safeguarding within the outpatient departments on the hospital sites. An action plan has been put in place to provide these departments with Safeguarding posters and postcards for display in waiting areas.

LEARNING DISABILITY

The Service Area continues to have a number of dedicated Learning Disability Adult Safeguarding staff. This comprises of 9 DAPOs: 5 are SW Team Leaders in the hospital and community teams; 1x 8a Operations manager; 1x DAPO in Muckamore Abbey Hospital (MAH) who deals with patient on patient incidents; and 2x DAPOs in the Specialist Team who deal with allegations against staff or paid carers or where there are issues in relation to the quality of care provided in a group setting.

From September 2017 the Specialist team (2x Band 7 DAPOs) have been involved solely in the large scale adult safeguarding investigation into Muckamore Abbey Hospital. This has involved dealing with the historical CCTV incidents and historical incidents. This meant that the work, usually undertaken

by this Specialist Team, had to be dealt with by the core Community Learning Disability teams. This added additional pressure to their existing workloads.

The service area has 36 Investigating Officers who are embedded across the service area. There are now 3 ABE trained social workers.

Adult safeguarding (ASG) remains a major area of work for the Service Area. There has been an increase in the number of adult safeguarding referrals from 916 referrals last year to 977 this year with 560 investigations completed. 789 of these referrals were received from the hospital and 188 from the community. A large number of referrals have resulted from the large scale adult safeguarding investigation in Muckamore Abbey Hospital. This includes 236 referrals generated from the viewing of historical CCTV footage that has been downloaded from April- September 2017 relating to 5 wards in Muckamore. In addition, there remains a high number (519) of patient on patient incidents across the hospital site.
The figures are as set out in table below.

Number of safeguarding adult referrals within the period	977
Of the referrals at 6.1, how many were received from acute settings?	789
Number of investigations commenced within the period	560
Number of investigations completed within the period	560
Of the completed investigations at 6.4, how many required a Multidisciplinary Agency Risk Assessment Conference (MARAC)?	1
Number of adult protection plans commenced within the period	536
Number of adult protection plans in place on 31st March	536

Current allegations against staff in Muckamore Abbey Hospital

There have been current ongoing incidents relating to allegations against staff within the hospital site. These allegations have been investigated by the community teams with the support of 1x Band 6 Investigating officer.

CCTV is now running across all the wards at Muckamore. The adult safeguarding team can therefore view CCTV as part of their investigation. The introduction of CCTV across all the wards has been extremely positive in that it has allowed for independent checking of allegations, which has aided in the ASG process. It has also provided reassurance to the families, senior management team, Trust Board and Department of Health. This helps to clarify information quickly and incidents can either be very quickly screened out or the CCTV can be used to provide details and evidence in relation to the allegations made. From viewing the CCTV learning can be achieved in relation to what precipitated the incident, the intervention of staff etc. This helps to set a context to the incidents. The adult safeguarding team now meet regularly with the Service manager, ward managers and operations managers to ensure there is good communication, shared learning and protection plans are reviewed.

There are significant resource implications for the ASG team given the length it time it takes to view the CCTV (as there are a large number of cameras in any given area), time to identify the staff, accurately record the viewing and at times to obtain input from the MAPA trainer in respect of any Physical Interventions used. A number of issues viewed would fall under staff conduct issues and would not reach the threshold for an adult at risk or an adult at need of protection. However, they would be matters of concern for the Adult Safeguarding team, which remains a challenge whether such matters should come under Adult Safeguarding.

The vast majority of the ongoing referrals made against staff relate to one particular patient who is very autistic and assessments of his communication have showed that he has limited use of expressive language.

As per the Regional policy, any incident deemed to meet a criminal threshold have been referred to the PSNI.

The CCTV policy has been reviewed. For assurance purposes contemporaneous CCTV is also underway across the site. Any good practice is documented and shared through the service manager to each ward area.

The Adult safeguarding team are now planning to complete a more in-depth audit of data to identify any trends or patterns. This will ensure the adult safeguarding responses are better informed and consider a range of factors including the skills mix, staff ratio, time of incident, environment, the patients presentation, etc. which may impact on the safety of patients. This will inform the entire multidisciplinary teams' decision making to improve patient safety.

Historical CCTV allegations against staff in Muckamore Abbey

This has continued to be an extremely challenging year for the service area in respect of adult safeguarding incidents reported because of viewing historical CCTV within the Hospital. The large-scale ASG investigation commenced in August 2017 following the delay in reporting an Adult safeguarding incident. CCTV was viewed at this stage in relation to this incident and during this viewing a number of other adult safeguarding incidents, which were not reported, were noted. This included mostly incidents of a physical nature on patients by staff and the inappropriate use of seclusion. These incidents were later reported as an early alert to the Board. For assurance purposes a further 25% random viewing of CCTV took place across the Muckamore Abbey Hospital (MAH) site which revealed further incidents in one ward. Subsequently, an incident was reported by a patient against a staff member in another ward. Further allegations were made by a whistle-blower against 2 staff members. A number of these allegations resulted in a joint PSNI/ Social services investigation.

Following these incidents an independent Serious Adverse Incident Level 3 Investigation was commissioned focussing on adult safeguarding from 2012-17 including the above incidents. This panel was chaired by Margaret Flynn. The findings of this report 'A way to go' have now been shared with the affected families through workshops and individual meetings and with the staff across

learning disability. A written copy of the report has been made available to families, including an easy read version for patients.

The main themes emerging from this report were as follows:-

- The criteria for admission to the hospital was too low with patients being admitted for a large number of reasons including, those who required assessment and treatment, those whose placement had broken down, short breaks etc. In addition, once admitted these patients were extremely difficult to discharge and therefore the length of admission became protracted with many having no discharge plans.
- There was a high incidence of patients being bored in the hospital due to a lack of meaningful activity on and off the wards. This undoubtedly led to frustrations and an increase in patient on patient incidents but also of incidents of staff on patients.
- There was an inappropriate use of seclusion sometimes for long periods of time and poor recording detailing the rationale for the decision surrounding this.
- Despite a large number of RQIA inspections and a very high number of Adult safeguarding referrals, (even resulting in referral to the police) there was a lack of action taken which actually reduced the number of incidents or improved the safety for patients.
- Families were not allowed access to the patients' bedrooms or to the actual ward. This was particularly so in one ward.
- There was a lack of visible leadership across the site

Some of the recommendations from the report that now form part of the Trust action plan are as follows-

- People with learning disabilities should be able to live their lives with their families and in communities and the services provided should understand that ordinary lives require extraordinary supports – which will change over the life course.

- The hospital should review its criteria so that admission is for assessment and treatment only, for the shortest time possible.
- The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services.
- There should be better advocacy services.
- Development of a co-produced communication strategy with parents/carers/ appointment of carer consultant aimed as repairing and establishing relationships and trust with patients and with their relatives as partners. Families should have greater input in relation to decision-making.
- Families and advocates should be allowed open access to wards and living areas.
- Patients should be engaged in more meaningful activities during their admission.
- Patients and families should have better information in relation to how to complain.
- Families should receive regular progress updates.
- The families wanted an end to seclusion.
- There should be a review of Adult Safeguarding culture and practices at Muckamore so that the responses to safeguarding incidents and allegations are proportionate and timely, that the perception that people with learning disabilities are unreliable witnesses is changed and that the safeguarding documentation is substantially revised.

Much progress has been made in relation to these action points but there is still a lot of work ongoing. Whilst this SAI investigation was ongoing it was agreed that all the downloaded CCTV (April-Sept 2017) be viewed for all 5 wards. This proved to be very challenging for all adult safeguarding staff in learning disability services. The Muckamore investigation has been unprecedented in terms of numbers of allegations and its complexity. This has resulted in a huge amount of work relating to the historical allegations and the historical CCTV incidents being undertaken by the 2 DAPOs in the community. This has had a knock on effect on the community teams as they had to take on the work previously covered by this specialised team.

Since the start of the investigation, the 2 DAPOs have processed 191 referrals for one ward with 177 of these being referred to the PSNI. 14 other incidents were not referred to PSNI. These incidents are all mostly of a physical nature and include inappropriate use of seclusion. In addition, a further 158 incidents relating to the other wards have been triaged by the ASG team. To date only a small number of these incidents have been viewed by the adult safeguarding team. However, of what has been viewed an additional 44 referrals have been forwarded to the PSNI. These incidents are again mostly of a physical nature and involved a number of staff who were either involved in actual physical incidents and or other staff who allegedly witnessed the incident and or failed to intervene.

The CCTV was taken by the PSNI in February 2019 and at this stage the percentage viewed for each of the 5 wards was as follows –82%,-64%, 66%, 48% and 46%. This clearly continues to create difficulties for families who know that there is further historical CCTV to view. The Trust remain committed to the viewing of all CCTV during this specified period.

The PSNI have an identified taskforce dealing with this investigation and have a team of additional officers. They have been working very closely with the PPS and are looking at a whole range of potential offences in relation to this investigation including Article 121, wilful neglect, common assault and misconduct in a public office.
Unfortunately, over the reporting year attempts to recruit additional DAPOs to assist with this investigation have been largely fruitless resulting in the 2 DAPOs undertaking the viewing of CCTV, as well as preparing large voluminous files for the Police and HR department. This has been a hugely complex task and both the PSNI and the HR department have complimented the team for the complex work completed.
All the affected families have a nominated DAPO attached to them and with their agreement there were updated on a regular basis regarding any further developments as well as offered supports including psychological support from the Trust. The DAPOs have been working in close partnership with the PSNI and a number of visits to families were done jointly between the Trust and the PSNI. At the end of the reporting period the service area managed to secure a part time DAPO whose sole role is family liaison with some of the affected families.

As a result, of the current ASG investigations 20 staff have been placed on precautionary suspension and other staff are subject to protective measures. This along with staff sickness has given rise to a number of challenges for the service in ensuring that there is adequate staffing across the site to ensure patient safety.

There has also been ongoing liaising with the other Trusts to update them regarding the current investigation but also to address any specific issues relating to their service users.
Whilst the CCTV remains outstanding, there is also a feeling of uncertainty across the staff group at the hospital. Staff across the site have been supported at this difficult time through a large number of initiatives including a counsellor who provides 1:1 emotional support, reflective practice sessions, workshops

with staff, massage sessions and support sessions with HR and OH. In addition, a health fair is planned and 'Bewell' sessions planned.

The Service Area has continued to work within the Adult safeguarding Regional Policy, the HR disciplinary processes and Joint protocol. This has resulted in many challenges balancing the requirements of each process and being proportionate in relation to staff but at the same time protecting patients.

The hospital SW staff have continued to roll out the ASG 'Keeping yourself safe programme' across MAH. There has also been further ASG training provided across the hospital site. There is further CCTV to view and the 2 DAPOs who had been doing the investigation are now due to be replaced by a new ASG team which was appointed at the end of March. This team currently comprises of 1x Band 8B and 3x 8A staff. There remit is take forward the remaining historical CCTV and provide support to the affected patients and families.

Muckamore Abbey Hospital current patient on patient referrals

The social work department in the hospital continues to lead in relation to safeguarding patient on patient incidents. In this reporting year, there have been 519 incidents in the hospital. Most of these incidents are of a physical nature. Many of these incidents include multiple incidents relating to the same patients either as alleging causing harm or and victims of alleged abuse. All these referrals are processed by one Band 7 Lead DAPO, who is supported by the Senior Social Worker and by 2 Investigating Officers. Together they support the Multi-disciplinary team in the development of risk management, alternative safeguarding responses and protection plans. Support is also provided to the patient and a referral to the PSNI if deemed appropriate, or at the request of patient or carers. As part of the screening and or as part of the investigation into the incidents CCTV will also be viewed by the DAPO.

As a result of staffing difficulties (suspensions and staff off sick) and also as a means of stabilising the hospital, the hospital has been closed to admissions. In addition, over the last year the hospital has been retracting as patients have been discharged and therefore the number of inpatients has significantly declined. However, there remains a high level of incidents of a physical nature between patients in the shared setting of the hospital. There are ongoing difficulties related to the physical environment and the mix of patients in the wards, many of whom have complex needs and present with challenging behaviours associated with autism and other conditions, communication difficulties and limited insight into the possible consequences of their actions or that of others. Very few of the patients have skills to protect themselves Staffing levels can also often mean that patients are unable to avail of opportunities to be off the ward and this can increase the number of incidents on the ward.

Despite good multidisciplinary working including robust risk assessment and risk management plans, it continues to be a challenge implementing suitable protective plans to reduce the likelihood of further incidents. All these ASG incidents are now reviewed on a weekly basis at the multidisciplinary team but also the data forms part of the SITrep report, which allows the Senior Management team / Directors Oversight group the opportunity to understand

trends and patterns in relation to this and consider what further steps can be taken to address the matter.

In order to reduce the number of patient on patient incidents in the wards considerable work has been done:

- In Jan 2019 an activity Co-ordinator was appointed following a review of day care at the hospital. This has significantly improved the level of activities for inpatients across the Hospital Site. Therapeutic Day services are now also provided within the hospital at weekends and evenings activities on the ward and off the ward. This has helped to reduce contact between patients and thus reduce frustrations levels and the likelihood for incidents. Activities for patients ensures the holistic needs of patients is catered for with intervention, which may include recreational input, social input or skill development. By extending the frequency and range of appropriate and meaningful activity the mental, physical and emotional wellbeing and social needs of patients is promoted.
- Joint Therapy Aims and Free time Plan/Activity Boxes have been introduced which allows ward staff to work on individualised therapy aims with patients, which forms an important part of their treatment. The box can also be used to de-escalate a situation or redirect a patient from a difficult situation, which promotes the safety and well-being of patients.
- Plans are place to resettle a large number of patients whose discharge has been delayed. There has been work done by the service area with a large number of providers along with the other Trusts to put in place plans to successfully resettle patients in the community.
- The Trust has also developed a supported living scheme in Cherryhill, which is due to open in June 2019 and will be accommodating 9 patients who are to be discharged from the hospital.

- The hospital SSW and lead DAPO have regular meetings with the service manager and the 8a nursing operations managers to address any ongoing concerns in relation to patient safety.
- The hospital SW team are currently piloting real time feedback from patients and from carers prior to and post Adult safeguarding intervention to understand what would make them feel safer.
- Safeguarding procedures, including use of special observations, has been used to minimise targeting of vulnerable patients.
- The ASG team will now be auditing data in relation to ASG and identifying trends and patterns so that a collective understanding can be achieved in relation to the issues re ASG across the site and then identifying how this can be addressed.
- There continues to be discharge meetings convened to expedite community placements and notify Trusts of the number of safeguarding concerns for each patient remaining in hospital.
- Ongoing training of nursing staff in Muckamore regarding the thresholds, their responsibilities under adult safeguarding protocols, completing the forms correctly and developing robust interim protection plans.
- Viewing CCTV assists the ASG team to understand the factors precipitating/ leading up an ASG incident and the context of the incident, which is then shared with the ward managers/ management team.
- Positive behaviour practitioners provide support to reduce incidents of challenging behaviour.
- The Keeping You Safe Training to patients remains a key function of the SW team in the hospital. Within the last year, 21 patients have been provided with the training. Various

methods have been used, group and individual sessions, depending on the ability of patients.

Social Work staff in MAH are now aligned to each ward, which ensures there is a full MDT approach to address the issues and reduce the potential risk to patients e.g. through making environmental improvements, use of positive behavioural support, increased day activities etc.

In the last year, the service have implemented a new process in the management of safeguarding. This process is in keeping with the Adult Safeguarding Policy and provides opportunity for ward managers to become nominated Adult Safeguarding Champions. The vast majority of incidents managed through this process are minor in content and only require an Alternative Safeguarding response. The hospital SW department continues to provide support and advice to ward managers and nursing staff. The Senior Social Worker has been auditing this new initiative and raising any issues with hospital management.

Community based investigations

Allegations against staff

The service has continued to investigate concerns raised in nursing homes, residential homes and supported living projects. The referrals cover a range of abuse including alleged physical abuse, psychological abuse, financial abuse of service users and institutional practices.

The service remains concerned about quality issues which, while they do not meet the threshold for safeguarding, may have significant impact on the quality of life for service users. Many of these facilities continue to experience high turn overs of staff, low staff morale and poor resilience. The Trust continues to work with providers to build their capability and improve their resilience.

Allegations of service user on service user abuse

Most of these referrals relate to low level physical incidents of one service user on another which reflect the reality of group care for service users who can display behaviours, which challenge and have communication difficulties. As noted in previous reports, where the victim and person who is alleged to have caused harm have learning disabilities, behavioural issues and share the same space it can be difficult to put in place protective plans. Again, as noted in previous reports suitable alternative placements are required.

All group living services are aware of the need to review care plans, environments and the mix of service users in order to promote a safe living environment for all.

The Service Area believes that many preventative measures are required to address these issues such as good quality staff recruitment, retention, support and training.

MENTAL HEALTH

There continues to be a significant increase in the volume of Adult Safeguarding referrals, investigations and protection plans in the last twelve months with an increase in referrals by 20% and in investigations by 10%. The Mental Health Adult Safeguarding Team continues to provide the majority of DAPO cover and has endeavoured to continue to improve awareness of Adult Safeguarding procedures in recognising and reporting of abuse in community teams that are non-Social Work led. DAPO's from the Mental Health Adult Safeguarding Team continue to embed the process and knowledge of the procedures and to assist Team Leaders in fulfilling their responsibility for initial screening, implementing interim protection plans, governance responsibilities and onward referral to DAPO.

The Mental Health Adult Safeguarding Team currently consists of a PSW – who is also the named Adult Safeguarding Lead for the mental health service area in addition to the PSW role, 2 Band 7 Senior Practitioners/DAPO's, a Band 7 Senior Practitioner/Professional Social Work development lead and Think Family lead, who also provides sessions into Adult Safeguarding for DAPO. All DAPO's in the Mental Health Adult Safeguarding Team are ABE trained.

The Mental Health Adult Safeguarding team currently acts as a single point of contact for Adult Safeguarding referrals for mental health services who do not have trained DAPO's within their team. There are plans for all mental health referrals to be sent to the Adult Safeguarding Protection Gateway team in the future for screening and decision making on the level 3 cases to be taken forward for investigation, but to date the current process remains and there is no date for APGT screening of all referrals. The Adult Mental health team currently screen all referrals received and identify an IO and DAPO. They are also the point of contact for guidance and referrals from outside agencies and are advised on issues which would require a safeguarding investigation and arrange for the allocation of an IO and DAPO to commence the safeguarding process. The Mental Health Adult Safeguarding Team continues to act as the central point of contact for PSNI for PIA / ABE interview consultations and requests and allocates referrals to trained staff within the mental health service area. There continues to be well established support groups for IO, DAPO and ABE trained staff across the Trust and staff are encouraged to attend these groups to keep them updated regarding any changes or issues and is also a forum for shared experience and learning.

The Mental Health Adult Safeguarding Team meet weekly to review and discuss Adult Safeguarding investigations and management of cases. The team has a Band 7 Senior Practitioner for MARAC cases and referrals for MARAC process.

The Mental Health Adult Safeguarding Team also provides supervision and support to DAPO's and IO's across all services who are not line managed by a

qualified Social Worker DAPO. They also provide an advisory and consultative role for all professional staff across the 41 mental health teams / services and outside agencies including voluntary organisations and PSNI.

Referrals are received from a wide range of service areas, including hospital settings, the 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.

There has been an increase in the number of protection plans by 15%. The figures reflect a reduction in PIA/ABE interviews. The figures for 2018/2019 show a reduction of 50% in PIA interviews and a 70% decrease in the number of ABE interviews completed within mental health. This is largely due to the police thresholds for joint protocol investigation and a high proportion of referrals to CRU have been assessed by the PSNI as only requiring a single agency investigation. The PSNI thresholds assess domestic abuse, historical abuse, physical and sexual assaults as single agency investigations. The PSNI/CRU thresholds also assess any patient in receipt of 24 hour care in a hospital setting are not vulnerable adults in need of protection and will only agree this a single agency PSNI investigation. DAPO staff in their consultations with CRU continue to challenge these decisions and the need for a joint investigation with PSNI on a case by case basis. However, it remains our experience that the PSNI will make the final decision. It is predicted that there will continue to be a decline in PIA/ABE interviews under the new thresholds for assessment by PSNI. Given the reduction in joint protocol investigations mental health services will not be nominating social work staff to undertake the ABE training this year. Staff currently trained have reported that they are having difficulty meeting the two ABE interview requirements to continue with the role given the reduction in ABE interviews.

Within Mental Health services there is a significant deficit in DAPO's across the service as not all of the services are led by Social Work staff. There are 6 social work Team Leaders across the 41 mental health teams, 10 senior practitioner staff including the 3 Senior Practitioner DAPO'S in the Mental Health Adult Safeguarding Team and a two year time limited temporary addition of 2 CSM Social Work posts who will undertake a DAPO role within their service area if there is no Senior Social Worker/DAPO in post. An expression of interest has been circulated for an additional two temporary Senior Practitioner Social Work staff to undertake additional roles within the community teams – this will include a DAPO role along with other enhanced duties and there continues to be increased pressure on DAPO's within the mental health service area who also undertake a number of functions i.e. Team Lead, ASW, ASW assessors, Professional Social Work Supervision and DAPO. There is also a deficit of Band 6 staff due to vacancies within the community teams and of IO trained staff within nursing staff in mental health with Nursing staff declining to undertake the IO role supported by their unions, therefore Social Workers tend to undertake the majority of Adult Safeguarding investigations. In addition some community teams have AYE Social Work staff who are currently unable to undertake the IO role until they are at Band 6 level while other teams report only one Social Worker within their team and the remainder of staff are support staff who are also unable to undertake the IO role. This has continued to impact

on Social Work front line services delivery and has placed considerable pressure on the Social Work workforce who also undertake all of the other statutory functions within mental health. There continues to be an increase in referrals from the voluntary sector and from the Leaving and After Care teams who have no provision of IO/DAPO within their service area and victims may not be currently open to mental health services. However as they meet the key definitions of an adult at risk of harm or an adult in need of protection an IO has to be sourced from the existing mental health IO trained staff which also increases pressure on their service delivery and caseloads.

There are on-going challenges within mental health services with the introduction of the Adult Safeguarding policy July 2015. Joint agency working with PSNI, RQIA, professional bodies regarding procedures, protocols and practice issues remains an ongoing priority. The mental Health Adult Safeguarding Team have implemented a database to capture the recording of Adult Safeguarding as an interim measure while plans continue to implement all of mental health safeguarding recording and investigations to the Trust information system – PARIS. All staff within mental health services will require some additional training for the implementation of recording of adult safeguarding referrals and investigations on PARIS, however there is no current timescale for this due to the new APP documentation which needs to be designed for PARIS but planning meetings continue with the PARIS implementation team. The service area remains committed to the delivery of adult safeguarding, while recognising significant workforce pressures. A priority for the service is to ensure that Band 6 non-Social Work staff are encouraged to undertake IO training and that there are suitable supervision and support arrangements put in place to support non-Social Work IO staff. Additional bespoke IO and DAPO training has been facilitated by the Learning and Development Team in addition to the IO/DAPO training offered twice per year to relieve pressures on community teams so that newly appointed staff could undertake the IO and DAPO roles.

Workforce planning continues to be encouraged with the Service Leads within each service area to ensure that appropriate levels of Band 6 staff and Band 7 Social work staff are recruited to undertake the assessed safeguarding requirements for their service. Consideration is also required of the capacity of Band 7 Senior social work practitioner staff to meet the demand within the service area and fulfil the statutory requirements of the Band 7 role to undertake the ASW and DAPO / ABE function.

The Mental Health Adult Safeguarding Team continue to offer essential support to all DAPO's and IO's within the Service Area and in quality assuring all aspects of Adult Safeguarding. The Mental Health Adult Safeguarding Team has completed an initial audit of safeguarding within the service area and plans to do this on an annual basis to ensure governance arrangements, appropriate safeguarding investigations are undertaken and review decision making, and alternative responses to safeguarding. Refresher training for IO/DAPO is also being planned with the Learning and Development Team which would be an addition to the IO/DAPO support groups currently in place so that IO/DAPO's can maintain and update their skills and knowledge in safeguarding. It is anticipated that the current level of DAPO/IO need within mental health

services will remain at the same rate when the Adult Protection Gateway Team become the single point for referrals for mental health. The Adult Protection Gateway Team will take responsibility for level 3 investigations which include joint protocol investigation, institutional care investigations and investigations involving paid members of staff and have a team of DAPO and IO staff to manage the investigation. All other referrals will remain the responsibility of the mental health service to progress the investigation. Within mental health services the level 3 investigation for joint protocol and paid staff allegations of abuse have decreased due to the police thresholds for joint protocol investigation and the level of referral for institutional abuse referrals remains low, therefore the majority of referrals currently referred and dealt with by the mental health Adult Safeguarding team will remain at its current level.

SECTION 5: LASP Partner Updates

Belfast and Lisburn Women's Aid

- All the staff team are given Adult Safeguarding training which is Core. (every three years) Last training session 2018.

- Four staff 1. Board member, Two Senior managers, Outreach worker have completed Adult Safeguarding training Champion/Appointed persons.

- We have one Adult Safeguarding Champion Liz Brogan and three appointed persons.

- All staff and volunteers are aware and can identify the above.

- We have created a template for collating all adult safeguarding queries, discussions, referral activity.

- Each of our three refuges use the pro forma to record ASG activity.

- All information is sent to the ASC.

- All information gathered is used in the yearly ASG report.

- Adult Safeguarding is regularly on staff meeting agenda's; Senior Management team meetings, Board meetings, individual team meetings, and full staff meetings.

- We have an Adult Safeguarding policy which outlines procedures for dealing with Adult Safeguarding referrals etc.

- ASC attends all LASP meetings throughout the year.

- Our key worker in the Older Women's Project has had the following additional training/awareness raising sessions –

Dementia Awareness – Advice NI – Integrated services for Older people-Action on elder abuse conference.

Cedar Foundation

Our Quality Improvement Plan included:

- Assurance that all staff and volunteers have the appropriate Level of 1,2,3 Safeguarding Training-Achieved 100%

- Continue to use ISO accreditation as the framework for ensuring systems and processes to monitor and evaluate our Safeguarding Practices; we updated our Policy to reference the European Convention on Human Rights, and to include our Complaints Procedure

- We reviewed incidents monthly and reported quarterly to the Executive Board

- We completed the Adult Safeguarding Champion Position Report for 18/19

- We participated in LASP and ARC Networks to ensure the currency of knowledge regarding best practice approaches to Adult Safeguarding

Lisburn & Castlereagh City Council

Please record your organisations/service activity under the Prevention, Protection, Partnership headings for the year 2017-18. This will be included in the LASP report. If you also know or plan to complete activity in the forthcoming year please also record in the 2019/20 section.

Activity	2018-19	2019-20
Prevention	• Reviewed all 14 SG Procedures • Produced New Procedure – 'Dealing with a Person in Crisis / at risk of suicide' • 4 In house LCCC Keeping safe trainers attended an up skilling/bridging course with Volunteer Now to add adults at risk training to Child protection training to ensure staff only have to be released once for training. • SG champions (SP and BT) Attended Appointed persons training and mental capacity training • SG Champions attend SG Champion network meeting re Position report • Completed the 18/19 Position report • Attended Elder Abuse Conference in February • SG Champions have both attended Mental Health First Aid training	To review and update LCCC Safeguarding Policy - New CEO Revise the e learning management system for Safeguarding and roll out to all staff. Members of in-house working group to attend Appointed person training. SG champions to attend any relevant training

	• February 2019 – Arranged a meeting with GRO (births, deaths and marriage registration) to discuss the sharing of personal information to ensure a referral can be made to the relevant statutory bodies if abuse is suspected. This was following concerns about a GRO Memo that was sent to Council staff. • Have now achieved Platinum membership of ONUS – workplace domestic Abuse. Have carried out a number of awareness raising session in community for businesses and churches	
Activity	**2018-19**	**2019-20**
Partnership	• Attend SET and Belfast Trust LASPS meetings • Elder Abuse day 15 June 2018 – Bow street mall – partnership with PCSP, SET LASP, Banks and Trading standards on scam awareness • SG champion on working group for action plan –' accessing safeguarding services'	Work in partnership for Elder abuse day 2019 - loneliness theme

	• SG champions are active members of NI Safeguarding Network • PCSP now members of our internal working group	

Volunteer Now

Core KAS Sessions

Throughout 2018-19 Volunteer Now has continued to work in partnership with the Health and Social Care Board and Belfast LASP to deliver free 'Keeping Adults Safe' training to participants from voluntary, community, independent and faith sector organisations in the Belfast Trust area.

The following courses were delivered:

- 3 full day KAS M2 'Keeping Adults Safe: Training for Staff and Volunteers'
- 2 full day KAS M3 'Keeping Adults Safe: Recruitment, Selection and Management'

There were **79** participants in total and the average participant evaluation score was **4.6** (on a scale of 1 to 5, where 5 is excellent).

Additional Activities

Volunteer Now has been actively involved with the Belfast LASP throughout the year, attending LASP meetings and events.

Volunteer Now Enterprises Ltd also continues to promote the 'Keeping Adults Safe: Adult Safeguarding Champion & Appointed Person' training through the LASP.

Core KAS Sessions – Break down

A full break down of the **core KAS sessions** in the Belfast LASP area is included below:

19th October 2018, Module 2: Keeping Adults Safe: Training for Staff and Volunteers
Belfast (Volunteer Now)
16 participants
Average Score: 4.6

Participant Comments: Enjoyed the group discussions, hearing people's different opinions on situations. / Invaluable to keep everyone up to date with expectations. / Nice relaxed refresher to safeguarding / lots of respect and space to discuss issues, plenty of clarity and guidance / Useful for my organisation.

8th November 2018, Module 3: Keeping Adults Safe: Recruitment, Selection and Management

Belfast (Volunteer Now)

11 participants
Average Score: 4.6

Participant Comments: Invaluable information, well organised and presented / Will go back and look at our policy / Excellent update / Found Access NI info particularly useful / Content of the training was very relevant.

17th January 2019, Module 2: Keeping Adults Safe: Training for staff and volunteers

Belfast (Knockbracken Health Care Park)
14 participants
Average Score: 4.9

Participant Comments: Very interesting training and in depth, really useful and has improved my knowledge greatly. / The training was very thorough – I enjoyed the discussions with the entire group to get different opinions. /

11th February 2019, Module 3: Keeping Adults Safe: Recruitment, Selection and Management

Belfast (Knockbracken Health Care Park)
21 participants
Average Score: 4.4

Participant Comments: Good level of interaction. [Trainer] made you feel very comfortable]. / Well put together course. Good interaction with the group. / Interactive group discussions, useful and informative. / Enjoyable interactive training which raised awareness and evoked thought. / Very well presented. / Trainer was knowledgeable. Room was cold in the morning, warmed up in the afternoon. / Excellent training – enjoyed all the interaction and group exercises. / Lots of food for thought for my organisation as we consider expanding the range of services that we provide. / The resource pack was great. Really enjoyed the case studies and discussions. / Good use of resources. / Good opportunity to revise and recap on existing knowledge and to network with others.

19th March 2019, Module 2: Keeping Adults Safe: Training for staff and volunteers
Belfast (Knockbracken Health Care Park)

17 participants
Average Score: 4.7

Participant Comments: Room was cold. / Great lunch facilities, / Easy to understand, and use in my workplace. / Enjoyed the training – very informative and related to my work place. / A high standard of training, very informative and felt very comfortable and able to ask questions. / Trainer very good. / Well laid out training with experienced facilitator. / Very well delivered. / Room was freezing, everyone uncomfortable.

Core KAS Sessions – Analysis

Participant Feedback

The average participant evaluation score for the Belfast M2 sessions was **4.7**, and for the M3 session was **4.5** (on a scale of 1 to 5, where 5 is excellent). As demonstrated by the participant evaluation comments included above, feedback has continued to be excellent with respect to the trainers, course content, delivery and interactive nature of the sessions.

Booking and Attendance Numbers

The 3 KAS M2 sessions were attended by 47 participants and the 2 KAS M3 sessions by 32 participants, giving a total of **79 participants across the 5 sessions.** This averages at 15 participants per session (the maximum is 25 per session).

A significant issue across all KAS sessions is ‘drop out’ of participants who have signed up for sessions and then failed to attend or made late cancellations. This can be difficult to manage due to the courses being free to book and has continued in 2018-19 despite our formal booking/confirmation process via our website and reminder emails being routinely sent to participants prior to delivery dates.

SECTION 6: Belfast LASP work plan 2019/20

There will be a strong emphasis on taking forward areas of adult safeguarding work within the Belfast Trust in response to regional and local learning.

There will be a review of adult safeguarding structures and local procedures to ensure that adult safeguarding is fully embedded across all areas within the Trust.

In addition, the Belfast LASP will work to deliver on the NIASP annual objectives for 2019/20 and will consult with Belfast LASP members regarding a local LASP work plan for 2019/20.

APPENDIX D

DATA RETURN 10 – Children's Community Services Directorate

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

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

10.1 CHILDREN IN NEED		
10.1.1	How many Children in Need are there in your area as at 31st March? (exclude children on the caseloads of statutory mental health services)	**4088**

Article 17 of the Children (Northern Ireland) Order 1995 (the Children Order) identifies a child as being in need if:
"she/he "is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by an authority; her/his health or development is likely to be impaired, or further impaired, without the provision for her/him of such services; or she/he is disabled".

Article 18 of the Children Order places a general duty on the Trust to:
"(a) safeguard and promote the welfare of children within its area who are in need; and (b) so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of personal social services appropriate to those children's needs".

The Trust's children in need figure relates to those children who, as at 31 March 2019, were open to a social worker within the Trust's Family and Child Care and Children with Disabilities Services.

Please see below children in need data trend-table for the period March/September 2015- March 2019.

Belfast Trust Children in Need

Children in Need	2015	2016	2017	2018	2019
As at: 31 March	5739	5153	4262	4331	4088
As at: 30 Sept	4939	4778	4272	4179	

<table>
<tr><td>10.1.2</td><td>Ethnic Origin of Children in Need</td><td>See Excel</td></tr>
<tr><td>10.1.3</td><td>Religion of Children in Need</td><td>See Excel</td></tr>
<tr><td>10.1.4</td><td>(a) How many children have been referred for an Assessment of Need during the reporting period i.e. 1st September - 31st March?

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

(c) Of those children referred how many have been known to Social Services in the past referred 6 months, 6 months to 12 months, >1 year from date of referral this period (ie previously known and case closed)
Note: this is NOT for collection. This has been passed to BSO to be automated.</td><td>See Excel - 3619</td></tr>
<tr><td>10.1.5</td><td>How many children are currently awaiting an Assessment of Need at period end by length of wait (unallocated cases including disability as at 31st March)</td><td>See Excel - 80 F&CC 166 CwD</td></tr>
<tr><td>10.1.6</td><td>How many of these Children in Need are Disabled and known to Trust Social Workers (by major category) at 31st March?
Guidance – grand total will match the total row at 10.1.1</td><td>See Excel</td></tr>
<tr><td></td><td colspan="2">
<table>
<tr><th>Children with Disabilities</th><th>2014</th><th>2015</th><th>2016</th><th>2017</th><th>2018</th><th>2019</th></tr>
<tr><td>End of March</td><td>667</td><td>667</td><td>677</td><td>671</td><td>975</td><td>958</td></tr>
<tr><td>End of September</td><td>689</td><td>701</td><td>819</td><td>659</td><td>884</td><td></td></tr>
<tr><td colspan="7">The Trust has included all Children in Need across both Family and Child Care and Children with Disabilities Services respectively in this return. The Trust has previously highlighted the need for a review of the current definition of Disability to facilitate the collation of consistent data across all childrens social care service settings.</td></tr>
</table>
</td></tr>
<tr><td>10.1.7</td><td>Disabled children known to the Trust who left school during the reporting period and the transition plans that are in place.</td><td>See Excel</td></tr>
<tr><td>10.1.8</td><td>How many Children in Need are currently awaiting assessment or treatment with child and adolescent mental health services as at 31st March</td><td>Board Return</td></tr>
<tr><td></td><td colspan="2">Trend analysis and commentary (Refers to ALL i.e. tiers 2-4 children awaiting CAMHS regardless of the pathway to the waiting list)</td></tr>
<tr><td>10.1.9</td><td colspan="2">What preventative action is being taken by the Trust to ensure that children in need are not involved in offending behaviour (offending behaviour is defined as: formally cautioned or convicted).</td></tr>
</table>

	The Trust's Family Support Strategy provides the framework within which services are delivered to children in need 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-informed, 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 Citywide four local Partnership Groups. The Trust's Director for Children's Community Services chairs the Belfast Outcomes Group, which is driving forward a Belfast-wide Early Intervention Service (EIS). The EIS is seeking to improve outcomes for vulnerable children and their families through the provision of a range of tailored local, accessible, inclusive, enabling and evidence-informed services to support families and children facing emotional, social, behavioural and psychological difficulties. This initiative is predicated on an integrated, multi-sectoral approach to supporting families at different points and to building relationships and partnerships with families and their local support networks. The template for the EIS 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. Evaluation of the impact of the Hubs to date 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 BHSCT residential care staff along with police from Musgrave Police station have continued to consolidate their collaborative approach to reducing Children Missing from Care incidents by 46% in the past twelve months. The Trust's PACS Project delivers 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.

	PACS provides a rapid response and intensive supports to enable young people and families to manage the immediate crises and to develop coping skills to prevent further crises occurring.	
10.1.10	How many of the Children in Need are Young Carers There were 63 young carer payments made during the reporting period. In relation to referrals to Action for Children Young Carers Service, 19 children and young people were referred during the reporting period and 83 children and young people were supported by the service.	
10.1.11	How many young people aged 16 and 17 years presented to the Trust as homeless / or were referred by NIHE to Trust as homeless during the period and their outcome **This information will be sourced by HSCB. Trusts are not required to complete.**	**Board Return**
10.1.12	(a) How many Trust sponsored Day Care Places provided through any means including Article 18, Fostering or others are there for Children in Need at period end? (b) How many of these children have a disability?	**See Excel**
	The Trust's Sponsored Daycare Service (SDC) commissions day care as opposed to playgroup placements. SDC is a core Trust Family Support service targeted at Tier 2 and Tier 3 children and families with significant and complex needs. It affords bespoke supports to a cohort of children in respect of whom there are significant concerns. Following the identification of a suitable placement, an SDC placement review process addresses placement objectives, indicators and review arrangements in the context of overall case management objectives. A focus on engaging and working with parents are of core importance in securing placement and overall case management objectives and outcomes. Sponsored Day Care works closely with local social economy providers, as a large percentage of the day care facilities in the areas of highest need in the Trust have evolved from this background. These settings are often local hubs for the delivery of a broader range of family support services, including benefit advice, counselling projects, health promotion and other family support initiatives. The Trust's Contracts Department works closely with scheme co-ordinators to assure value for money and compliance with corporate governance requirements.	

	<table><tr><th>Sponsored Day Care</th><th>2014</th><th>2015</th><th>2016</th><th>2017</th><th>2018</th><th>2019</th></tr><tr><td>As at: 31 March</td><td>520</td><td>421</td><td>448</td><td>295</td><td>440</td><td>407</td></tr><tr><td>As at: 30 Sept</td><td>346</td><td>460</td><td>454</td><td>543</td><td>517</td><td></td></tr></table> The activity level for the March 2019 return represents a lower figure than that in the previous return, September 2018. By way of explanation, the September figure has historically been higher than the March SDC return. This is due to increased levels of placement activity over the summer period, with requests for summer placements and summer-schemes to meet the needs of children and families. The figures reflect both placement allocations as well as placement closures. As a result, summer activity is usually higher as places close at the end of the summer. The overall figure also represents children who remain in placement from the previous return period as well as new placements and closures.	
10.1.13	Trust usage of Family Centre Places for interventions	**See Excel**
10.1.14	This is intentionally blank	
10.1.15	Please provide the number of children (if any) subject to a Supervision / Interim Supervision Order at period end (moved from Child Protection section)	**See Excel**
10.1.16	During the period, please provide the number of children (if any) that became subject of a Supervision / Interim Supervision Order (moved from Child Protection section)	**See Excel**

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

CHILD PROTECTION		
10.2.1	How many children are on the Child Protection Register as at 31st March?	**334**
	<table><tr><th></th><th>0</th><th>1-4</th><th>5-11</th><th>12-15</th><th>16+</th><th>Grand Total</th></tr><tr><td>MALE</td><td>27</td><td>49</td><td>70</td><td>21</td><td>3</td><td>170</td></tr><tr><td>FEMALE</td><td>22</td><td>55</td><td>61</td><td>24</td><td>2</td><td>164</td></tr><tr><td>Grand Total</td><td>49</td><td>104</td><td>131</td><td>45</td><td>5</td><td>334</td></tr></table>	

	The Safeguarding Board for Northern Ireland (SBNI) revised and took forward arrangements for the operationalising of the Regional Child Protection Policy and Procedures in January 2018. The Procedures provide a conceptual definition of child abuse embracing four domains across four domains: ➢ **Physical abuse:** the deliberate physical injuring of a child or the wilful failure to prevent physical injury or suffering. ➢ **Emotional abuse:** persistent emotional ill-treatment of a child such as to cause severe and enduring adverse effects on the child's emotional development. ➢ **Sexual abuse:** forcing or enticing a child to take part in sexual activities, which may or may not involve physical contacts. ➢ **Neglect:** persistent failure to meet a child's physical, emotional and/or psychological needs resulting in significant harm to the child. In its role as a corporate parent, the Trust has a range of statutory duties to protect children from abuse under Part VI of the Children Order, including a duty to investigate concerns about the possible abuse of a child and the initiation of statutory proceedings to secure a child's welfare when necessary**.** The following are central to safe, qualitative and effective child protection services. ➢ An organisational culture, which profiles child protection as a core priority across all service delivery sectors. ➢ A learning and improvement organisational focus which prioritises and supports workforce knowledge and skills development. ➢ Strong multi-disciplinary and multi-agency working. ➢ Effective communication within and across those services and systems delivering supports to children at risk and their families. ➢ A focus on the "voice" of the child and the paramouncy of their best interests in assessment and planning processes. ➢ A commitment to working in partnership with a child's parents. ➢ Robust uni and multi-disciplinary assessment, identification of risks, effective risk management and review processes. ➢ Listening to the voice of a child and recognising the paramouncy of their welfare in all interventions. ➢ A child-centred, outcomes-focused/evidence-informed practice approach. ➢ An ongoing engagement with the wider public, seeking to promote their understanding of child protection issues and secure their active engagement in keeping children safe.	
10.2.2	How many of these children have a learning disability?	**8**
10.2.3	How many of these children have a physical disability?	**2**
	The Trust has previously indicated its view that further guidance in the operationalising of the current rights-based definition of disability is required to inform consistent collation of data returns	
10.2.4	Religion of children on the Child Protection Register	

Row Labels	0		1-4		5-11		12-15		16+		Grand Total
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	
CHURCH OF ENGLAND	0	0	0	0	1	1	0	0	0	0	2
CHURCH OF IRELAND	3	0	1	0	1	1	0	0	0	0	6
METHODIST	1	0	0	0	0	0	0	0	0		
MUSLIM	0	1	0	1	2	1	0	0	0		
NO RELIGION	0	2	0	1	1	0	0	0	0		
NOT COMPLETED	0	1	5	5	12	4	2	3	1		
OTHER	1	1	3	2	0	1	0	0	0	1	9
OTHER CHRISTIAN	1	0	3	6	12	10	5	3	0	1	41
PRESBYTERIAN	3	4	6	7	8	9	3	4	0	0	44
ROMAN CATHOLIC	4	4	18	17	18	18	7	5	1	0	92
UNKNOWN	9	6	11	15	14	16	4	8	1	0	84
(blank)	5	3	2	1	1	0	0	1	0	0	13
Grand Total	**27**	**22**	**49**	**55**	**70**	**61**	**21**	**24**	**3**	**2**	**334**

Count of PARIS ID
Value: 0
Row: METHODIST
Column: 16+ - FEMALE

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

Row Labels	0		1-4		5-11		12-15		16+		Grand Total
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	
ANY OTHER ETHNIC GROUP	1	1	0	0	2	2	0	2	0	0	8
BLACK AFRICAN	0	0	0	2	3	1	0	1	0	0	7
BLACK OTHER	0	0	0	1	2	2	0	0	0	0	5
INDIAN	0	0	0	0	0	0	0	0	0	1	1
IRISH TRAVELLER	0	0	0	2	0	5	0	0	0	0	7
MIXED ETHNIC GROUP	0	0	2	3	1	1	1	0	0	0	8
NOT COMPLETED	0	0	0	0	0	1	1	0	0	0	2
NOT STATED	1	0	6	3	4	7	0	3	0	0	24
WHITE	15	16	39	43	57	42	19	18	3	1	253
(blank)	10	5	2	1	1	0	0	0	0	0	19
Grand Total	**27**	**22**	**49**	**55**	**70**	**61**	**21**	**24**	**3**	**2**	**334**

10.2.6	How many registrations have there been during the period?	**126**
10.2.7	How many de-registrations have there been during the period?	**124**
	NB: The Service is currently engaged in the process of consolidating our PARIS Implementation. This has proved a hugely challenging task and has inevitably given rise to challenges / difficulties in synergising information flows. This remains a key priority for the Directorate as we seek to move to a whole service, digital recording and data collection system.	
10.2.8	What percentage of registrations are re-registrations?	**13.49%**
10.2.9	How many re-registrations were there within 6 months? NB include an explanation for each incidence. Young person, who had previously been on the Child Protection Register, subsequently admitted to care and de-registered, re-registered following their return home in September 2018. Young person re-admitted to care in October 2018 following a significant deterioration in home circumstances. Subsequently became the subject of an Interim Care Order and further re-registration in October 2018. De-registered in February 2019.	**1**

10.2.10	For children on the register, how long have they spent on the Register (as at 10.2.1)?	

	Under 1 Year	1 - 4	5 - 11	12 - 15	16+	TOTAL
Less than 3 Months	10	11	17	5	0	43
3 Months < 6 Months	16	17	28	10	2	73
6 Months < 1 Year	23	16	27	9	2	77
1 Year < 2 Years	0	47	43	15	1	106
2 Years < 3 Years	0	8	13	4	0	25
3 Years or More	0	5	3	2	0	10
TOTAL	49	104	131	45	5	334

10.2.11	How much time is spent on Child Protection Gateway, Family Intervention Service, Looked After Children	Not Required
10.2.12	Commentary on Trends of Child Protection Register	

As at the end of the current reporting period, there has been a decrease of approximately 8% in the number of children on the Trust's Child Protection Register relative to the figure as at 30 September 2018.

Children on CP Register	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
As at: March	**362**	**382**	**382**	**351**	**317**	**334**
As at: September	**373**	**373**	**349**	**331**	**342**	

10.2.13	Commentary on length of time children spend on register, particularly >1 year

As part of assurance arrangements, the responsible Senior Manager samples and reviews reports on minutes of Case Conferences to ensure appropriate risk assessment, risk management and child protection planning – incorporating the appropriateness of on-going registration. This involves a focus on the risk assessment review and child protection planning for those children on the Register for more than 12 months.

10.2.14	Commentary on what measures are being taken to tackle overdue case Conferences and the length of time children spend on the register

A range of factors contribute to overdue case conferences including difficulties in securing the attendance of key professional staff; difficulties associated with finding a suitable date to accommodate parents/young person/advocate/representative to attend; and unexpected issues resulting in the cancellation of a scheduled conference. (Please see 10.2.13 above re measures to monitor length of time on the CP Register).

10.3 Children (NI) Order 1995

Looked After Children

10.3.1	Provide the current legal status for all Looked After Children at 31st March (excluding any who are LAC on that day only by virtue of a short break arrangement)	**824**
	Article 21 of the Children Order provides for the Trust's accommodation of any child in need who appears to require such a service and, in respect of whom, the provision of accommodation is consistent with her/his welfare as a result of: a voluntary agreement between a child's parent(s) and the Trust; a voluntary agreement between a child (if over 16) and the Trust; or as a result of the child being lost or abandoned without anyone to exercise parental responsibility in respect of her/him. The Trust does not assume parental responsibility for a child accommodated under Article 21 of the Children Order. Article 50 of the Children Order specifies that, on application by the Trust, the Court may make a Care Order/Interim Care Order to the Trust in respect of a child if it is satisfied that: the child concerned is suffering or likely to suffer significant harm; the harm or likelihood of harm is attributable to the care previously afforded to the child or likely to be given to her/him if the Order was not made; and not that which it would be reasonable to expect a parent to give to her/him. (A Care Order/Interim Care Order may not be made in respect of a young person who has reached the age of 17 years, 16 with regard to a young person who is married). On the granting of a Care Order/Interim Care Order, the Trust assumes shared parental responsibility for the individual child. In exercising its role as a corporate parent to a child who is looked after, the Trust is required to provide that child with the supports which any good parent would give to their child. **Looked After Population March 2014 – March 2019** **Looked After Children** / **2014** / **2015** / **2016** / **2017** / **2018** / **2019** **As at: 31 March** / **721** / **742** / **739** / **743** / **766** / **824** **As at: 30 Sept** / **714** / **740** / **763** / **757** / **795** /	
10.3.2	Religion and Ethnic origin of Looked After Children (please provide by new list of ethnic minorities)	**See Excel**
10.3.3	Number of Looked After Children (as at 10.3.1) by type of placement at 31st March	**See Excel**

	The following is a synopsis of the placement profile of the Trust's looked after children population: As at the end of the reporting period, the majority of the Trust's looked after population were in fostering placements (both stranger and kinship arrangements) **637 / 77%.** Of the total fostering figure, **356 / 56%** were placed with stranger (non-relative) foster carers including independent carers. The remaining **281 / 44%** were with kinship carers. **A total of 58** young people, **7%** of the looked after population were placed in residential care placements. A total of **116** children and young people **(14%)** were placed at home with parents. The remaining **2%** were in a range of other placement settings. **Please note the Trust did not include in its Looked After population those children placed for Adoption with adoptive parents.**	
10.3.4	Age bands and length of time looked after for all Looked After Children at period end	**See Excel**
10.3.5	Number of children provided with a short break during the period who become Looked After by virtue of the short break arrangement	**See Excel**
10.3.6	Number of children accommodated for 3 months or more in a hospital	**11**
10.3.7	Number of children accommodated for 3 months or more in an adult facility. For example Residential Care Home, Nursing Home, Private Hospital	**See Excel**
10.3.8	(a) What facilities – statutory, voluntary and private are available to care for these Looked After Children i.e. how many places in residential homes, foster care placements (b) Provide your number of foster carers (should agree with 10.5.1) Provide the number of approved places offered (should agree with10.5.2)	**See Excel** **531** **557**
10.3.9	How many Looked After Children have had placement moves throughout the period? Trust must provide separate narrative / detailed explanation of every child who has 'moved more than 4 times or more' during the period. **= 4 Children** **Child 1:**	**See Excel**

	Young Person with significant emotional difficulties and challenging behaviours. Currently subject of an Interim Care Order. During the reporting period, has had a total of 12 moves across a series of short term placements, including 1 return home. Currently placed in residential care since mid-March. **Child 2:** Young Person currently subject of an ICO, has had a total of 5 placement moves during reporting period. Significant difficulties in securing appropriate placement option in light of young person being subject to a police investigation and challenges associated with a requirement that he will not be placed in a setting with children under 16 years of age. No alternative kinship options available. **Child 3:** Young Person subject of a Care Order has had a series of 7 placement moves during the reporting period. Young person present significant challenging behaviours and emotional difficulties. A potential long-term placement was identified. Young person remained in this placement for approximately 2.5 months. Placement ended following a series of absconding episodes and allegations against carer. Majority of short-term placement followed on from the breakdown of this arrangement and difficulties in securing longer term fostering placement option. **Child 4:** A baby with ongoing medical issues. Currently subject to ICO. Has had a series of 4 placement moves during the reporting period related to difficulties in securing a foster placement able to meet the specific and significant challenges associated with this child's complex needs.	
10.3.10	(a) How many Looked After Children are awaiting assessment or treatment with child and adolescent mental health services at 31st March (b) How many Looked After Children have been referred for therapeutic services and their waiting time (c) Please provide narrative to contextualize data and provide additional relevant data It is important to note that all new cases are seen within 6 weeks of receipt of referral. This initial meeting is regarded as an intervention in that we aim to support the system to think about the child/ren and their emotional needs. If it is deemed at that point that the child/ren require direct therapy then they will be placed on an internal therapy waiting list. At the moment the waiting list is approx. 58 weeks. Three main reasons for this waiting time	**6** **See Excel**

	1. We have a vacancy for a psychologist 2. Our discharge rate it very low – cases are usually open for a number of years, so all staff have full caseloads 3. We have yet to discharge a significant number of 18 + year olds due to a lack of appropriate services available to those leaving care Despite the child/ren waiting to be seen, the system around the child, e.g., the social worker, school, foster carer will be supported by regular reviews and training if required.	
10.3.11	How many Looked After Children are also on Child Protection Register at 31st March	**See Excel – 38**
10.3.12	How many Looked After Children are Disabled by major category at period end?	**See Excel - 187**
10.3.13	How many Looked After Children have a Statement of Educational Needs (SEN) by school status at period end?	**See Excel – 160**
10.3.14	(a) Has each Looked After Child an allocated and named social worker at period end? (b) Please state the number of Looked After Children who were without an allocated and named social worker during the period and give explanations. Due to ongoing staff vacancies, a LAC team leader on long term sick leave and then retiring and two staff on long term sick leave in one of the LAC teams a number of measures were put in place: ➢ Prioritisation of cases proceeding through Court or recently through Court. ➢ Monthly workforce meetings have been held throughout the year to review vacancies increasing to weekly meetings for LAC managers during March 2019. ➢ Two recruitment campaigns for new staff were held in August and March. Staff appointed to vacancies after the August campaign unfortunately did not take up post as expected. ➢ Overtime payments to staff willing to undertake additional cases. Of the remaining 39 without an allocated social worker these were allocated to the PSW and the following supports put in place on a temporary basis: ➢ Kinship fostering support staff assisting with statutory visits to young people in kinship placements.	**No** **39**

	➢ Residential staff assisting with statutory visits to LAC within the residential homes. ➢ Remaining statutory visits were prioritized through the duty system.	
10.3.15	(a) Did each Looked After Child receive a statutory visit by their allocated and named social worker at least once a month during the period? (b) Please state the number of Looked After Children who did not receive a statutory visit at least once a month during the period by their allocated and named social worker and give explanations. **Children with Disabilities – 2** Child 1-Social Worker had to cancel visit due to an emergency with another service user. Due to the child's scheduled activities with his direct payment carers, it was not possible for the Social Worker to see him for a further week. Child 2- could not be seen in his hospital setting due to concerns regarding his mental health. Social Worker visited the hospital, spoke to staff, and consulted with his mother. However, in October, December and January nursing and medical staff advised SW that direct contact with the young person was not appropriate due to his significant mental health issues. The young person in question has a serious mental health condition. **Family Support Service – 8** Child 1 – SW off sick. Visit not undertaken due to workforce issues. Child 2 – misunderstanding between LAC and FS SWs during transfer process resulted in visit not being completed. Child 3 – SW off sick. When covering SW tried to complete and carer was not available to facilitate visit. Child 4- SW off sick. Visit not undertaken due to workforce issues. Child 5 – SW off sick. Visit not undertaken due to workforce issues. Child 6 – visit arranged at short notice due to SW leave- Family unable to facilitate this visit within timescale Child 7 – visit delayed due to allocated social worker going on maternity leave and child being away on holiday at end of December 2018. Visit was outside of timescale while case was being transferred to a new social worker. Child 8 – visit not undertaken due to allocated social worker going on sick leave **Looked After Children Service – 57**	**No**

	LAC 1 – 5: 4 LAC due to crisis on caseload and 1 LAC where SW completed multiple visits to placement address and was unable to meet with young person. LAC 3 – 22 as named SW had left post and no cover able to be provided to cover all visits. LAC 6 – 30 did not receive a statutory visit from their Named SW as 2 SWs in the team went off unexpectedly within a two-day period and remain off sick. However, these visits were covered by other SWs on the Team. The following measures have been put in place by the Directorate to address the workforce issues: **Pro-active recruiting campaign**: A pro-active recruitment campaign supported by Trust's HR Service has been ongoing since July 2018. Focussing on: ➢ engagement with universities/Belfast Met to promote career opportunities in the Trust building on positive experiences of Trust's student placement cohorts. ➢ Participation in Job Fairs. ➢ Focus on workforce data to identify emerging issues and particular situational challenges to facilitate development of contingency and longer-term planning **Emphasis on retention:** ➢ Workforce engagement events to recognise and celebrate achievements of workforce. ➢ Strong focus on staff wellbeing, participation and engagement through structured listening and engagement events. ➢ Ongoing investment in career development and accreditation opportunities. ➢ Introduction of support for new Team Leaders through additional monthly workshops. ➢ Introduction of Therapeutic Family Support Service. Pro-active engagement with staff side across spectrum of workforce themes to maximise opportunities for a partnership approach in challenging service delivery context. Monthly workforce meetings have taken place since April 2018 chaired by the Co-Director for Family and Child Care. Escalation of workforce recruitment and retention issues to Corporate Risk Register. Staffing levels have been placed on the Corporate Risk register.	
10.3.16	Was the case of each Looked After Child reviewed in line with	**No**

	Statutory requirements?	
10.3.17	No. of Looked After Children Reviews held during the period	**825**
10.3.18	No. of these Looked After Children Reviews which during the period were outside of statutory timescales and why A total of 118 children's Looked After Children Reviews did not take place within the prescribed timescales. The reasons included the following: ➢ Social worker not available due to sick leave ➢ Staffing vacancies at social work and team leader level ➢ High turnover of social workers in some teams ➢ Reviews having to be rescheduled due to urgent service delivery priorities ➢ Delays in case transfers ➢ One Young person just had a baby. Rescheduled to allow young person to recover. ➢ Foster carer/social worker on holiday ➢ Unavailability of an interpreter ➢ Awaiting expert reports (Please see commentary at 10.3.15)	**118**
10.3.19	For children accommodated by the Trust under Article 21 of the Children Order, what arrangements has the Trust in place to ensure that it has the appropriate degree of parental responsibility to care for these children? The needs of children accommodated by the Trust under Article 21 are assessed prior to admission to care and are reviewed on an on-going basis within the Looked After Children's Review Framework. The Framework affords a structure for the review of all aspects of a child's welfare and planning for their future care. The Trust gives full consideration in consultation with the child, her/his parents and the multi-disciplinary network as to whether an accommodated arrangement effectively promotes a child's best interests.	
10.3.20	Is there an adequate supply of placements for children to enable placement choice? There are ongoing substantial pressures in sustaining and refreshing placement options for children in light of the rise in number of young people currently Looked After. This reflects the position both regionally and nationally. The Trust seeks to optimise its current placement capacity to secure the best interests and welfare of the individual Looked After Child.	

	➢ The ages, specific needs (sibling, disability needs) and duration (fulltime, long term, respite) of potential placements are regularly reviewed and incorporated into subsequent recruitment plans in order that the needs of children referred are appropriately met. ➢ The Fostering Service has a dedicated kinship team to enable children to remain within extended family if assessed to be in a child's best interests. ➢ A specialist Adolescent Fostering Scheme that provides placements for young people aged 12-18 years. ➢ All registered foster carers are approved for various age ranges, including sibling groups, and for both short term and long term duration dependent on children's assessed needs and also on the ability of the carers to offer various types of foster care ➢ The fostering service in partnership with children's disability service has developed a disability project which assesses applicants who can meet the very specific needs of children with disabilities. The project now provides placements or four children with complex needs on the edge of care. ➢ At the point of referral, attempts are made to match children to carers taking into account carers skills and capacity, child's views, geographical considerations, birth family contact, cultural and identity needs and education. ➢ In the event of an emergency placement being required, placement choice can be limited and dependent on carer availability at that given time. However no such placements would be made without the agreement of the child's social worker and will be reviewed immediately in terms of attempting to identify a more suitable alternative placement, if required. ➢ As above, in relation to emergency referrals, fostering do try and identify "emergency carers" who are available to provide these type of placements for a minimum of 6 weeks to allow more appropriate matching of placements to occur for any child placed in an emergency however this is dependent on the volume of emergency referrals received into fostering as the amount of emergency carers available is limited ➢ The PACS service also allows "time out" for young people aged 12-18 years living in the community who are experiencing "crisis" with a PACs foster carer and the frequency and timescale for time out is again based on the needs of the young person and their families	
10.3.21	How many exceptions to the normal fostering limit were made to foster care approvals in order for a child to be placed in an emergency in the reporting period? ***(Narrative)*** There have been four exemptions during this reporting period. 15.04.18-10.9.18, this was to facilitate a short term bridging placement to a 14 year old who required a foster placement on an emergency basis	

	17.09.18-4.1.19 this was to accommodate an emergency placement of a 15 year old male and was time limited 1.2.19- current : This exemption remains on-going and allowed a young sibling group of two females to be placed together in the same foster placement. Potential kinship options are being explored for this sibling group and it is anticipated therefore this placement will only be required for a time limited period. All of the above exemptions have been presented and endorsed at the Belfast Trust fostering Panel.	
10.3.22	What is the formal scheme of delegation that specifies who can agree such an exemption? This is done via the completion of a report under Regulation 11 of the Foster Placement (Children) Regulations (NI) 1996. The Supervising Social Worker will complete a report outlining this request. This will incorporate the carers views and views of any field social worker using the placement. This will be quality assured by the SSW and PSW. Arrangements will be made for this to be heard at the next available fostering panel. If the foster carers live outside the Trust area, then consultation will occur with the Principal Social Worker in The Trust area where the foster carers reside. If agreed the Exemption report will be sent to the identified Trust for consideration at their next available fostering panel. Panels will usually set time limits for Exemptions to be reviewed.	
10.3.23	How many children are deemed to be in an inappropriate placement given their assessed needs? ***(Narrative)*** ➢ There remains a consistent and regular review of those children whose care plans indicate that they should be identified for long term foster placements but are currently in short term placements. These children are highlighted and prioritised via the Long-Term Referral List which is reviewed on a weekly basis via placement review meetings that includes the PSWs and SSWs within the Fostering Service. This is also reviewed daily by duty officers with a view to matching any potential placement availability to the wide-ranging, individual needs of the children requiring long term placements. Children who require long term placements can also be profiled at the annual Til I grow up event to identify and match children with long term approved foster carers.	

	➢ These review processes promote the securing of permanence arrangements. Five of the children on the Long Term Referral List are currently deemed to be in inappropriate placements, given their assessment needs. This includes a sibling group who are currently in three different short term placements and also another sibling group of two who are also in a short term placement together but require a long term joint sibling placement. All five of these children will be profiled at the Til I Grow up event in May 2019. ➢ There continues to be an increasing growth in the past six months of children and young people entering the care system displaying more challenging and risk taking / sexual harmful behaviours, in particular, are those children who are entering the care system at a later age and have experienced significant adverse childhood experiences. Although placements are secured for these particular group of young people, it is resulting in multiple moves for the child/young person as foster carers are unable to manage these specific needs, particularly those of high level risk/aggression. Consequently, given the risks of multiple moves for these children, they require access to therapeutic / specialist placement arrangements. ➢ In regard to the above there have been eight looked after children in who have experienced multiple foster moves across their Looked After histories. One child (9 years old) was in a kinship placement with siblings, which broke down due to difficulties associated with the management of numerous allegations made by the child along with the child demonstrating highly aggressive behaviours. Subsequently, the child was placed with a non-kinship foster carer, however due to personal circumstances, the carer could not maintain this placement and he had to move to a private fostering agency placement. This private fostering agency placement also subsequently broke down due to an increasing number of allegations made by the child against his foster carers and levels of aggression had spiked for this child during a specific significant incident which resulted in the child having to leave the foster placement and be placed in residential care on a temporary basis. The child was then placed in a mainstream residential children's home, with a statement of purpose amended for his age group where the child remains. The child is making significant progress in all areas of the child's development with no allegations made to date. The child's care plan remains long term fostering. The Fostering Team have engaged in various recruitment options to specifically find a suitable foster family for the	

	child. This child is also being profiled at the annual Til I Grow up event in May along with a specific recruitment campaign across the Organisation. ➢ One (8 years old) admitted into foster care on an emergency basis following making an allegation of physical abuse to a visiting adult who was in the family home. The child was placed within a private fostering agency placement, however this broke down very quickly due to significant behavior management issues including dysregulated behaviours which were volatile, unpredictable and highly aggressive. The child was moved to an alternative private fostering agency placement which also broke down after the first night. Another private fostering agency placement had to be identified for the child and this also broke down within a day. The child was subsequently then moved to a specialist, bespoke children's residential home. This was to prevent further trauma in multiple moves within fostering and it was assessed that this child was not able to engage or invest in a foster placement at this time. The child is making good progress within the home, however further therapeutic work is required for the child regarding the child's excessive control and behavior management issue so that the child can learn to appropriately relate and attach to adults and peers, and the child's emotional presentation would suggest that the child requires intensive strategies to assist the child to the point the child may be able to engage and invest in a foster placement. ➢ A child (aged 11) was admitted to foster care on an emergency basis and had previously been in the care of the child's uncle via residence Order. This child had made allegations of a physical nature against the uncle and remained in foster care for a short period of time. This child's mother at this stage, had re-engaged and the child subsequently returned to the care of the mother. This lasted very briefly with the child making allegations of a physical nature against the mother, and was re-admitted into foster care again on an emergency basis just before Christmas. It was following this second emergency admission to care that patterns began to emerge of the child exhibiting behaviours that foster carers were finding difficulty in managing. Behaviours included making allegations against her foster carers, stealing, assaulting a carer and being verbally abusive to carers. The child was also displaying destructive behaviours with carers own belongings and was beginning to self-harm. All of these behaviours were indicative of feelings of rejection. The child consistently absconded from placements and returned to family who in turn indicated they could not care for the child and the	

	mother advised she was no longer In a position to consider caring for the child again as she had two younger children of her own and felt that the child was beyond parental control and she had to prioritise the care of her other two children. This child experienced a significant number of placement moves in a short period of time and was admitted into residential care in March 2019 with statement of purpose amended to accommodate this until the child reached 12 years old in April 2019. ➢ Another child (13 years old) was admitted into foster care, again on an emergency bass following an allegation of a sexual nature by the child's sibling whilst both were at home in the care of their father. Given the nature of the allegation and the on-going investigation, this child was placed with a respite carer who had no other Looked after Children or children of their own. This child remained there until an AIM assessment could be completed to inform matching requirements for the child. This child then moved to another placement with no other children however the foster carers could only provide a bridging placement. A longer term placement is still trying to be identified for this child to allow police investigation to conclude and to allow the Trust to review any potential risks in either a return home to his father or a care plan of fostering ➢ A placement group of 3 siblings (oversees nationals aged 7, 8 and 10) were referred for foster placements from Gateway and were placed together initially in a foster placement within a private agency. This placement only lasted a few hours with the foster carers feeling unable to manage the three children together. English is not the first language of the children and, whilst this was not a barrier to the children being placed with the support of interpreting services, the carers described the children as unmanageable. Due to the emergency need to identify alternative foster placements internally, the children were separated and placed with different carers and also with one support worker who was working closely with the family on an assessed kinship arrangement but they could not maintain placements other than on a short term basis. The two younger children moved to foster carers in another private agency and have settled very well. The oldest sibling experienced more multiple moves due to a series of placement breakdowns, and had to move to different bridging placements until a suitable match was identified for him and he has settled very well in his current full time placement ➢ Another child (aged 12) has experienced multiple foster placement moves due to a breakdown in the child's long	

	term placement within a private agency. The child moved to an internal foster placement but subsequently made allegations against the male carer and absconded on numerous occasions to the mother's home. The child found it very difficult to settle in any further placements identified given his strong desire to be in the child's mother's care. The child is currently in a respite placement which is not suitable as a longer term placement and Fostering Services continue to identify a more suitable and longer term placement.	
10.3.24	Please provide the number of restraints carried out by staff on young people within **each** Home during the period	**See Excel**
10.3.25	Do all looked after children have a concurrent plan by the time of their first 3 month statutory LAC Review ? Yes	
10.3.26	Permanency Planning for Looked After Children at period end Permanence provides children with a foundation from which to develop their identity, values and relationships, not only throughout childhood but on into their adult lives. It is generally better for most children/young people to find continuity and stability within their birth families. There are, however, circumstances where it is in a child/young person's best interests to remain looked after either in the longer term or permanently. In such circumstances the child's views (dependent on age) will be central to determining and securing the most appropriate option, including adoption, to achieve permanency. Trust practice in this significant and complex area of work is informed by the Regional Policy on Permanence.	**See Excel**
10.3.27	Can foster carers get access to support 24 hours a day throughout the period? ➢ Approved kinship and non-kinship foster carers have a dedicated named supervisory social worker from the Fostering Service and named field social worker staff. ➢ Foster carers can get access to social work staff during office hours 9am-5pm. ➢ The Regional Emergency Social Work Service is available to carers after the above hours. All kinship and non-kinship carers are issued with the contact details and are aware of this service.	
10.3.28	What action is being taken to monitor and reduce the number of placement moves experienced by Looked After Children? ➢ Weekly placement review meetings within fostering to ensure appropriate placements are made to meet the individual needs of the Looked after Child, matched with the skill base of foster carers to avoid minimum disruption/placement moves when	

	Looked After children are being matched for placements. These review meetings also take cognizance of Looked after Children placed within private agencies and this is reviewed to ensure there is no “drift” in care planning of children placed out with the Trust. ➢ Quarterly review meetings are also held with private agencies to ensure the needs of children placed with these agencies continue to be met and identify any potential difficulties/disruptions in a timely fashion with these agencies to ensure contingency planning is implemented to avoid any unnecessary additional placement moves. ➢ Regular review of recruitment campaigns to ensure that carers recruited meet the needs of children referred i.e. requirement for full time carers, sibling groups, children with learning or disability needs .and carers who can provide permanent care. ➢ Ensuring effective use of current and projected resources, ensuring information on carers is accurate, regularly updated. ➢ Identification of early signs of potential disruption and timely access to therapeutic and support services. ➢ Ensuring foster carers are fostering within their agreed registration to avoid overload and potential disruption. ➢ Timely referral of children to permanence panel. This enables regular monitoring of care plans, exploration of potential permanence options for children, thus reducing multiple moves. ➢ Timely referral of children and young people to resource panel and earlier exploration of options for young people at the edge of care, greater use of family group conferencing, and use of appropriate supports/early interventions in the community. ➢ Increased numbers of dual approved/concurrent carers. This can ensure identified young children can achieve permanency at an earlier stage and avoid drift in care. This process also increases the number of foster carers increasing placement choice, potential matching and thus reducing placement moves. ➢ Quarterly review meetings with Adoption to ensure children requiring adoptive placements that are currently within short term foster placements are identified and approximate timescales given to ensure projected availability planning for fostering and placements required. ➢ Evaluation of Til I Grow Up project – the next Til I Grow is scheduled for May 2019. ➢ Regular monitoring & review of Looked after Children referred for long term placements, ensuring timely delivery of permanence plans. ➢ Identification of an ECR fostering link person to ensure those children/young people who are placed within a specialist unit continue to be monitored and reviewed by fostering to ensure at point of discharge, robust planning and matching has been considered for mainstream fostering as a placement option ➢ Appropriate gatekeeping of referrals made to Fostering and ensuring PACS service is involved if appropriate, with families and young people in the community.	

10.3.29	(a) How many Looked After Children are involved in offending behaviour (are formally cautioned or convicted) and (b) How many Looked After Children are suspected to use drugs and/or alcohol?	**See Excel**
10.3.30	What is being done in partnership with other agencies to reduce the volume of Looked After Children involved in offending behavior? The Trust has consolidated practice informing the operationalising of the Regional Guidance in relation to Police Involvement in Residential Units and the Missing Children Protocol. Local Operational Liaison Groups provide important opportunities to develop inter agency relationships and to co-ordinate intervention approaches at organisational and individual levels. The residential care staff along with the police from Musgrave Street Police Station have continued to consolidate their collaborative approach to reducing Children missing from care. The Trust has developed Service Area procedures to inform the reporting of Untoward Events incorporating a particular focus on learning and related actions to reduce the incidence of young people who are looked after being detained or committed to a Juvenile Justice facility.	
10.3.31	What action is being taken to address the health needs of Looked After Children? With regard to Looked After Children's health needs, children in all placement settings are registered with a General Practitioner and have access to the range of primary care provision as required. A child's physical, emotional and mental health needs are addressed within the LAC Review process. Initial assessments and ongoing review and planning arrangements incorporate a comprehensive focus on physical, emotional and mental health wellbeing A dedicated health professional (LAC Nurse) provides a service to the Trust's children's homes as part of the overall wrap-around supports for Looked After Children. The LAC Nurse's remit includes health assessment of new admissions, preventative health promotion and training and consultation for staff on the management of specific health issues. The HYPE Project works closely with the young people who are in residential care with regard to safe relationships and sexual health.	
10.3.32	What progress are children making at school and what are their examination results – School Year Ended 30th June 2018 (this will	~~**LAC 31.03.19**~~

	be collected in September Data Return only) (HSCB will source this directly from DoH)	
10.3.33	Looked After Children, School Attendance – School Year Ended 30th June 2018 (HSCB will source this directly from DoH)	~~**LAC 31.03.19**~~
10.3.34	(a) Number of children notified to the police as having gone missing from residential or foster care for 24 hours or more? (This data will be sourced directly from the Untoward Event Report) (b) How many Looked After Children have been reported to the Police for reasons other than having gone missing for 24 hours or more during the period? (This table should be completed for each Residential Facility, it is not required for Foster Carers) (c) What is being done to address the problem of children going missing ➢ On a monthly basis, Co-Director for Corporate Parenting has monthly meetings with PSNI Superintendent responsible for missing persons across the region. Over the last 12 months, there has been a further significant decrease in the number of episodes of children in the number of such episodes, decreasing by 46 %. ➢ There are monthly operational liaison groups, which are chaired by social services and involve PSNI and senior social workers, which collate intelligence of those young people who habitually go missing and may have other associated risk taking behaviours such as CSE and poly-substance misuse. ➢ On a monthly basis, the Head of Service for Residential along with the CSE Lead meet with the PSNI Superintendent responsible for children who go missing to review those young people who are at risk and formulate joint strategies to ameliorate the reduction of missing episodes. Those young people whom habitually present as at high risk when missing will be brought before the Trust's Secure Accommodation Panel and admission to Lakewood may be recommended. ➢ On a three-monthly basis senior management from social services, all Residential Team Leaders and PSNI meet to review those young people who habitually go missing from care in order to optimise all preventative and safeguarding strategies that can be implemented. ➢ The Belfast Trust's residential service, in collaboration with the PSNI and IFA, have developed the 'Dare to Win' initiative, which is a twelve week programme, that aims to redirect young	**Board Return** **See Excel**

	people from risk taking behaviours, teach young people sport and coaching skills, and in the long term provide work opportunities to young people. ➢ The Belfast Trust are involved in a regional initiative in relation to developing multi-agency strategies, to address the problem of LAC young people who go Missing from Care. There has been Service User Engagement sessions to ascertain LAC young people's views on Missing from Care and actions taken by the services involved.	
10.3.35	Number of children accommodated by ELB for 3 months or more by category	**0**
10.3.36	(a) Number of sibling groups accommodated: • Together = 103 • Not accommodated together = 113 Reasons for separation: The following are recurring issues in relation to kinship placement availability/sustainability: ➢ The availability of kinship placements. ➢ The complexity of individual children's needs. ➢ The individualised nature of care plans, particularly in those circumstances in which a sibling group may have a number of different fathers. Often there are half siblings who are not directly related to one of the kinship carers, and there are situations where allegations have been made between siblings and therefore deemed not appropriate to place together. ➢ The particular challenges associated with large family groups. ➢ The assessed capacities of individual kinship carers to manage the demands of the role. ➢ Availability of appropriate accommodation (b) How many sibling groups became Looked After during the period? If placed apart provide an explanation for each occurrence. Team Return - There were 19 sibling groups who became looked after during the period due to the various reasons as outlined in 10.3.36 (a)	
10.3.37	Number of young people admitted to Secure Accommodation and the reasons for admission during the period **(data now sourced directly from Lakewood)**	~~**LAC 31.03.19**~~
10.3.38	Please provide report into the operation of the Trusts Restriction of Liberty Panel **(to be completed for March only return)**	
10.3.39	(a) During the period how many children or young people became a Looked After Child by age, gender and first placement	**See Excel**

	(b) To your knowledge have any of the children admitted during the period been subject to a full Adoption Order (c) Of those children at 10.3.39(a) admitted to care during the period how many have previously been on the Child Protection Register in the last 2 years from the period end date (d) Number of Children and Young People who became Looked After during the period had a CLA1 form completed and forwarded to School? (e) Can you assure the Commissioner that all the above admissions to care are properly recorded and do not include what should rightly be reported as a placement move (eg a fostering breakdown where the RESWS moves the child to a children's home) The Trust has endeavoured to ensure that no child who has moved placement during the reporting period has been mis-recorded as a new admission to care.	
10.3.40	(a) During the period how many children or young people became a Looked After Child by age, gender and legal status on admission; (b) (i) Were these admissions planned, unplanned or emergency; (ii) Of those that were unplanned or emergency how many were admitted to kinship foster care? (iii) Of those unplanned or emergency admissions how many were admitted by RESWS?	**See Excel**
10.3.41	During the period how many children or young people ceased to be Looked After by age, gender and length of time looked after at discharge	**See Excel**
10.3.42	(a) Of all the children and young people reported at 10.3.41 what was their destination at discharge by age and gender (b) Of those 16+ year olds who ceased to be Looked After during the period what was their entitlement to Leaving Care Services by age and gender	**See Excel**
10.3.43	This is intentionally blank.	
10.3.44	(a) Please provide the total number of children that became subject of a Residence Order during the period. For (a) above please give the number of children that were formerly placed with Stranger (Foster Carers), Kinship (Foster Carers), Residential Care or other placement. (c) How many Residence Orders are in place at period end?	**See Excel**

10.3.45	Number of Children or Young People who died during the current reporting period and were Looked After by the Trust by cause/age	**See Excel**

Note: Sections 10.3.41 to 10.3.43 should include all discharges including those reported in section 10.4

10.4 CHILDREN (LEAVING CARE) ACT (NI) 2002

Article 34E, Article 34F

The Trust has a range of statutory responsibilities under the Children (Leaving Care) Act (NI) 2002 in relation to the following groups of young people:

- *An **eligible** young person is one, aged 16 and 17 who has been looked after for at least 13 weeks since the age of 14 and who is still looked after.*
- *A **relevant** young person is one aged 16 and 17 who was eligible and who has left care.*
- *A former **relevant** young person is one aged 18-21 who has been either eligible or relevant or both.*
- *A **qualifying young person** is one aged under 21 who ceases to be looked after or accommodated in a variety of settings or privately fostered after the age of 16 and includes those who do not fall into any of the three above categories and who is aged under 21 (under 24 if in education or training).*

***A Pathway Plan** is a document drawn up by Trust staff and an individual young person which sets out the manner in which the Trust proposes to meet the needs of the young person. The Plan must address a range of areas detailed in the Schedule to the Leaving Care legislation. These include areas such as personal support, accommodation, education and training, employment, financial support and family and social relationships.*

***A Personal Adviser** fulfils a bespoke role as specified in the legislation and accompanying Guidance. The Personal Adviser is an advocate on behalf of the young person and acts as a mentor to her/him, offering support and advice in the manner of a "good parent".*

The Trust is required to:

- *Assess and meet the care and support needs of all eligible, relevant and former relevant young people.*
- *Keep in touch with all its care leavers who qualify under the legislation.*
- *Develop a Pathway Plan in consultation with the young person.*
- *Ensure that all eligible, relevant and former relevant young people have a Personal Adviser.*
- *Maintain and accommodate all relevant young people.*
- *Assist a care leaver in full-time, further or higher education with vacation accommodation where required.*
- *Assist a former relevant young person with costs associated with employment as her/his welfare requires.*
- *Assist with the costs of education and training up to the end of an agreed programme.*
- *Assist a former relevant young person to the extent that her/his welfare requires either in kind or, exceptionally, in cash.*

10.4.1	Number of young people subject to Leaving Care Act by category, age and gender.	**See Excel - Number**
10.4.2	Of those eligible young people reported at 10.4.1 give the Children Order Legal Status at period end. Age reference table will automatically update as spreadsheets completed.	**See Excel**

10.4.3	This is intentionally blank.	
10.4.4	This is intentionally blank.	
10.4.5	This is intentionally blank.	
10.4.6	Of the young people reported at 10.4.1 (a) What are the social worker and personal adviser arrangements in place for each category of young people? (b) Of the young people with a named personal adviser, how many have a Person Specific Personal Adviser? (c) How many do not have an up to date Pathway Plan at period end?	**See Excel**
10.4.7	Of the young people reported at 10.4.1 how many do not have a completed needs assessment and how long have they been waiting at period end?	**See Excel**
10.4.8	**Narrative** on failure to comply as detailed in 10.4.5, 10.4.6, 10.4.7 at period end. With regard to 10.4.6(a) 79 young people do not have a Personal Advisor. This figure is partly due to one vacancy during the reporting period, which has now been filled, plus a long-term PA staff absence. Within the core funded staff level however, even with all in post, there will still be a deficit to be able to meet full statutory responsibilities, as the Trust would require an additional 1.5 PAs to be fully compliant based on current numbers. With regard to 10.4.6(c), 8 young people do not have an up to date Pathway Plan; and in 10.4.7, 7 young people do not have a completed Needs Assessment. This failure to comply is within one LAC team which has been severely affected during the reporting period by a number of social work staff leaving the team including the Senior Practitioner and the retirement of the Senior Social Worker. The SSW post has now been filled, the SP has just been confirmed and recruitment is underway for the vacant social work posts. The completion of the Needs Assessments and the updating of the Pathway Plans will be a priority to ensure compliance.	
10.4.9	Of the young people reported at 10.4.1 what are their living arrangements at period end? Please complete for (a) Eligible; (b) Relevant; (c) Former Relevant; and (d) Qualifying young people	**See Excel**
10.4.10	Of the young people reported at 10.4.1 what is their current education, training and employment status, and how many are being supported financially at period end?' 10.4.10 (a) Eligible; (b) Relevant; (c) Former Relevant; and (d) Qualifying young people.	**See Excel**
10.4.11	Of the young people reported at 10.4.1 how many were convicted during this reporting period?	**See Excel**

10.4.12	Of the young people reported at 10.4.1 how many have a disability by major disability – physical, sensory, learning, chronic illness, Autism (see definition) and other, type and gender at period end?'	**See Excel**
10.4.13	Of the young people reported at 10.4.1 what is their parental status at period end?'	**See Excel**
10.4.14	'Of the young people reported at 10.4.1 how many are receiving treatment for mental health issues at period end? Of these, how many were new referrals to mental health services during the period?	**See Excel**
10.4.15	Number of Young People who are no longer Looked After but who died during the current reporting period and were in receipt of aftercare services by cause/age.	**See Excel**

10.5 FOSTERING

10.5.1	(a) How many foster carers are registered with the Trust at period end?	**453**
	How many of the carers above also provide a GEM placement?	**43**
	Of the carers above how many are:	
	Prospective adopters dually approved as foster carers?	**44**
	Of the Prospective Adopters/Dually Approved carers above how many are Concurrent Foster/Adoptive Carers?	**8**
	(b) Please give the number of other foster carers;	**61**
	(c) Please give a breakdown of the number of foster carers de-registered during the period and the reason; 8 in Kinship: 4 cases where child became subject to Residence Order, 4 where the young person reached 18 years of age and/or was rehabilitated home with parents. No de-registrations in Support and Development or Recruitment and Assessment Team 4 cases in Adolescent Fostering Partnership Team: Older carers wishing to retire - One carer who recently had a baby and no longer wishes to foster as a result - Change of lifestyle and personal decision - De-registered but wished to maintain GEM placement	**12**
	(d) Please advise of the recruitment process activity during the period;	68 kinship
	(e) Please give the number of regional enquirers received by the Trust 13	
10.5.2	For the foster carers return at 10.5.1 how many **places** are they registered for and the number of vacant places at period end. Please also provide the number of fostering households that have no child placed with them at period end.	**See Excel**

10.5.3	How many foster carers have annual reviews outstanding? 9 in Support and Development team 8 in Adolescent Fostering team 8 in Recruitment and Assessment team 20 in kinship team Please provide the number of viability visits undertaken during the reporting period. (moved from 10.5.1f)	**See Excel – 73**
10.5.4	Please provide details of the reasons for outstanding reviews *(Narrative)* The 8 annual reviews outstanding in the Recruitment and Assessment Team is due to long term staff sickness. These outstanding reviews will be completed in May/June 2019. The 9 annual reviews over due in the Support and Development Team is due to allegations being made against the foster carers, staff sick leave and transfer of cases The 20 outstanding annual reviews in the Kinship Team are due to social workers being on long term sick leave, two full time vacancies within the team, maternity leave and also foster carers own health issues. The 8 outstanding reviews within the Adolescent Team are due to staff case transfers and foster carers own health issues. Total number of outstanding annual reviews within the Service is 45.	
10.5.5	What action is being taken to maintain and increase the range, diversity and supply of foster care places *(Narrative)* The Trust has a marketing and recruitment strategy which seeks to maximise opportunities to profile fostering via targeted advertising across regional and local media, dissemination of good news stories about fostering, regular initiatives to profile particular aspects of fostering and an emphasis on the specific needs of individual or groups of children. The strategy seeks to engage the public in a discussion about the challenges, opportunities and rewards of foster care. In addition, we are embracing social media as a means to connect with the public although the scope and effectiveness of this continues to be limited by the Trust's social media policies. Following engagement with the Regional Adoption and Fostering Service and Fostering Services, an audit of HSC fostering recruitment activity across Northern Ireland was undertaken. ASG (Marketing Consultancy) has recommended that going forward recruitment should be a regional activity, via a regional recruitment team. There will be a rebranding of HSC Fostering to include all marketing tools and materials. The Trust alongside the HSCB are jointly chairing a N.I. regional recruitment and retention strategy for Fostering.	

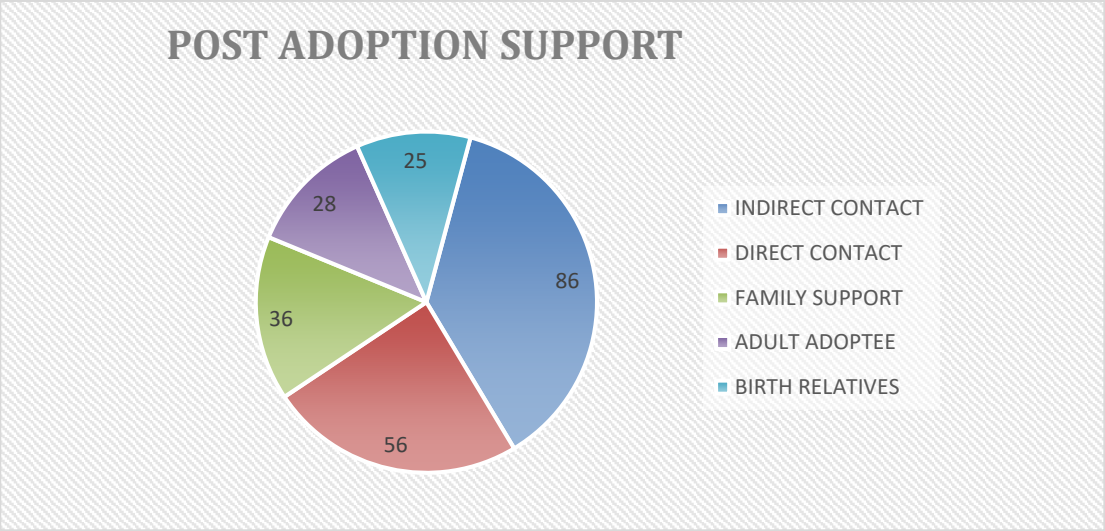
	In addition, there has been a recent focus on recruitment amongst Trust employees which has included: • securing an information stand in the 'marketplace' at Trust monthly inductions; • regular posting to the HUB, Trust intranet site, highlighting forthcoming recruitment events, recruitment initiatives and foster carer profiling • refreshing recruitment banners at Trust sites to be seen by staff members • increased activity on social media channels including the Trust's Facebook and twitter accounts, which many staff follow • inclusion of foster carer recruitment information in Family and Childcare Directorate magazine • feature on trust employee and foster carer within the Directorate magazine. 'Til I Grow Up' [TIGU] is scheduled for the fifth time in May 2019, the third time it has been undertaken in partnership with South Eastern Trust Fostering Service. TIGU provides an open information evening to inform and engage with members of the public who have been thinking about fostering and would like to find out more. Over 70 households from across both Trusts attended the 2018 event. As a result of this event, Belfast Trust has carried out 20 follow up requests and continues to evaluate the outcomes of this in terms of conversion rates including from enquiry to approval and application to approval versus alternative recruitment methods. As an update to the February 2018 TIGU event, 10 households were invited to Skills to Foster. Of these, 5 were counselled out and 1 withdrew, 2 applications were received and 1 was approved. We have one assessment ongoing. The Trust also continues to encourage respite carers to explore moving from the provision of respite to the full time care of Looked After Children and this is continually reviewed by supervising social workers and their Managers. The specialised Adolescent Fostering Partnership (AFP) Service which was in partnership with Barnardos is now managed solely by Belfast Trust. This Service provides full time placements to adolescents 12-18 years of age either from the community or residential care and continues to be a very successful initiative. The Trust is currently planning promotional and recruitment material within the next 6 months. The Parenting and Adolescent Support (PACS) Service consists of 1 specialised PACS foster carer, providing emergency or time limited "time out" for young people living in the community to ensure they can return to live safely with family if it is felt in their best interests. This offers families under crisis and stress an opportunity for time out. It is also acknowledged that the Fostering Service is currently unable to meet some of the on-going demand for emergency placements required and this continues to impact on the use of private agency foster agencies. As a direct result of this and to ensure that we can make appropriate emergency placements, the service has developed an Out of Hours foster care scheme

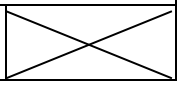
	with a small pool of foster carers who will be available to provide emergency placements on a rotational basis to ensure consistency of service delivery for emergency placements required. The Fostering Service continues to promote and encourage the growth of kinship care in accordance with the interim Kinship standards and continues to contribute effectively, based on practice and safe guarding issues, in improving the standards with the HSCB to ensure that kinship care remains a quality safe permanence option for Looked After Children. The Fostering Service continues to experience workforce pressures and related capacity challenges. It has, however, maintained supervisory social work supports to its foster care population. The retention of foster carers is vital and remains a priority for the Trust. The provision of regular training events and the delivery of a range of supports and social events for foster carers are central elements of the Trust's retention strategy. A sample of such activities has included: ➢ Family Fun Day at Lady Dixon Park, in partnership with VOYPIC which will be held in June 2019 ➢ Annual Christmas Party at the Dundonald Ice Bowl planned ➢ Annual Christmas Coffee morning at Belfast Castle ➢ Monthly support groups for all kin, and non kin foster carers with a different focus each month, whether it be an identified training need or a particular issue that carers would like to discuss further as a group ➢ Annual Fostering Achievement Awards which was held in October 18 with over 100 children along with non kin and kin foster carers in attendance and this occurs an annual basis in partnership with Fostering Network and this is always a very positive event for carers and Looked After children in celebrating the achievements of children in foster care and giving recognition to the carers ➢ A newsletter which is issued three times per year to keep all foster carers up to date with what is happening within the service as well as regular updates to the Regional website

10.5 PRIVATE FOSTERING **The Children Order (NI) 1995 - Part X** **NB *Advice from DLS is that the 28day period should be continuous.***		
10.5.6	What steps has the Trust taken to encourage notifications? *(Narrative)* The DHSSPS Circular and covering letter Children Living with Carers in Private Fostering Arrangements, including Children from Overseas – CCPD 1/11 has previously been disseminated across the Trust. It has previously been discussed at the Trust's Safeguarding Committee and Adult services interface meeting.	
10.5.7	How many Private Fostering Arrangements under Article 106 are in place within the Trust as at the 31st March?	**0**
10.5.8	How many Private Fostering notifications under Article 106 has the Trust received during the period?	**0**
10.5.9	Please provide DOB and Date notification was received in respect of each child/young person reported at 10.5.8.	
10.5.10	Of the notifications received (10.5.8) how many has the Trust accepted?	**0**
10.5.11	Of those notifications not accepted please summarise reasons and action taken by the Trust.	**0**
10.5.12	Number of appeals made during the year under Article 113	**0**
10.5.13	Are supervisory visits undertaken in accordance with Regulation 3(1)(a) and (b) as a minimum to children privately fostered? Please provide details of any circumstances where the Regulation has not been adhered to.	**N/A**
	Notifications under Regulation 4 of the Children (Private Arrangements for Fostering) Regulations (NI) 1996	
10.5.14	How many notifications has the Trust received in respect of children being adopted from abroad i.e. Intercountry Adoption within the period.	**0**
	Please specify the child's DOB and the date the Trust received each notification	

10.6 Adoption (NI) Order 1987 Adoption (Intercountry Aspects) Act (NI) 2001		
Article 3(as amended by HPSS Order 1994), Article 11		
10.6.1	(a) Number of enquiries, by type, received by the Trust and what prompted their initial approach? (b) Please provide the waiting time from initial inquiry to commencement of training	**See Excel**
10.6.2	Number of domestic applications for assessment received by the Trust by civil status of applicant	**See Excel**
10.6.3	Number of Prospective Domestic Adopters awaiting assessment at period end, length of time waiting, and reason waiting	**See Excel**
10.6.4	Number of inter-country applications for assessment received by the Trust by civil status of applicant (to be completed by NHSCT on behalf of the region)	**See Excel**
10.6.5	Number of Prospective Inter-country adopters awaiting assessment at period end (to be completed by NHSCT on behalf of the region)	**See Excel**
10.6.6	Of all adoption assessments (both domestic and inter country) completed during the period please give details of the outcomes	**See Excel**
10.6.7	Number of looked after children freed for adoption and not yet placed with their prospective adopters as at 31st March; and duration of wait since freeing order as granted.	**See Excel**
10.6.8	(a) Activity under the Adoption (NI) Order 1987 during the period; Of the number above please give the number who were adopted in a Hague designated country and therefore not through the Courts in NI and have had their Article 23 reports completed in the time period; Please provide the number of Freeing Orders made during the reporting period; (b) Of those children who were adopted this period please give the length of time from becoming looked after (last episode) to going to live with the family who went on to adopt them. (c) Number of children on the Adoption Register and number on Register of Approved Adopters at period end;	**See Excel**
10.6.9	Please provide the number of children who, at period end, had received a best interest decision for adoption and had not been placed with approved adopters (either adopters, dual approved carers including concurrent carers) and the duration of that wait.	**See Excel**
10.6.10	How many children are in receipt of an Adoption Allowance at 31st March and how many households is this?	**See Excel**
10.6.11	Of the number at 10.6.10 how many commenced during the period and how many households is this?	**See Excel**
10.6.12	Details of recruitment, assessment, training, support for prospective adopters	

	Belfast Health and Social Care Trust Adoption Service continues to respond to enquiries that progress to initial visits and to deliver preparation to adopt training and then on to assessment. Whilst these have dropped in numbers, there continues to be interest in progressing towards adoption with 10 couples booked to attend the preparation to adopt course in April 2019. The Adoption Service also works closely with our colleagues in the Family Centre to provide bespoke parenting assessments alongside concurrent placements. Adoption Service's staff are responsible for the recruitment, assessment and support of concurrent carers. The number of carers open to considering concurrency as their preferred adoption pathway is increasing and the Trust has in the reporting period made two concurrent placements with an additional 8 couples approved awaiting matching . There are 9 assessments of prospective adopters currently ongoing. Adoption services has collaborated with Fostering services to create a bank of staff to assist the Adoption Service by undertaking additional adoption/fostering assessments. This has reduced the length of time prospective adopters have to wait to be assessed. This has also enabled Belfast Trust to create a pool of approved prospective adopters who can meet the needs of our adopted children and reduce the need to place children in cross Trust placements. In the reporting period the South Eastern Trust has placed a child with a Belfast Trust couple due to our current pool of approved adopters. Adoption services have now established an "in house" learning and development programme for prospective adopters who have completed the preparation to adopt course. This takes place bi-monthly and covers the following topics: ➢ The Importance of Play ➢ Attachment and Trauma ➢ Transitions/Preparing for placement ➢ Medical and developmental conditions of children ➢ Understanding behaviours ➢ Telling and Life story work In addition to these, Belfast Trust invites our approved adopters to Trust information sessions such as Concurrency and Til I Grow Up as well as regional courses facilitated by Adoption UK and our Nurturing Attachments programme. The next Til I Grow Up is scheduled for 21st May 2019 co-facilitated with the South Eastern Trust., In October 2018 the Belfast Trust Adoption Service participated in the first Regional Adoption campaign, "Adoption Changes Lives". This proved to be very successful and all Trusts experienced higher number of enquiries at this time. Information stands were also on display in the three major hospital sites during this week-long campaign. All of our approved adopters avail of regular support from their social worker and are signposted and referred when necessary to TSS, Trauma Centre, TESSA, Child Care Centre and Adoption UK support groups and training.

	Adoption services in Belfast also facilitate a bi-monthly support group for adoptive mums which is led by the adopters. This has proven to be very successful.
10.6.13	Details of Post Adoption Support - this section should include data in respect of the number of and action taken in respect of placement breakdowns both pre (i.e. where adoption is the Care Plan) and post Adoption Order
	Summary of current workloads and type of work undertaken The current team of 3 social workers are providing a service to **231** clients. This can be broken down to the following areas of support:  **Indirect contact** Managed by one social worker and involves administrative task of exchanging letters between adoptive parents /child and birth relatives. It also involves providing support to all parties involved in the process of writing letters. **Family Support Case** The support provided varies in kind and is dependent on the needs identified as part of the assessment of need at point of referral. The service provided to-date includes, access to training, support to parents to respond to child/ren's behaviours using a therapeutic model of parenting and on specific parenting tasks relevant to adoption, i.e. sharing information regarding the child's history. Support to extended family on how to support the child/parents. Direct work with children including, life-story work, anger management work, managing anxiety, therapeutic support. The team have also provided support to nursery, primary and secondary schools when the need has arisen for specific children who are struggling in the school environment. Assistance in accessing other services through referrals to TSS, TESSA, Extern, etc. In addition to this there is an established monthly support group for mothers that is run by the adoption team on a monthly basis and is open to all adoptive parents pre and post-Adoption Orders. It is currently well attended with 6 parents regularly attending following adoption orders being granted in respect of their children. **Training** The team deliver an 18-week nurturing attachment programme in conjunction with TSS and Fostering. This is delivered to maximum of 9 adoptive families on a yearly basis.

	Two further training events are planned for 2019 - Topics include "How to promote open communicativeness in adoption", scheduled for July 2019; and "Supporting your child with post adoption contact", planned for May/June 2019. **Future areas for development based on identified needs** ➢ Earlier intervention, reaching families before they self- refer which is usually when family unit is very fragile. **How this may be achieved :** Establishing links with adoptive parents/children prior to Adoption Order being granted and then maintaining contact with families post adoption order, through informal keeping in touch days which may take various forms. ➢ Maximising resources by making use of the experiences/inputs/ proposals of experienced adoptive parents who are keen to provide support to other families who would benefit from their knowledge and skills in managing the challenges inherent in adoptive parenting. **How this may be achieved:** Developing a mentoring service for adoptive parents provided by experienced adoptive parents and managed by a social worker from the Post Adoption Team. Meeting will be held with those wishing to be involved in providing this service in May 2019. ➢ Expand the therapeutic services available to parents/children within the Post Adoption Team to include (but not exclusively) play therapy, narrative therapy, DDP, NVR, counselling support to parents. **How this will be achieved,** financial investment from the Trust in training staff to ensure they have the skills and relevant training to respond to the complex therapeutic support needs of children and adoptive parents. All staff in the post adoption team will be trained in narrative therapy in June 2019. ➢ Developing a support service for young people to include, one to one therapeutic support, an activity based group aimed at promoting confidence and self-esteem, peer mentoring service, support group. ➢ Regular evaluation of service through obtaining formal feedback from clients on the effectiveness of interventions and providing opportunities for service users to shape and enhance service development. ➢ Collating data on post adoption contact statistics that can be analysed to inform recommendations regarding post adoption contact arrangements. There have been no adoption breakdowns in the reporting period.
10.6.14	Number of inter-country adoption orders pending at period end 

10.7 EARLY YEARS

10.7.1	Please provide the current early years provision / places, registrations and de-registrations Include Number of Approved Home Child Carers	**See Excel**

10.7.2	Registration issues and commentary as at period end *(Narrative)* The most significant issue is the anomalies between the Minimum Standards and the accompanying guidance. Providers are anxious with regard to reports going online. However the teams are providing support to those who have expressed any concerns.	
10.7.3	Total number of annual Inspections required, number carried out, number outstanding and time outstanding as at 31st March	**See Excel**
10.7.4	Number of outstanding applications for each of the above categories as at 31st March .	**See Excel**
10.7.5	Number of current applications being assessed at period end and duration of assessment .	**See Excel**

	10.8 Complaints & Representation	
10.8.1	Does the Trust have an appropriately authorised and experienced children's complaints officer? The Trust has appointed a Designated Complaints Officer to assist in the co-ordination and management of all aspects of complaints and representations in respect of children. In addition, a Children's Services Manager has been appointed to act as Trust Officer for the purpose of overseeing the management of all complaints received about services listed under Part 4 of the Children (NI) Order 1995. Both officers have been appointed in line with Departmental Guidance on HPSS Complaints (April 2000) and Handbook of Policy and Procedures Volume 5 Children Order (NI) 1995, Representation and Complaints.	
10.8.2	Does the Trust have an independent advocacy service for children and their families? Children, parents and carers are encouraged to access a range of independent advocacy provision including: the Northern Ireland Commissioner for Children and Young People; the Commissioner for Complaints; VOYPIC; the Children's Law Centre; and the Patient Client Council in pursuance of any complaint in respect of services provided by the Trust. The Trust has engaged VOYPIC to provide an advocacy service to its residential units. Trust foster carers access the advocacy and representation services of the Fostering Network.	
10.8.3	What arrangements are in place to ensure that all complaints – both formal and informal – from children and their families are recorded and dealt with? All complaints received are dealt with in accordance with the Trust's Complaints Procedure and the Handbook of Policy and Procedures Volume 5 Children Order (NI) 1995, Representation and Complaints. The Trust's Corporate Governance processes provide robust reporting and scrutiny arrangements in relation to individual Directorate's management of complaints and arrangements for the dissemination and sharing of learning emerging from complaints.	
10.8.4	What whistle-blowing arrangements are in place to ensure that concerns raised by staff working in children's services are recorded and dealt with? The Trust's Whistle Blowing Policy provides the framework within which concerns raised by staff are recorded and dealt with. The Policy fully adheres to the requirements specified in the Public Interest Disclosure (NI) Order 1998.	
10.8.5	How many *Children Order* complaints – both formal and informal have been received since the last report?	**Board return**

10.8.6	How many complaints *(which do not fall within the Children Order definition)* – both formal and informal have been received since the last report?	**Board return**
10.8.7	How have these been dealt with?	**Board return**
10.8.8	What was the outcome?	**Board return**
10.8.9	What percentage of the complaints i.e. Children Order and non Children Order were resolved within the required timescale.	**Board return**

Note: Data for sections 10.8.5 – 10.8.9 – will be sourced by Board officers from existing returns.

10.9 SEPARATED CHILDREN

THIS INFORMATION IS COLLECTED ON A QUARTERLY BASIS

10.9.1	Number of separated children referred to Gateway Teams by status of children for this period (self-reported age at presentation) Total of 7 presentations. ➢ 3 children reported to be 17 years ➢ 2 children reported to be 15 years ➢ 1 child reported to be 16 years ➢ 1 child reported to be 8 years	**7**
10.9.2	Please provide the source of the referral of each child. ➢ Border Force ➢ Bryson House x 3 ➢ School ➢ Voluntary Agency ➢ Health Visitor	**Separated Children 31.03.19**
10.9.3	Please provide the country of origin for each child referred during the period. ➢ Iran x 1 ➢ Kuwait x 1 ➢ Eritrea x 2 ➢ Portugal x 1 ➢ Somalia x 1 ➢ Romania x 1	
10.9.4	This is intentionally blank	
10.9.5	Pathway following completion of UNOCINI: Of those separated children with a UNOCINI completed during this period specify the Pathway/Legal status at period end. Note: Two primary pathways: Looked After and Child Protection ➢ LAC Pathway & Care Order x 3 ➢ LAC Pathway x Art.21(1) Accom. < 16 x 1 ➢ Family Support Pathway & no legal status x 2 ➢ Closed & no legal status x 1	**Separated Children 31.03.19**
10.9.6	Separated children and 'Looked After' Pathways Please provide the total number of 'separated' children who are currently Looked After Children within the Trust Area at period end? (This figure must include all separated children looked after irrespective of their admission date)	**11**

	(a) Provide legal status for these children 6 voluntary accom and 5 Care Orders (b) Provide placement, for 'other' category please specify placement type 7 residential care 3 supported living 1 foster care (c) Number where trafficking is suspected / confirmed and a NRM has been submitted 2 (d) Number who are claiming asylum and subject of immigration process 8 (e) Provide the total number of children at period end who are receiving after care support in line with entitlements under the Children (Leaving Care) Act 2002 11	
10.9.7	Number of Looked After 'Separated' children who have gone missing from care during the period: (a) Please provide the number of Looked After children who went missing from care during this specific period; 1 (b) Please provide the total number of Looked After 'Separated' children missing from care at the period end; 0 (c) Provide a commentary on each of the children identified in (b) above. 16 year old, first referred to the Trust in November 2018. Young Person is subject to a Care Order. Was identified as a flight risk at point of placement and a management strategy initiated to seek to obviate same. Young Person left the Unit without permission on a series of occasions through November 2018 to February 2019. Ongoing work to address risks associated with such	**Separated Children 31.03.19**

	behaviours and to seek to engage in purposeful planning for young person's education and health and wellbeing, and to address young person's emotional and social and psychological wellbeing. The situation appears to have stabilised in the period since February 2019. Ongoing management and review of flight risks and related care needs.	

OVERALL SUMMARY OF ISSUES RAISED WITHIN CC3/02	
Staffing – situation as outlined in the reports and strategy implemented in relation to recruitment and retention to manage same. More recently, vacancy and sickness levels have had an impact on our ability to discharge fully our statutory functions in relation to a number of LAC children. Following recent recruitment campaign the Directorate hopes that the majority of vacancies will be filled by summer 2019.	Unallocated Cases – management arrangements are in place to screen and review on an ongoing basis.
Caseload Pressures – complexity of presenting and assessed need alongside increasing levels of demand for services have led to additional workload pressures. Other factors affecting caseloads are - demands of court processes, management of complaints, CMR processes, data access requests, FOIs and Constituency Enquiries.	Placement availability – successes of Fostering, Adoption and Residential in sustaining and managing placement base, however, significant pressures associated with rise in LAC numbers, complexity of needs, children entering the care system, pressures across joint commissioning provision particularly in relation to young people with significant behavioural and emotional needs.
PARIS Implementation – a major transformational project which involves the adoption of digital working fundamental to future organisational structures and service delivery processes, crucial to quality improvement and strategic planning. Major challenge for staff to adopt new ways of working and new business processes, essential that Children's Social Care is positioned to optimise potential of Encompass roll-out. The Implementation of PARIS in CCS was subject to Internal Audit and the Service received satisfactory level of compliance.	Rise in LAC Numbers – recognition of the impact of the rise in LAC numbers. It is important to develop an understanding of the key factors underpinning this rise at both local, regional and national levels and the implications for workforce and placement resources.
Collective Leadership – progress has been made in developing Directorate Structures, with the re-engineering of Senior Management roles at Tier 3 and Tier 4, the development of a workforce strategy with investment in individual career development opportunities, investment in coaching and mentoring opportunities, a focus on workforce wellbeing, engagement and listening. The Directorate has also invested in an infrastructure to support professional service delivery through the development of Directorate information and ICT expertise, and increasing corporate and professional governance capacity.	Quality Improvement. The Directorate has fully engaged with the Quality Improvement agenda with over 50% of its workforce having completed level 1 training. Staff from across all levels of the Directorate have engaged in the full range of QI training programmes to support the bedding down of a continuously improving ethos and culture.

IiP – The Directorate has prioritised the development of a People and Culture plan focusing on areas such as engagement with the workforce, communication and reward and recognition. The Directorate, as part of the wider Trust was assessed for accreditation for IiP and has recently been awarded the Silver Award.	

APPENDIX E

RESTRICTION OF LIBERTY PANEL REPORT

Introduction

Secure accommodation
The children (Secure Accommodation) Regulations (Northern Ireland) 1996 provides that a child may have his liberty restricted in a facility that can be physically secured for an aggregate period of 72 hours within any 28 day period without the authority of the court. Thereafter, the Trust must apply to the court for a secure accommodation order under article 44 of the Children (NI) Order 1995. The maximum period for which a court may authorise a child to whom Article 44 applies to be kept in secure accommodation is three months. A court may authorise a young person to whom Article 44 applies to be kept in secure accommodation for a further period not exceeding six months at any one time. A young person under 13 years of age cannot be placed in secure accommodation without the prior approval of the DHSPPS.

Northern Ireland's only secure accommodation centre is a regional facility, based in Bangor, County Down.

Restricting the liberty of children is a serious step which must be taken only as a measure of last resort. Therefore, trusts have a duty to take all reasonable steps to avoid the need for children to be placed in secure accommodation.

A trust may apply to a magistrate's court to admit a young person to secure care, if a child meets one or all of the following criteria:

a) S/he has a history of absconding and is likely to abscond from any other accommodation; and
b) If kept in any other description of accommodation s/he is likely to injure himself or other persons.

The Restriction of Liberty Panel
The gateway to the secure care facility is through a referral to the Trust's restriction of liberty panel which has been established to consider applications to secure accommodation. The panel comprises a group of senior representatives from the trust who have differing areas of responsibility for the looked after population.

The panel must ensure that the criteria have been met in relation to those children who are being considered for secure accommodation. Based on those who are most in need or those who pose a greater risk to themselves and others, this panel must prioritise referrals in respect of all young people who require a secure place.

This report provides an overview of the work of the BHSCT Restriction of Liberty Panel during 2018-2019

10.3.38 (b) ANNUAL REPORT INTO ROL PANELS OPERATION

PLEASE COMPLETE FOR EACH PANEL

10

1. Number of Panels held during the year:

2. Please outline the make-up of each panel and identify who the independent person was in each:

Date of Panel:	
Names of Panel Members	Name of Independent Chair
28 August 2018 Maeve Gillen CSE Co-ordinator Siobhan Rogan PSW Colette McKenna LAC PP Robin Jordan Clinical Psychologist Jacquie Wilson CAMHS Carolyn McEvoy LAC PP	Kerrylee Weatherall CSM
13 September 2018 Maeve Gillen CSE Co-ordinator Siobhan Rogan PSW Colette McKenna LAC PP Mark Conachy Consultant Psychologist Jacquie Wilson CAMHS Carolyn McEvoy LAC PP	Kerrylee Weatherall CSM
21 September 2018 Carol Lamb Court PP Siobhan Rogan PSW Eimear Hanna PSW	Kerrylee Weatherall CSM
25 September 2018 (Review)	Kerrylee Weatherall CSM

Eimear Hanna PSW Siobhan Rogan PSW Robin Jordan Clinical Psychologist Jacquie Wilson CAMHS	
27 November 2018 Eimear Hanna PSW Maeve Gillen CSE Co-ordinator Siobhan Rogan PSW Frances Agnew Clinical Psychologist	Kerrylee Weatherall CSM
7 December 2018 Eimear Hanna PSW Maeve Gillen CSE Co-ordinator	Siobhan Rogan PSW
7 February 2019 Carolyn McEvoy LAC PSW Siobhan Rogan PSW Mark Conachy Consultant Psychologist Colette McKenna LAC PP Maeve Gillen CSE Kevin Brookfield Clinical Psychologist	Kerrylee Weatherall Interim Co-Director
19 February 2019 Siobhan Rogan PSW Mark Conachy Consultant Psychologist Robin Jordan Clinical Psychologist Jacquie Wilson CAMHS Colette McKenna LAC PP	Kerrylee Weatherall Interim Co-Director
22 February 2019 (Review) Colette McKenna LAC PP Robin Jordan Clinical Psychologist Carolyn McEvoy LAC PSW Jacquie Wilson CAMHS	Siobhan Rogan Interim CSM
11 March 2019	Siobhan Rogan Interim CSM

Eimear Hanna PSW Maeve Gillen CSE Co-ordinator Kevin Brookfield Clinical Psychologist Jacquie Wilson CAMHS	

3. Please give the number of children considered / age / gender / presenting issues, advise if secure accommodation was considered appropriate and, if so, how quickly the children requiring secure accommodation were placed. Also please indicate if the child attended the panel or expressed a recorded view regarding the application:

SOSCARE REF / Paris ID	AGE	GENDER	ISSUE	SECURE ACCOMMODATION CONSIDERED APPROPRIATE? (Y/N)	IF YES, HOW MANY DAYS TO SECURE PLACEMENT	DID CHILD ATTEND PANEL? (or express a recorded view re application (Y/N)
28.08.18 107446	16	M	Subject to community/paramilitary threat, deterioration in mental health, risk to others re verbal and physical threats and aggression, involvement in criminal activity	Y	1	Young person (YP) did not attend, view recorded
13.09.18 191634	17	F	CSE, MFC, deterioration in mental health, self-harm, substance use	Y	43	YP did not attend, view recorded
13.09.18 179850	16	M	Risk to public regarding Harmful Sexual Behaviour, (HSC) risk of physical and sexual violence, Self-harm. Lack of	Y	7	YP did not attend, view recorded

			parental insight with regard to safeguarding and potential risk their son poses to public, parental non adherence with safety planning			
13.09.18 50343	17	M	Polysubstance use, deterioration in mental health, medical needs and physical deterioration, suicide ideation, criminal behaviour risk to others re possession of drugs and concerns re supplying younger children.	Y	6	YP did not attend, view recorded
21.09.18 388122	14	M	Concerns with regard to HSB, physical health, use of substances/solvents and potential impact on physical health, MFC episodes, risk of self-harm, deterioration in emotional and mental health, fragmented relationship with mother, increased levels of aggression	Y	0	YP did not attend, view recorded

			directed towards mother.			
25.09.18 (Review) 191634	17	F	CSE, MFC, deterioration in mental health, self-harm, substance use	Y	43 (from date of first panel on 13.09.18)	YP did not attend, view recorded
27.11.18 53396	17	M	High level of MFC episodes, including overnight, polysubstance use, deterioration in mental health and suicide ideation, criminal activity, related to vulnerability to peers, involvement in paramilitary activity, risk to others re suspected supplying of drugs, involved in assaults on others.	Y	3	YP did not attend, view recorded.
7.12.18 250183	16	M	Significant polysubstance use, solvent use, deterioration in physical health, involvement in criminal activity in the community, potential exploitation in	Y	5	YP did not attend, view recorded

			relation to criminal activity re drug debt, potential vulnerability to bullying from peers.			
6.02.19 507441	15	F	CSE, MFC episodes, potential risk of domestic violence from relationship with another LAC YP, polysubstance use and alcohol use. Alleged victim of sexual assault from adult male.	N	N/A	YP did not attend, view not recorded.
19.02.19 107314	15	M	Potential paramilitary threat, deterioration in physical and emotional health, poor sleep/eat patterns, increased levels of aggression directed towards staff.	N	N/A	YP did not attend, view recorded.
22.02.19 (Review) 507441	15	F	CSE, MFC episodes, potential risk of domestic violence from relationship with another LAC YP, polysubstance use and alcohol use. Alleged victim of sexual assault from adult male.	Y	7	YP did not attend, view not recorded.
11.03.19 250183	15	M	Deterioration in mental and emotional	Y	2	YP did not attend,

			presentation, polysubstance use, MFC, vulnerability to criminal/sexual exploitation related to substance use, risk of further criminality			view recorded.

4. Please outline any special arrangements required to manage a child where there was a delay in placement. Outline the arrangements for each occasion.

The Trust ROL Panel will make recommendation of a 'step up' plan, which focuses on maximising safeguarding options/alternatives to support young people who meet the criteria for a secure placement in those circumstances where there is no bed availability. The HSCB is notified by the Trust when a young person requires a secure placement and there is no availability and this is kept under review within 10 working days.

The 'step up' plan is likely to include:

- Multi-agency Risk Strategy Meetings are convened weekly or fortnightly which inform safety and risk management planning. These meetings include the police representative from the MFC team, the CSE co-ordinator where appropriate, CAMHS, TSS and other relevant agencies.
- For young people in residential care, staffing levels have been increased to ensure robust supervision of young people, provide direct work, diversionary activities and time away from the home as a means of cementing the relationships and disrupting the risk taking behaviours.
- Continued offers of support from relevant agencies such as Safe Choices when young people are at risk of sexual exploitation or DAMHS when the young person is misusing substances on a persistent basis. There is a Drug and Alcohol worker within the Parent and Adolescent Community Support Service (PACSS) who

provides direct work with young people and consultations with staff teams, managing the impact of polysubstance use.

- Some of the young people are on strict bail conditions due to offending behaviour and may be taken into custody for periods of time due to breaches of bail conditions or for charges for further offences.
- There would be close liaison with CAMHS, DAMHS and the CAIT team for young people who present with mental health issues which can also be linked to significant substance use.
- Where appropriate, family and previous foster carers have been involved in a comprehensive support package that promotes young person's feelings of stability and provides time away from peer influences that draw young people in to engaging in harmful behaviours. Given the escalation in young peoples' pain-based behaviours can be related to fractured family relationships, there is a focus on repairing these relationships which has the potential to reduce young peoples' feelings of isolation.
- Operational Liaison Group meetings (involving the Trust and Police) review those young people in care and in the community when they present as being at significant risk of CSE and/or going missing.
- Senior Management meetings between the Police and Social Services devise joint strategies to safeguard the young people awaiting admissions in the interim period prior to entry into secure.
- Therapeutic network meetings have been put in place for some young people as a means of helping the young person be participative in keeping themselves safe and engaging with the support being provided by the team and other significant people in young person's life.
- Occupational Therapist, CAMHS, has provided consultations with staff team to inform activities that can improve emotional regulation for young people and design the environment within the children's home that contributes to a calm and stable living space.

5. Please outline if any advocates attended a panel and provide brief details of the advocate's views regarding the application where secure accommodation was considered appropriate for the young person:

Prior to ROL Panel taking place, all young people are informed that they have been referred to and are offered support from VOYPIC Advocacy Service to have their views independently represented within the Panel process. The Trust provides young people referred to ROL Panel with an information leaflet about secure accommodation. Information about VOYPIC Advocacy Service will be offered to the young person so that they can make an informed choice as to whether or not they want to avail of the service prior to their personal information being shared with VOYPIC.

Furthermore, the views of the young people and their parents/carers are documented in the written information provided by the presenting social worker contained within the CLA14 report and in their verbal presentation to the Panel. The social workers, in their ongoing involvement with the young people, ensure that the young people are well informed that their behaviours are presenting such a high level of risk to themselves and/or others and, if they are unable to curb their behaviour sufficiently, that the social worker is left with no other option but to consider them for a placement in secure accommodation for their own safety and protection and to address the issues which have contributed to their risk taking behaviour.

The Trust has discussed with VOYPIC the need to review the improvement of advocacy attending at ROL Panels.

Advocacy workers regularly attend each of the children's homes and have developed relationships with most of the young people in the homes. This is also a means of young people being able to discuss the potential for a secure application more informally.

6. Please provide an analysis of the presenting need / the interventions being sought from Lakewood:

There are multiple contributing factors, which lead to young people meeting the criteria for Secure Accommodation. For some of the young people, the risks can escalate over a period of time, and even with a high level of support and targeted, multiagency intervention, the need for containment in a secure unit becomes necessary.
For other young people, the risk can escalate over a short period of time, and the need for secure accommodation becomes more immediate and urgent.

The common themes regarding the presenting needs of young people include:

-Missing from care or family home

This can be a critical issue when the whereabouts of young people are generally unknown and young people are returning to their care/ family placements, where there is a significant deterioration in their physical and emotional presentation.

- Misuse of substances/ solvents/alcohol

A number of the young people referred for secure placements were engaged in significant levels of polysubstance use, solvents and alcohol use which led to single or multiple hospital admissions, through young people experiencing unconsciousness and hallucinations. One young person had to be placed in an induced coma.
Of concern is the type of substances young people are using, MDMA, morphine and heroin. Some young people have been remanded into custody and incurred criminal charges as a result of their actions whilst under the influence of substances.
A number of the young people were also vulnerable to exploitation, as they need the financial means of purchasing drugs or paying off drug debts.

All of these young people have been referred to relevant services, such as DAMHS, Daisy Project and the PACSS Drug and Alcohol worker, however the young people do not have the ability to engage with these services, given their need for drugs and reduced cognitive capacity due to prolific use of substances.

-Child sexual exploitation

Two female young people were referred in the time period, where there were concerns in relation to vulnerability to CSE. One of these young people was allegedly raped and she remained vulnerable to further exploitation from parental and peer relationships. Therapeutic networks and agencies such as Safe Choices, Barnardos and police representatives from PPU and MFC teams, have worked alongside other professionals to mitigate the escalating risks. However due to young peoples' minimal sense of self-value and lack of insight to potential danger, a secure environment has been the appropriate option for safeguarding these young people.

- Non-engagement with services and relationships

For a number of young people, a further indicator of requiring a placement in secure accommodation, has been a chronic non-engagement with key relationships and services such as family, RSW team, school or the Therapeutic Support Service. Young people's withdrawal from relationships and services can be symptomatic of a sense of hopelessness, as young person isolates him/ herself from a consistent support network.

-Presentation, with Aggressive and Violent Behaviour

Some of the young people referred to secure accommodation, had a profile that included a propensity for violence, one of whom there were evident risks of sexual violence. Physical violence would be directed towards carers, peers, public and professionals. This cohort of young people can bring complexities that are a challenge to manage in an open residential or family placement, given the level of risk to others and self, and young people being so emotionally

dysregulated that they require physical containment and eventually a therapeutic intervention within a secure environment. Some young people presenting with violent behaviours was linked to the impact of substance use.

-Mental Health/ self-harm

Some of the young people have considerable mental health issues or diagnoses, linked to trauma and early/current life experiences. Furthermore, there can be a deterioration in their mental / emotional health linked to chronic substance/ alcohol use. The self- harming behaviours ranged from cutting, ligatures to deliberately breaking limbs. One young person's self- injurious behaviours included her burning different parts of her body. Most of the young people referred for secure accommodation were known to CAMHS, DAMHS and had had one or more inpatient admissions to Beechcroft.
Some of these young people can feel overwhelmed in open, group living settings, which is potentially linked to the competing needs of other LAC young people and the stimuli within the open residential environment.

-Low social functioning

A number of the young people referred for secure accommodation present with very poor social functioning, emotional intelligence and life skills. They are particularly vulnerable to pressures, bullying and exploitation by peers within residential settings. This cohort of young people require a placement setting which optimises their engagement with caring adults and affords them the essential space to develop their core social, emotional and life skills base. Some of the young people have a diagnosis of ADHD or ASD where there are high levels of impulsivity. Some of these young people can be non-compliant with medication regime which contributes to increase in impulsivity and dangerous behaviour.

-Paramilitary/Community Threat

A third of the young people referred for a secure placement were subject to a serious community and/or paramilitary threat. There was immediate threat to life as a result of criminal activity and for one young person, the threat was linked to a family member's historical actions in the community. Some of these young people had minimal insight to the very real threat to life.

-Harmful Sexual Behaviour

Two of the young people referred for secure care posed a high level of risk to others with regard to harmful sexual behaviours. Despite a robust safety planning for one young person in particular, these risks did not diminish, and other aspects of his lifestyle were having a detrimental impact on his physical health.

Alongside other presenting needs, some of the young people were engaging in criminal activity due to drug debts, which increased their levels of anxiety and distress when there were suspected threats of physical injury if these debts were not paid. One young person, whose cognitive capacity was limited, was highly susceptible to the influence of paramilitary groups.

Seven of the young people admitted to secure accommodation were 16-17 years old, two were 15 years old and one young person was 14 years old. Three were referred directly from the community due to the significant level of risk that could not be managed safely within a family placement, open children's home or supported living environment.
For all of the young people referred for secure placement, the immediate goals have been to ensure young people's safety and physical containment, and to disrupt a cycle of behaviour that is self- injurious and destructive.

The initial interventions with each young person were to respond to his/her primary need for stability, develop a healthy sleep/eat pattern, provide a period of time away to focus on self-care with the

support of the Lakewood team, RSW/FSW teams, and families (where appropriate).

For a number of young people, the secure placement has allowed them time to reduce substance use with the support of the Lakewood team, medical and DAMHS professionals which has provided a level of stability. It also allows young people, who have not complied with prescribed medication for ADHD or mental health issues, to reengage with the medication regime, to promote emotional equilibrium. When young people have the time to take pause, they can become overwhelmed by the impact of their experiences that preceded their admission to secure care, and require a high level of nurturing and therapeutic support.

For the young people, the secure placement provided the optimum forum to re-engage in key relationships, repair family relationships and work with services such as TSS, CAMHS, YJA, Safe Choices, Barnardos and Education.

The interventions were premised on partnership working and concentrated on promoting safety, establishing healthy routines, management of medication and substance use, direct and group work which focused on the issues that led to young people being admitted to secure care such as vulnerability to CSE: recognizing harmful situations, addressing underlying issues that led to violent outbursts and developing coping strategies where young people can regulate their emotions and improve self-care. There was a need for educative work on impact of substances/alcohol. A further intervention which was uniquely requested for the four 17 years old was to devise a programme that supported young people to prepare for their transition to adulthood and independent living.

The biggest challenge for the young people and the key professionals/services working alongside them, is being able to sustain the changes they have made in a secure environment, in an open setting within the community.

7. Please outline any areas for development regarding alternatives to secure accommodation, the operation of the panel and the services being sought from Lakewood:

In relation to the recommendation, from the Review of Regional Facilities for Children and Young People, secure care will potentially experience notable changes in the near future. Common themes for most of the young people who have been admitted to secure care from the Belfast Trust, are mental health and polysubstance use. The Review's recommendations of secure mental health placements and the provision of onsite services for drug/alcohol addiction and detoxification, are timely and welcome, as the profile of the young people would indicate that these specific, targeted services are essential.

There has been a greater need to provide tailored placements for young children and adolescents whose profiles and presenting needs are best managed in placements that have fewer numbers of young people.

The Trust has developed two bespoke arrangements in response to the particular needs of three children/young people, where fostering, differentiated children's homes or ECR placements had either been exhausted or assessed as not being appropriate.

The home adapted for two younger children has provided a nurturing environment with a team who are in tune with the needs of children/young people who have experienced ACES and significant trauma in their family life.

At the time of their admission, both of these children required a team providing care for them rather than a foster placement. The outcomes for both of these children has improved as they are emotionally regulated, family relationships/contact has stabilised and both have returned to school. Further planning of fostering is in place for one child and it is envisaged that both boys will be identified appropriately matched foster and residential care placements.

A further specialised placement has been developed in response to one young person who has been placed in secure care on two occasions. It has been evidenced that numerous placement moves can heighten young people's trauma and undermine efforts to promote stability. This one bedded home will provide intensive support with interventions tailored to the young person's immediate, short and long-term needs.

The Peripatetic Service is being developed within the Trust, whose purpose is to provide a wraparound support service to young people in the Children's Homes and redirect young people from harmful behaviours. There has been progress made in relation to child specific, formulation consultations, which are facilitated by the service's clinical psychologist. These provide a means of informing interventions with young people and providing reflective practice for staff teams, who can experience vicarious trauma in the direct care and safeguarding of young people who present with pain- based behaviours. There has been progress in the emotional containment of the team, which in turn leads to interventions that are responsive to young people's needs rather than behaviours.

APPENDIX F

BELFAST HEALTH AND SOCIAL CARE TRUST

REPORTING TEMPLATE FOR DELEGATED STATUTORY FUNCTIONS IN RELATION TO THE REGIONAL EMERGENCY SOCIAL WORK SERVICE

For Year end 31 March 2019

1. Introduction

The Regional Emergency Social Work Service RESWS) commenced on 29th May 2013. The Service provides a regional out-of-hours emergency social work and social care service. The RESWS model is based on having salaried staff working at all times that the service is operational. These staff are employed as senior practitioners. The Service also has four Assistant Service Managers who provide managerial cover for 5pm-2am and 9am-6pm shifts on a rota basis.

To ensure that the Service can respond appropriately to referral volumes, the senior practitioner staff work the following shifts:

Day	Shift	Number of staff
Monday – Sunday	5pm-2am	10
Monday – Sunday	1am-9am	4
Saturday/Sunday and Public Holidays	9am-6pm	11

On all shifts 50% of the staff will act as ASWs should the need arise.

The Service is delivered from four offices across the region: Belfast, Ballymena, Armagh and Londonderry.

Whilst staff are located across the Region, they are not restricted solely to the Trust area in which their office is based. Staff are deployed as part of a managed network so that, for example, a Senior Practitioner may be dispatched from the Ballymena or Armagh area to attend a call in the Western Trust area. This flexibility assists in circumstances where an additional response is required when staff in any one Trust area are already tied up responding to earlier calls.

The Service is supported by a bank of locum staff who provide cover for sickness, annual leave and absence due to training. Locum staff provide cover for the whole shift unless, in exceptional circumstances, a shorter period is agreed with management. Locums are based in one of the four offices and respond to referrals in the same way as permanent staff. However, there are occasions when locums work from other offices other than their base to cover shifts when required and as agreed with them.

An Annual Report is prepared which details activity levels for the service and which is provided to Trusts and the HSCB separately.

2. GENERAL

The Executive Director of Social Work within the BHSCT has overall responsibility for the provision of the Service.

2.1 Statement of Controls Assurance

All social work staff within RESWS are registered on the social work part of the NISCC Register. This is monitored through the Trust's established monitoring arrangements and via line management.

All Approved Social Workers within RESWS have been placed on the Trust's ASW Register. The Assistant Service Manager with lead responsibility for mental health in RESWS is responsible for ensuring that all Approved Social Workers within RESWS are placed on each of the other four Trusts ASW Registers and for updating details as required. He is also responsible for monitoring compliance with mandatory training associated with ASW registration requirements.

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

Within BHSCT, there is a clear line of accountability from the frontline senior practitioners to the Executive Director of Social Work, through the relevant Assistant Service Manager, the Service Manager and the Co-Director. Whilst BHSCT has overall responsibility for the management of the Service, the Executive Directors of Social Work across the five HSC Trusts retain responsibility and accountability for the discharge of delegated statutory functions as they pertain to the delivery and assurance of social work services within their respective Trust areas. Each Executive Director discharges this responsibility by being assured that the regional Service is providing safe and effective care. This assurance is provided to the Executive Directors through a Consortium Board arrangement, which meets on a quarterly basis. The Operational Management Group consisting of a range of senior managers from across all five Trusts and across all service areas meets on a bi-monthly basis. A Service Level Agreement is in place between BHSCT and the other four HSCTs detailing the service provided and governance arrangements.

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

The RESWS provides an emergency social work response across Family and Child Care, Learning Disability, Mental Health, Physical Health and Disability and Older Peoples Services.

The Regional Emergency Social Work Service is not an extension of the full range of services available during the working day; it is specifically for situations, which are of an emergency nature, including discharging the Trusts' statutory responsibilities for social care service delivery.

The RESWS will respond if someone's safety is deemed to be at risk of significant harm and the individual's welfare is seriously compromised if not responded to immediately and the situation cannot wait until 9am on the next working day for assistance and or support.

General Principles

- The Service is an emergency duty service and responds to situations that cannot safely be left until the next working day
- No work received or commenced by a daytime officer prior to 5.00 pm should be passed to RESWS with the expectation that RESWS will undertake this work. The fact that a case may run into the evening is not sufficient justification for an assumption of automatic handling of the case to RESWS**.**
- Requests for RESWS to become involved in cases that continue after 5.00pm should be restricted to assistance regarding accessing information, resources, or in relation to the daytime worker's safety.
- When arrangements are made by daytime staff for out of hour's visits, these should not be referred to RESWS. The RESWS **should not** be requested to undertake or sustain any planned work over weekends or evenings.
- RESWS is unable to pass on information to day services, unless of an emergency/urgent nature.

Child Care

RESWS will accept referrals where:

- There are concerns that a child has suffered, or is likely to suffer significant harm including unaccompanied minors/ trafficked children.
- There are concerns in relation to children, who are on the Child Protection Register (CPR) and those subject to Care Orders/Looked After by the Trust, or their carers including foster carers.
- There is suspected or confirmed abuse of a child.
- In cases where there is a serious and imminent risk of family breakdown both in the community, foster care or kinship placements.
- Act as an appropriate adult for young people who are subject of a Care Order and only when the offence in question has involved the residential unit and its staff.
- In the case of hospitals, where there is a need to make an enquiry to the CPR.
- RESWS will **not** become involved in management issues in relation to residents or staffing issues within the residential units.
- RESWS will **not** accompany young people from the residential units to hospital for medical attention

Adult Safeguarding

RESWS will accept referrals where:

- There are concerns about the safety of an adult at risk of harm or in need of protection.
- Where there is suspected or confirmed abuse of an adult at risk of harm and in need of protection.

Mental Health/ Learning Disability

RESWS will accept referrals where:

- Circumstances warrant an assessment to determine whether someone should admitted to hospital on a compulsory basis under the Mental Health (NI) Order 1986. RESWS will provide an Approved Social Worker to undertake a joint assessment with the GP.
- Families and carers have serious and immediate concerns in relation to an adult's safety.
- There are difficulties surrounding the care and safety of a person subject to Guardianship.

Older People/ Physical Disability

Any issues with regard to current and existing care plans and homecare arrangements should be directed the responsible Trusts' Out-of-Hours Homecare Service.

RESWS will accept referrals where:

- Informal care arrangements have broken down and it is essential that immediate action is taken to secure the health and well-being of a service user.
- **Extensive** attempts by the **homecare service** to locate a service user have proved unsuccessful and there is a necessity to liaise with PSNI regarding further action required.
- Admission to a Nursing Home Care is required.

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

Over the past 12 months, RESWS has continued to discharge its statutory functions across the service areas (out of hours) despite a number of challenges:

- There remains a shortage of acute inpatient beds for patients requiring an admission for assessment under the Mental Health (NI) Order 1986.
- Continuing large number of out-of-Trust admissions placing increased demands on the RESWS and other agencies involved in facilitating the conveyance of patients in need of an acute psychiatric care.
- A continuing difficulty for some Trust's to identify placements for children either requiring to come into care or requiring a change of placement.

2.5 Progress made 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.

RESWS has highlighted the issue of delayed conveyance and the availability of inpatient beds for psychiatric patients at Trust level and interagency forums. In addition, RESWS has explored ways in which a detained patient awaiting delayed conveyance can be handed over to an ASW colleague coming on shift, or handed over to a daytime ASW to complete conveyance.

The issue of a lack of identified placements for children has been brought to the attention of the relevant Assistant Directors of each Trust when required and Trusts have worked hard to identify placements. The recent recruitment and retention of foster carers to provide emergency short-term placements for young people has led to some improvement in placements. This is not in place in all Trusts which often leads to a shortage of placements or overreliance on out of Trust placements.

RESWS has been able to support 1 member of staff to complete the ASW course thus increasing the number of dually trained staff in the Service to 16, and the number of permanent ASW staff to 23.

Access to Epex in the Western Trust has also been progressed for RESWS staff alongside a current pilot of access to PARIS in the Southern Trust. Currently all staff have access to the Electronic Care Record.

During 2018, a review of staff working patterns was undertaken and following this review, the service is working towards introducing a new working pattern for staff that meets both the service needs and supports the health and wellbeing of staff working overnight shifts.

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

Not applicable.

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

Service delivery audits are undertaken bi-annually. The recent audits documented clear evidence of adherence to both professional and service standards. Work is currently underway with our staff to review our audit programme and include a more thematic approach to audit. This will explore the quality of work undertaken by the service and identify areas of good practice and learning opportunities. We continue to audit referrals that require no further action and this is assisting the service in identifying trends and patterns of calls that are not appropriate for an emergency service. When appropriate, this information is provided to stakeholders to address the issues related to inappropriate referrals from specific areas of care.
The Service Manager completes a yearly supervision audit. During 2018/2019, a quarterly group supervision for all ASW staff has been included in the service.

The Service completed its fourth-Annual Report at the end of 2018, which provided statistical information to the Consortium Board and Operational Management Group as well as the Trusts and the HSCB. No significant changes to referral rates or trends were identified in this reporting period with numbers of referrals remaining similar to the previous year.

3. GENERAL NARRATIVE

3.1 Named officer responsible for professional social work

The Acting Service Manager, Mr Des Flannagan, is a qualified social worker and has been responsible for the provision of social work services within RESWS from 4th April 2018 on a temporary basis.

3.2 Supervision arrangements for social workers

All permanent social work staff receive six-weekly supervision from their line manager. The senior practitioners are divided into four groups with an Assistant Service Manager responsible for providing supervision to the staff in each group. The Service Manager provides supervision to the Assistant Service Managers and the Co-Director provides supervision to the Service Manager on a four- weekly basis.

A Service specific Supervision Policy is in place and this outlines the supervision arrangements for all staff within the Service.

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 RESWS has addressed all of the recommendations of the RIQA Report presented in January 2017.

1. The Belfast should review the call management arrangements for the service and should include:
    - The training and support provided to the call handlers in relation to dealing with continuous crisis or emergency calls
    - The training requirements to ensure the call handlers can identify and have the confidence to redirect inappropriate referrals.
2. In the interim period until the implementation of regional IT initiatives, the Consortium Board should examine local measures for providing better access to the various IT systems with the aim of achieving appropriate access for RESWS staff.
3. The BHSCT should review the arrangements in relation to referrals associated with homelessness, in particular
    - Benchmarking the number of referrals received with similar jurisdictions across the UK, in relation to their appropriateness
    - Determining whether the work associated with referrals should be undertaken by a social worker
    - Confidentiality of information exchanged
    - Determining the appropriateness of the RESWS in providing such a service
4. The BHSCT should ensure that all staff are familiar with the arrangements for exchanging information between the RESWS and daytime services, and that a more robust process should be put in place for collating, recording and tracking referrals
5. The BHSCT should, as a matter of urgency, prioritise the development of arrangements for staff supervision and appraisal within the RESWS.
6. The BHSCT should review the current safety arrangements for staff within the RESWS and establish appropriate arrangements to minimise risks
7. The BHSCT should review the legacy arrangements with the SSA to determine the future need for the service provided by the RESWS.

Following receipt of the final report an Action Plan was compiled. The action plan was signed off as completed by the Consortium Board on 21 Jan 2019 and the Trust External Reports Governance Group on 23 March 2019.

Work completed in 2018/19 included the establishment and relocation of a new call handling service. This new service is now based in the RESWS Belfast office and commenced in September 2018.

In line with the review from RQIA, the RESWS is currently working with the NIHE on transition arrangements for the management of emergency homelessness out of hours. It is anticipated that the provision of emergency homelessness services out of hours will transition to the NIHE in September 2019.

The Service Audit Framework is now in place (as outlined in Section 2.7).

Emerging Trends

During this reporting period, a number of trends have emerged for RESWS as follows:

- There has been some improvement in relation to the availability of acute inpatient psychiatric beds following an assessment under Mental Health (NI) Order 1986. The circulation of bed availability for all Trust areas is helpful, however; it remains a concern that additional pressures are placed on ASW's and other agencies such as PSNI/NIAS when beds are not available in the Trust where the patient is assessed. The RESWS has undertaken some work with the BHSCT to pilot an arrangement between daytime ASWs and RESWS to safely transfer the conveyancing ASW duty when the ASW has worked excessive hours due to the delay in bed allocation, or Ambulance/ Police availability.
- The service continues to experience high levels of referrals for ASWs between 5-7 pm. This is likely to be influenced by GP working hours.
- The Service continues to review the Lone Working Standard Operating Procedure, which has been implemented.
- Recruitment for ASW staff continues to be challenging in some areas in Northern Ireland. RESWS has been very successful in developing its own staff to be dual trained to assist in addressing this issue. However, locum ASW availability in some Trust areas remains a challenge for the service.
- Continued difficulties for some Trusts in identifying emergency care placements for children and young people

Approved Social Worker (ASW) Register

1. Number of newly Approved Social Workers during period - 2
2. Number of Approved Social Workers removed during period - 0
3. Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards) - 26 permanent staff (including managers) and 16 locum staff

4. 5 Permanent RESWS staff and 1 Locum staff member completed re-approval training in 2018/19.

- During the reporting period, no permanent ASWs left the service
- 2 newly qualified ASWs began working in the service 2018/2019

The Service has routinely provided 2 candidates for ASW training each year. There is currently 1 permanent senior practitioner completing training and it is expected they will be able to fully practice by the end of 2019. In 2018/2019, the service focused on the training needs of ASWs with no direct childcare experience in order for them to undertake the dual role required by RESWS Senior Practitioners. This training was delivered in partnership with the BHSCT Social Work Training Department, with input from the PSNI. Staff also received follow-up training on-shift with the support of more experienced childcare social workers and managers. The expectation that all permanent staff will be ASW qualified is being realised in a planned and timely fashion; a significant achievement is that all of our candidates have achieved the ASW award from 2013, thanks to strenuous efforts both in terms of Internal Practice Assessor supports, and financial supports to provide easement.

The number of locum ASWs is reviewed regularly to ensure adequate cover is provided and RESWS is able to discharge its statutory functions.
During 2018/19, the service provided a number of secondment opportunities for staff from the Northern, Southern and Belfast Trust to cover maternity leave and cover for staff undertaking the ASW course. This worked very well, and provided an excellent opportunity for both the service and the staff who participated. Currently the RESWS is satisfied it retains adequate staffing to meet service need.

DELEGATED STATUTORY FUNCTIONS

DATA RETURN 9

REGIONAL EMERGENCY SOCIAL WORK SERVICES (RESWS)

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		BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
9.1	Total Number of Assessments made by ASWs under the MHO	**172**	**101**	**104**	**109**	**160**
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	**153**	**91**	**93**	**100**	**149**
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	**1**	**1**	**2**	**2**	**4**

Comment on any trends or issues in respect of requests for ASW assessment or ASW applications:

The figures above were the fourth year's data RESWS are able to report on using Paris Recording and Reporting systems. During 2018 / 2019, 652 assessments were undertaken by the service on behalf of the five Trusts. This includes 4 Assessments of ROI residents and 2 GB residents. Of the 652 assessments there were 590 detentions. There were 630 assessments in 2016/17 and 632 in 2017/18, so the figures have been quite stable over the past three years.

RESWS made assessments for admission for 23 young people in 2018/19, which is less than for the previous years (36 in both years), and are as follows: BHSCT 6, NHSCT 3 , SEHST 4, SHSCT 1, WHSCT 9.
The figure of 10 second opinions being sought is relatively low and reflects the relative rarity of the procedure, and has remained stable and outside being statistically significant (+/- 3%), ASWs remain vigilant in reminding Nearest Relatives of their rights in exercising their rights and are mandated in recording this on each assessment.
As with previous years there are trends emerging that RESWS continue to monitor, such as the large number of referrals coming in from 5pm-7pm, this is closely watched both in terms of causation- GPs preferences- and its effect on staffing numbers and impact of other aspects of service delivery.

RESWS remains confident that current ASW staffing levels remain effective in meeting need. Additional locum ASW staff were recruited in 2018 to help support the service.
It should be noted that the vast majority of RESWS permanent staff are now trained as ASWs, reflecting the time and financial commitment of the service in achieving this.
One emerging issue in 2019, which is of particular concern, is the situation relating to difficulties around adults requiring an admission for assessment to a Learning Disability Hospital. Given the recent reduction in admissions to Muckamore Abbey Hospital, assessment times have become quite elongated.

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ASSURANCE COMMITTEE

AGENDA

Tuesday 31st July at 2pm
Boardroom, A Floor, BCH

1 Apologies

2 Minutes of Previous Meeting – 8 May 2018

3 Matters Arising

4 Chairman's Report

4.1 Conflicts of Interest

4.2 Emerging Issues
- O'Hara Report
- Dunmurry Manor
- Audiology Update

5 Assurance Framework

5.1 Assurance Framework Principal Risk Document inc Corporate Risk - Register for approval
5.2 Risk Management Strategy Annual review for approval
5.3 Assurance Framework (Inc Updated Structure) Annual review for approval
5.4 Review of Terms of Reference for approval

6 Learning from Experience Steering Group – Dr Jack

6.1 Assurance Update
6.2 Trust Incident (including SAIs) Report 01 April 17 – 31 March 18 for noting
6.3 Complaints & Compliments quarterly 01 March 18 – 30 June 18 Report for noting
6.5 Outcomes Review 2017 -2018 annual report for approval

7 Governance Steering Group Report – M Edwards

7.1 Assurance Update

8 Safety & Quality Steering Group Report – Dr Jack

8.1 Assurance Update
8.2 QI Plan 2017-2020 & Graph Set 2017-2018 for noting

9 Social Care Steering Group Report – J Growcott

9.1 Assurance Update

10 External Reports – Dr Jack / M Heaney

10.1 RQIA Review Programme Status ? dates– Thematic Reviews for noting
10.2 RQIA Inspections within ASPC (01 April 18 – 30 June 18) for noting

11 Revalidation for Registered Nurses and Midwives 2017-18 Annual Report For approval – B Creaney

12 Supervision for Registered Nurses 2017-2018 Annual Report For approval - B Creaney

13 Whistleblowing Annual Report 01Jan 2017 – 31 Mar 2018 – C Cairns

14 Any Other Business

Date of next meeting – Tuesday 20 November 2018

Belfast Health and Social Care Trust
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TRUST ANNUAL INCIDENT AND SERIOUS ADVERSE INCIDENT (SAI) REPORT

1st APRIL 2017 TO 31st MARCH 2018
(as at 31st May 2018)

TABLE OF CONTENTS

EXECUTIVE SUMMARY

All Incidents - Summary

- 29,977[1] reported incidents occurred Trust-wide, 86 of which were Serious Advserse Incidents (SAIs). This represents an increase of 10% with levels of reporting across Directorates broadly unchanged from the previous year.

All Incidents by Severity

- Trends in relation to severity remains largely unchanged with 95% of incidents recorded as insignificant (meaning no harm) or minor.
- A total of 175 incidents (0.6%) were graded as catastrophic of these
  - 47 were cardiac arrests. There was no indication of concern with treatment or care leading up to the arrests.
  - 39 were reported as SAIs (Serious Adverse Incidents) and are subject to full investigation under this process.
  - 25 were stillbirths. These were discussed and investigated at internal maternity meetings.
  - 20 describe extremely unwell patients who deteriorated and died either during or immediately following surgery (18 incidents) or hospital wards (2 incidents) and these deaths were not unexpected.
  - 15 relate to service users who died in their own homes/residential homes. 12 of these are confirmed to be as a result of natural causes, whilst 3 are still awaiting confirmation of such from post mortem results.
  - 12 were neonatal deaths which, as of February 2016, are subject to the Child Death notification process.
  - 11 incidents relate to deaths not felt to be SAIs at the time but have been, or are currently being reviewed with SEA methodology / internal investigation to identify learning.
  - 4 require investigating by another organisation (3 Interface incidents and 1 general incident).
  - 1 incident was related to communication issues but these were unrelated to the death.
  - 1 was a patient charged with homicide. Review to be undertaken by another Trust.

All Incidents by Category

The three most commonly reported categories of incidents are

- Abusive , disruptive or self-harming behaviour
- Accidents that may result in personal injury
- Medications

Trend analysis over the past 3 years indicates minimal change. However an increase is noted in abusive incidents, many of which are low risk incidents with no or minor harm. The data has been provided to, and considered by, teams delivering care in these locations.
Incident data is used to support a wide range of quality Improvement projects

[1] It should be noted that quality assurance of data is ongoing, therefore statistics throughout this report are presented subject to alteration.

Serious Adverse Incidents (SAIs)
During this period a total of 86 SAIs were reported. This is compared to 89 for the same period in the previous year. Of these 86 SAI investigations 31 have been now closed by HSCB; 15 have final reports submitted; and 40 have investigations currently ongoing.
For this reporting period the main categories of reporting are summarised below*:

- **Abusive, violent, disruptive or self-harming behaviour**
  There were 39 SAIs reported under this category.
  26 of these SAIs were related to suicides.
  (Of these SAIs two were investigated as Level 2 RCAs while the remaining 24 were investigated as Level 1 SEAs. 21 of these 24 investigations have been completed and final reports submitted to HSCB, 14 of which were closed without learning).

- **Treatment/Procedure**
  There were 13 SAIs reported under this category.
  9 of these SAIs were connected to the management of operations / treatment.

- **Implementation of care or ongoing monitoring/review**
  There were 8 SAIs reported under this category
  5 of these relate to a possible delay or failure to Monitor

In addition to the main categories above there were 5 SAIs reported under 'Other'. Of these 3 were related to unexpected deaths, 1 unexpected injury and 1 cardiac arrest. For the unexpected deaths 2 SAI investigations are currently ongoing. For the other the investigation this has been completed and final SAI report submitted.

For further details of the reporting categories for **all 86 SAIs please refer to Appendix 1*

SAI Recommendations from O'Hara

Following publication of the O'Hara report and the recommendations issued around the SAI process, the Trust are currently undertaking further work in relation to this to strengthen existing governance & assurance arrangements.

SEA & RCA Methodology Training

To help ensure that SAI investigations are robustly carried out the Trust has secured formal training for the 2018 period.

1. INTRODUCTION – ALL INCIDENTS

During the period between 1st April 2017 and 31st March 2018 a total of 29,977[2] reported incidents occurred Trust-wide. In comparison, during the period from 1st April to 31st March 2017, a total of 27,327 reported incidents occurred. This represents an increase of 10%.

In addition, there were 1,629 incidents reported by Independent Sector providers inputted onto Datix during this reporting period. These incidents are not included in the following graphs and statistics. They are separately monitored and reported on by the Trust's Quality & Support Team and/or Contracts office.

Fig. 1

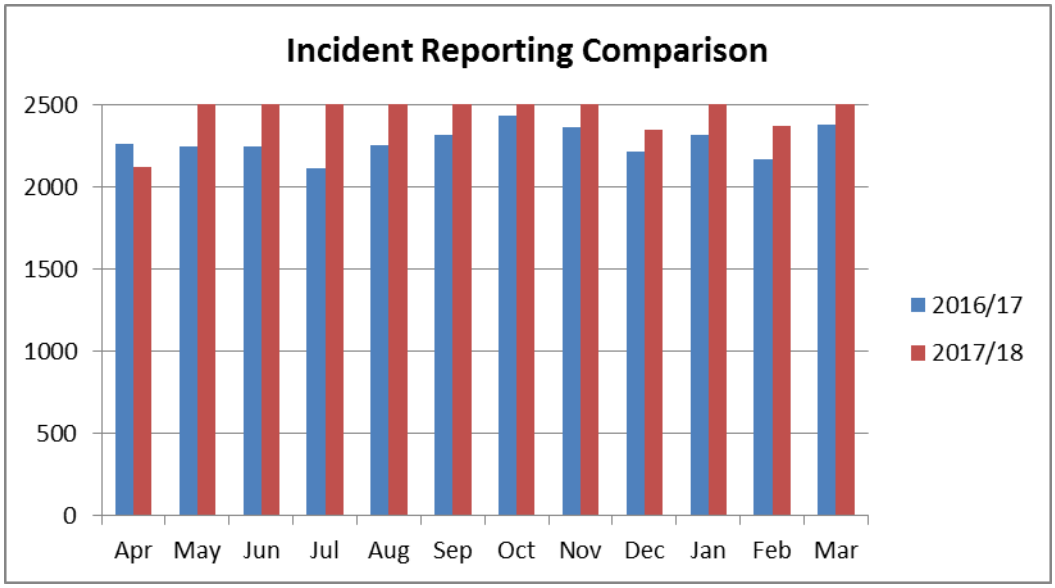


Fig. 1 shows the monthly comparison of incident reporting figures between the two periods in 2016/17 and 2017/18.

[2] 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 Directorate & Division

Fig. 2

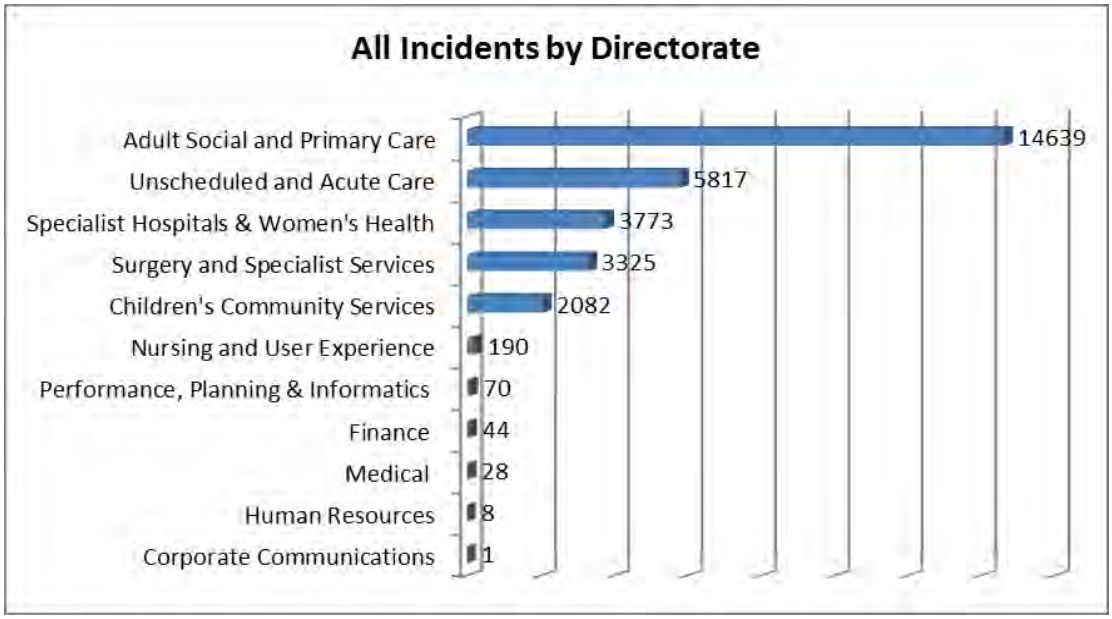
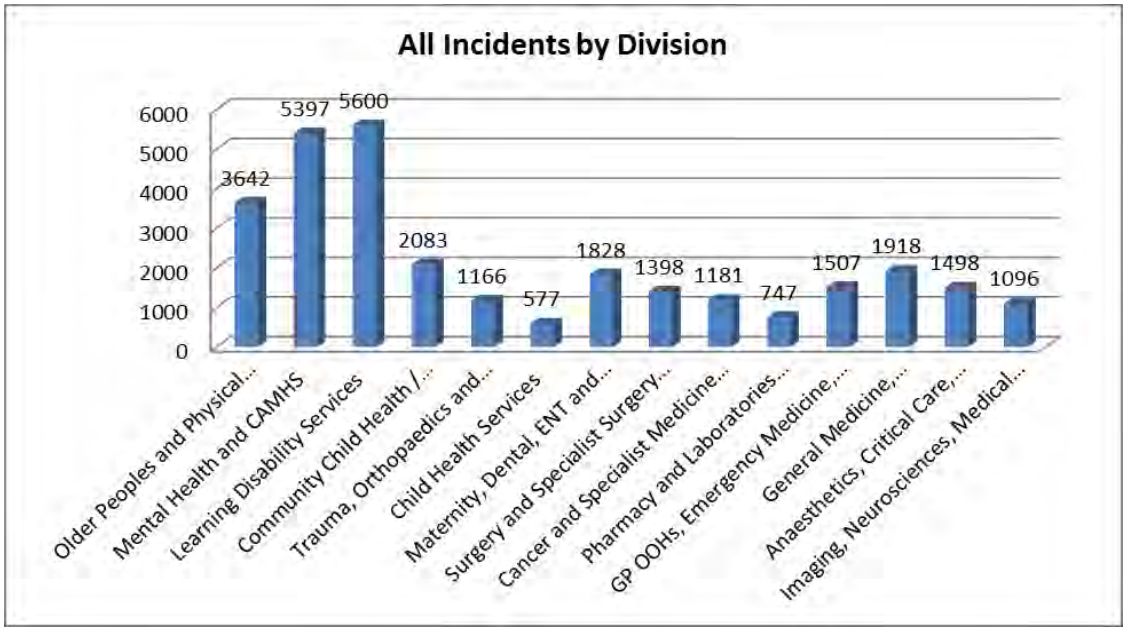


Figure 2 shows that the Directorates with the most reported incidents are Adult Social and Primary Care with 14,639 (49%) incidents and Unscheduled and Acute Care with 5,817 (19%) incidents.

The data above shows a broadly similar pattern to that for the same period in 2016/17.

Fig. 3



The top 5 categories of incident are broken down per Service Directorate in the following graphs (fig 4 to 8).

Fig. 4

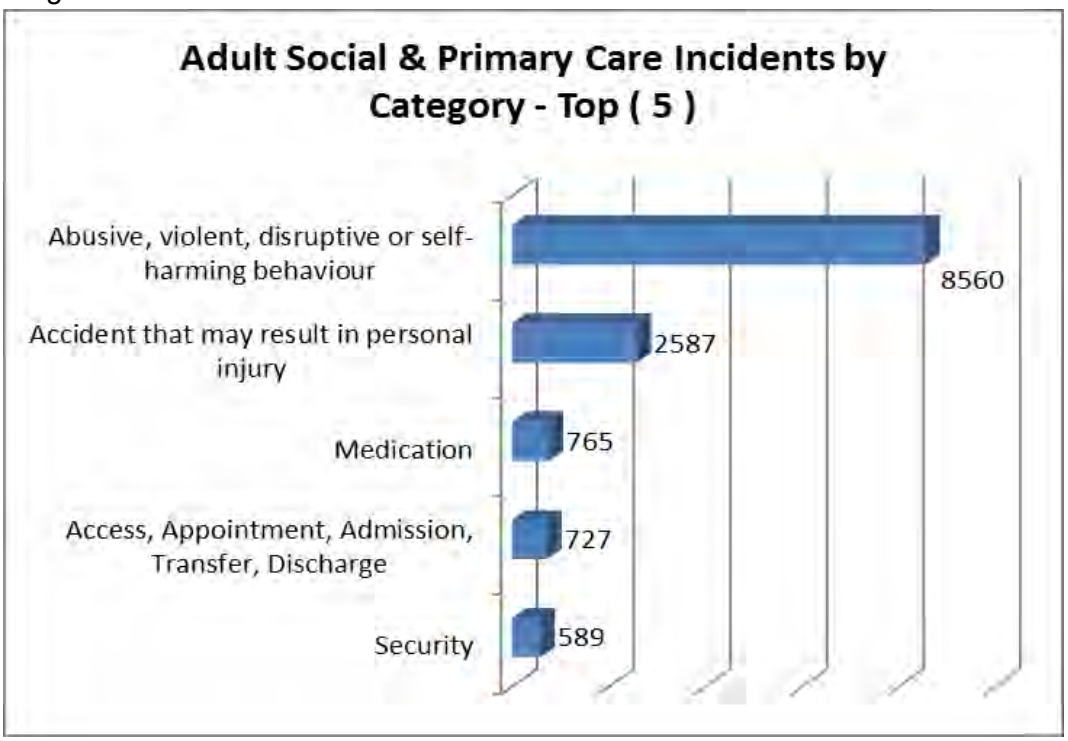


Fig. 5

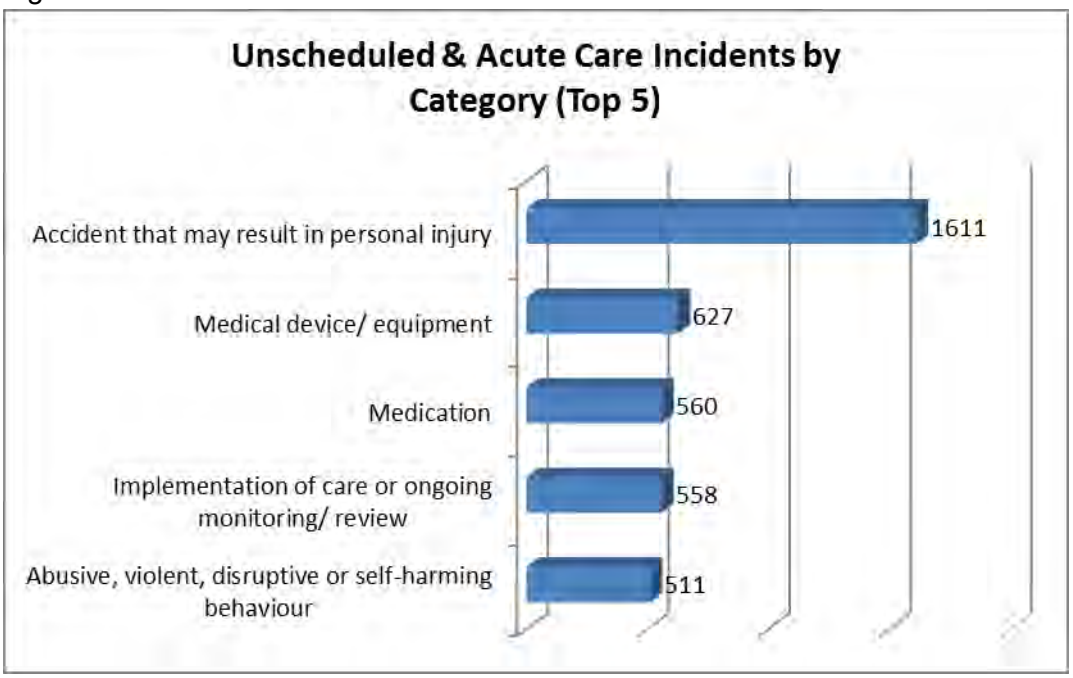


Fig. 6

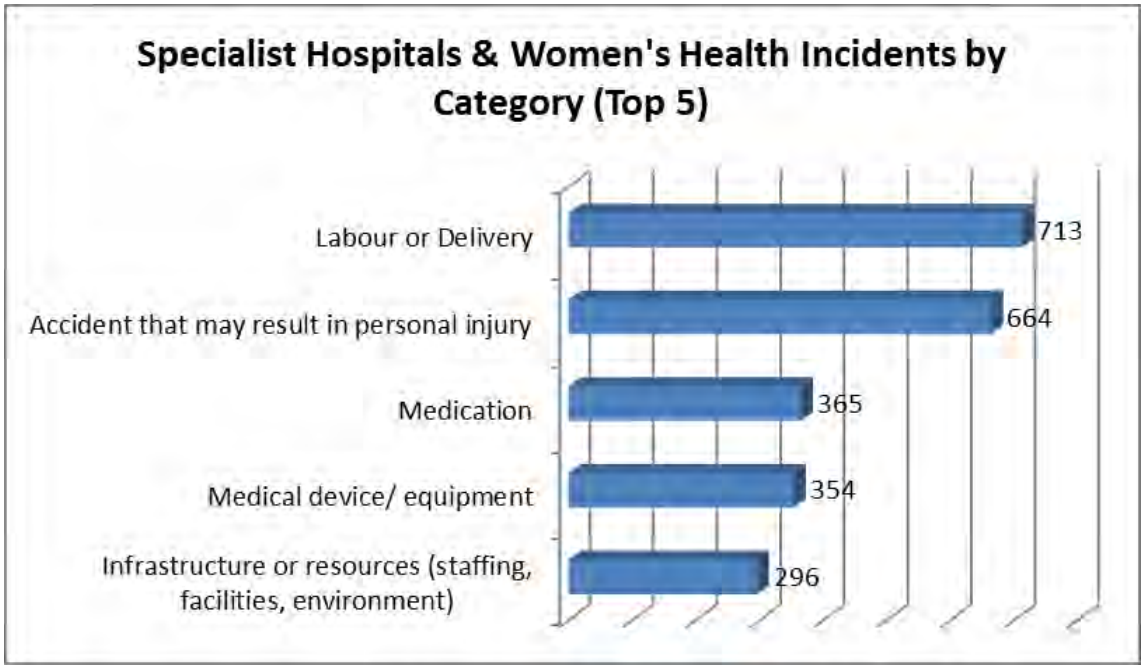

Specialist Hospitals & Women's Health Incidents by Category (Top 5)
Labour or Delivery
713
Accident that may result in personal injury
664
Medication
365
Medical device/ equipment
354
Infrastructure or resources (staffing, facilities, environment)
296

Fig. 7

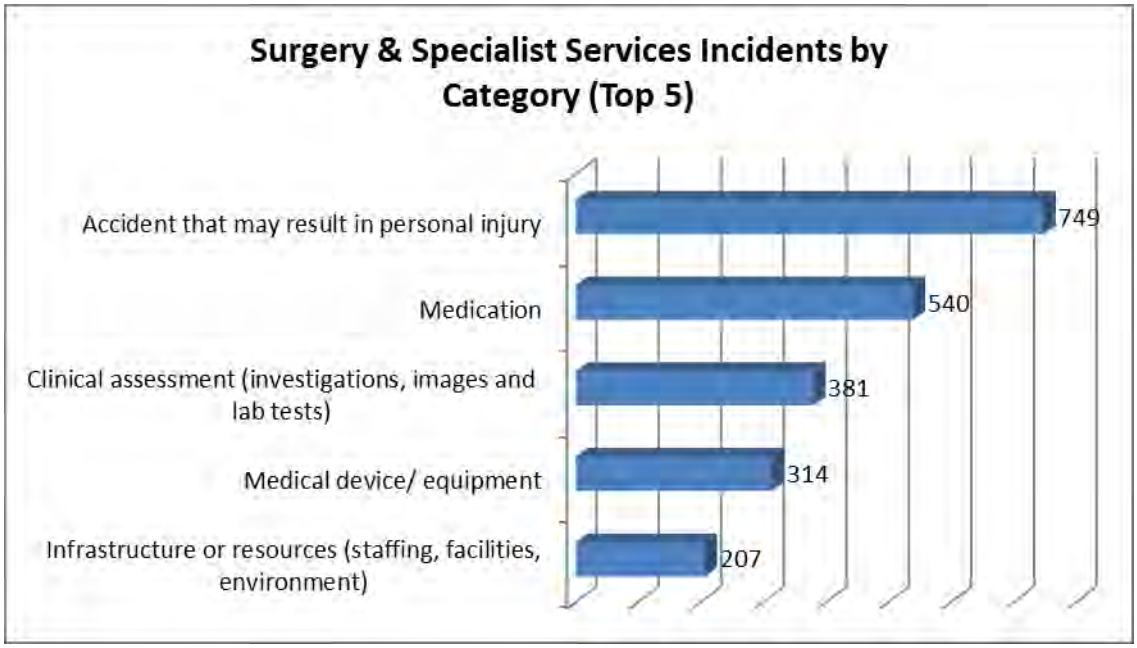
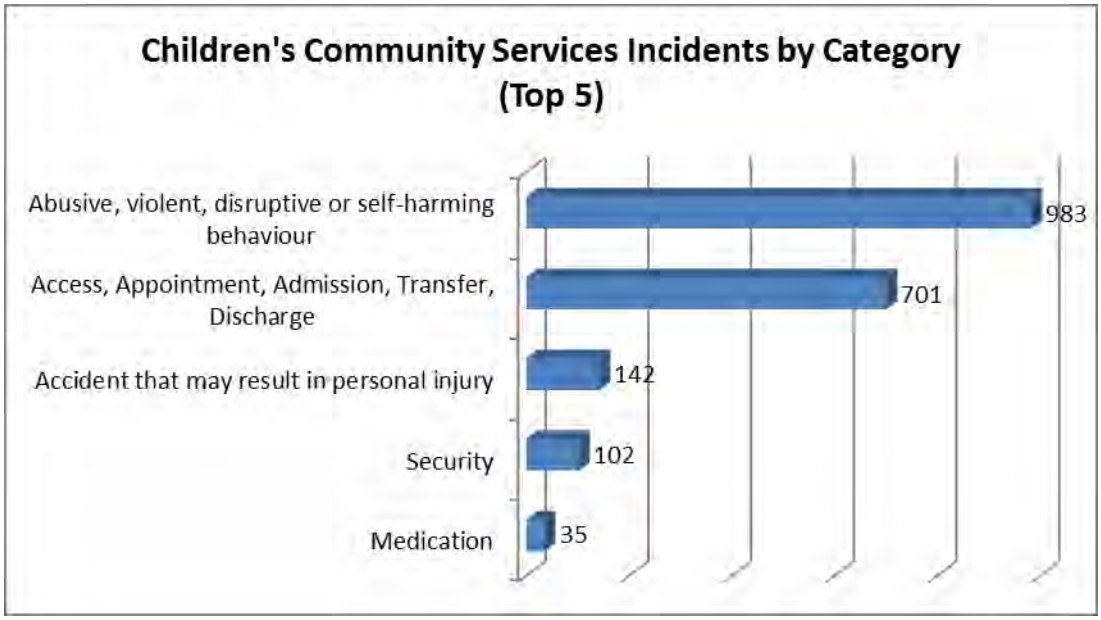

Surgery & Specialist Services Incidents by Category (Top 5)
Accident that may result in personal injury
749
Medication
540
Clinical assessment (investigations, images and lab tests)
381
Medical device/ equipment
314
Infrastructure or resources (staffing, facilities, environment)
207

Fig. 8


Children's Community Services Incidents by Category
(Top 5)
Abusive, violent, disruptive or self-harming behaviour
983
Access, Appointment, Admission, Transfer, Discharge
701
Accident that may result in personal injury
142
Security
102
Medication
35

2.2. Incidents by Severity

Fig. 9

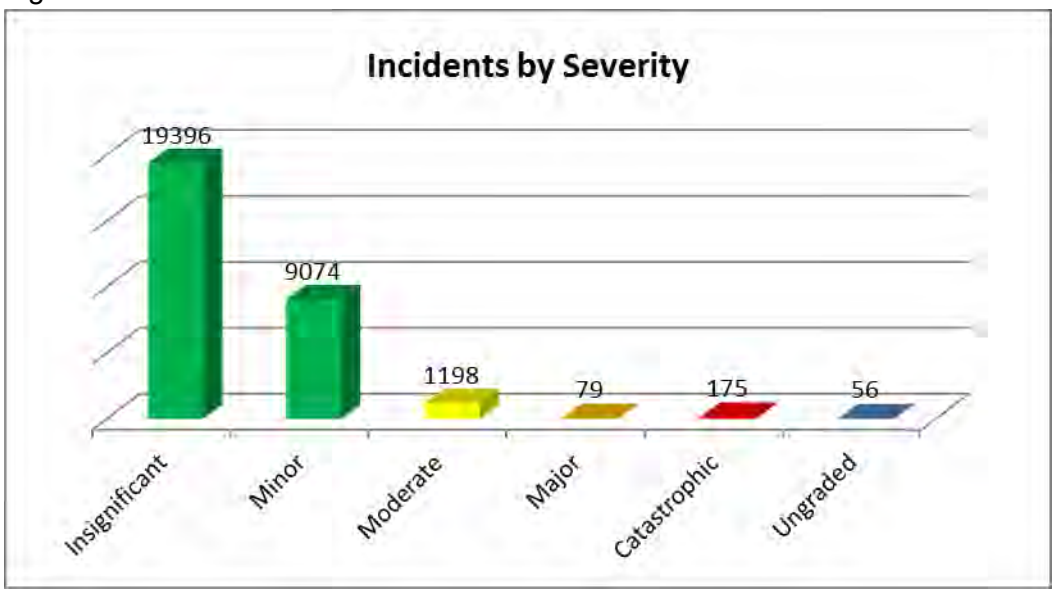


Figure 9 indicates that 28,470 (95%) of incidents were assessed as having a severity rating of insignificant or minor while 175 (0.6%) were rated as catastrophic. The severity rating indicates *actual* harm or damage as a result of the incident rather than potential risk.

Grading of incidents is included in Adverse Incident training, which is mandatory for all staff as per the Statutory Mandatory Training Policy.

The Corporate Governance Dept. have a number of measures in place to follow-up on major or catastrophic severity incidents to ensure appropriate grading and investigation:

- query re appropriate grading
- query re SAI reportable, if appropriate and not already reported
- request for further investigation/follow-up to be added to the incident record if required
- Weekly Governance teleconference to discuss catastrophic severity and extreme risk incidents.

<u>Ungraded incidents</u>

56 (0.2%) of incidents did not have the severity field completed (ungraded). These are from the few small remaining areas within the Trust still using paper incident forms where the severity question has not been completed, or those reported to us from other Trusts / Primary Care.

2.3.1. Further breakdown of Major / Catastrophic Severity Incidents

Major Severity Incidents by Category and Directorate

Fig. 10

	Adult Social and Primary Care	Children's Community Services	Specialist Hospitals & Women's Health	Surgery and Specialist Services	Unscheduled and Acute Care	Total
Access, Appointment, Admission, Transfer, Discharge	0	0	2	0	2	4
Abusive, violent, disruptive or self-harming behaviour	6	1	0	0	0	7
Accident that may result in personal injury	2	1	0	0	3	6
Consent, Confidentiality or Communication	0	0	0	0	1	1
Diagnosis, failed or delayed	0	0	0	0	1	1
Infrastructure or resources (staffing, facilities, environ	2	0	0	0	37	39
Labour or Delivery	0	0	3	0	1	4
Medication	0	0	0	0	2	2
Implementation of care or ongoing monitoring/ review	1	0	0	1	0	2
Other - please specify in description	0	1	0	2	2	5
Treatment, procedure	1	0	1	2	4	8
Totals:	12	3	6	5	53	79

Summary of Major Severity Incidents

Of the 79 incidents with a severity of major;

- 58 (73%) are being investigated / managed via normal Trust Investigation processes.
- 14 (18%) were reported as SAIs (Serious Adverse Incidents) and are subject to full investigation under this process.
- 3 (4%) are currently being queried as incorrectly graded.
- 2 (2%) were assessed as not meeting SAI reporting criteria, after querying with the Directorates and are being investigated / managed via normal Trust investigation processes.
- 1 (1%) was reported as an II (Interface incident).
- 1 (1%) is currently being queried as a SAI.

Catastrophic Severity Incidents by Category and Directorate

Fig. 11

	Adult Social and Primary Care	Children's Community Services	Specialist Hospitals & Women's Health	Surgery and Specialist Services	Unscheduled and Acute Care	Total
Access, Appointment, Admission, Transfer, Discharge	0	0	1	0	2	3
Abusive, violent, disruptive or self-harming behaviour	30	0	0	0	0	30
Accident that may result in personal injury	0	0	0	2	3	5
Clinical assessment (investigations, images and lab tes	1	0	0	0	0	1
Consent, Confidentiality or Communication	0	0	0	0	1	1
Patient Information (records, documents, test results,	1	0	0	0	0	1
Labour or Delivery	0	0	37	0	0	37
Medication	1	0	0	0	0	1
Implementation of care or ongoing monitoring/ review	0	0	1	1	2	4
*Other - please specify in description	17	1	3	20	46	87
Treatment, procedure	0	0	0	2	3	5
Totals:	50	1	42	25	57	175

No. of the above reported as SAIs	30	1	2	2	4	39
No. of the above queried as SAIs	2	0	1	3	9	15

*'Other' Incidents (from Fig. 10 above) by Detail

Fig. 12

Cardiac arrest	45
Unexpected death	42
Totals:	87

Summary of Catastrophic Severity Incidents

Catastrophic:

Of the 175 incidents with a severity of catastrophic;

- 47 (27%) were cardiac arrests. There was no indication of concern with treatment or care leading up to the arrests.
- 39 (22%) were reported as SAIs (Serious Adverse Incidents) and are subject to full investigation under this process.
- 25 (14%) were stillbirths. These were discussed and investigated at internal maternity meetings.
- 20 (11%) describe extremely unwell patients who deteriorated and died either during or immediately following surgery (18 incidents) or hospital wards (2 incidents) and these deaths were not unexpected.
- 15 (8%) relate to service users who died in their own homes/residential homes. 12 of these are confirmed to be as a result of natural causes, whilst 3 are still awaiting confirmation of such from post mortem results.
- 12 (7%) were neonatal deaths which, as of February 2016, are subject to the Child Death notification process.
- 11 (6%) incidents relate to deaths not felt to be SAIs at the time but have been, or are currently being reviewed with SEA methodology / internal investigation to identify learning.
- 4 (2%) require investigating by another organisation (3 Interface incidents and 1 general incident).

- 1 (0.5%) incident was related to communication issues but these were unrelated to the death.
- 1 (0.5%) was a patient charged with homicide. Review to be undertaken by another Trust.

2.3. 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. 13

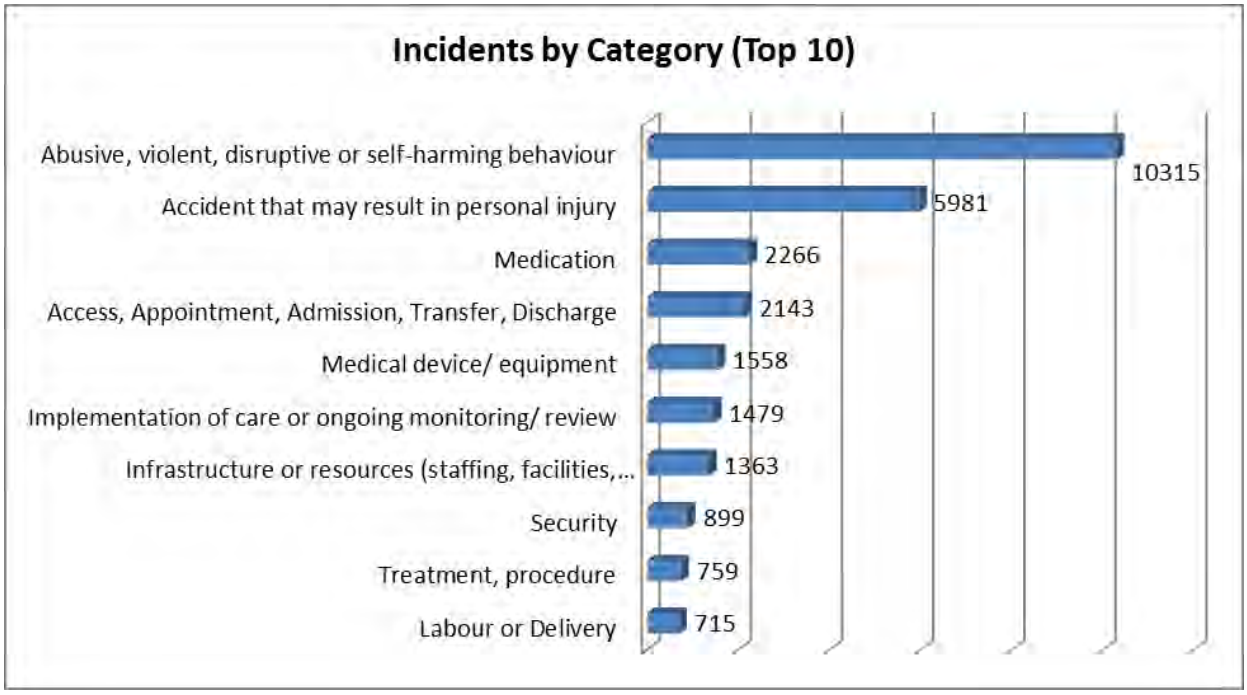


Figure 13 shows that the most commonly reported incident category is 'Abusive, violent, disruptive or self-harming behaviour' with 10,315 (34%) incidents.

The 2nd most commonly reported category is 'Accidents that may result in personal injury' with 5,981 (20%) incidents.

These figures show a very similar pattern to those for the same period in 2016/17.

Fig. 14

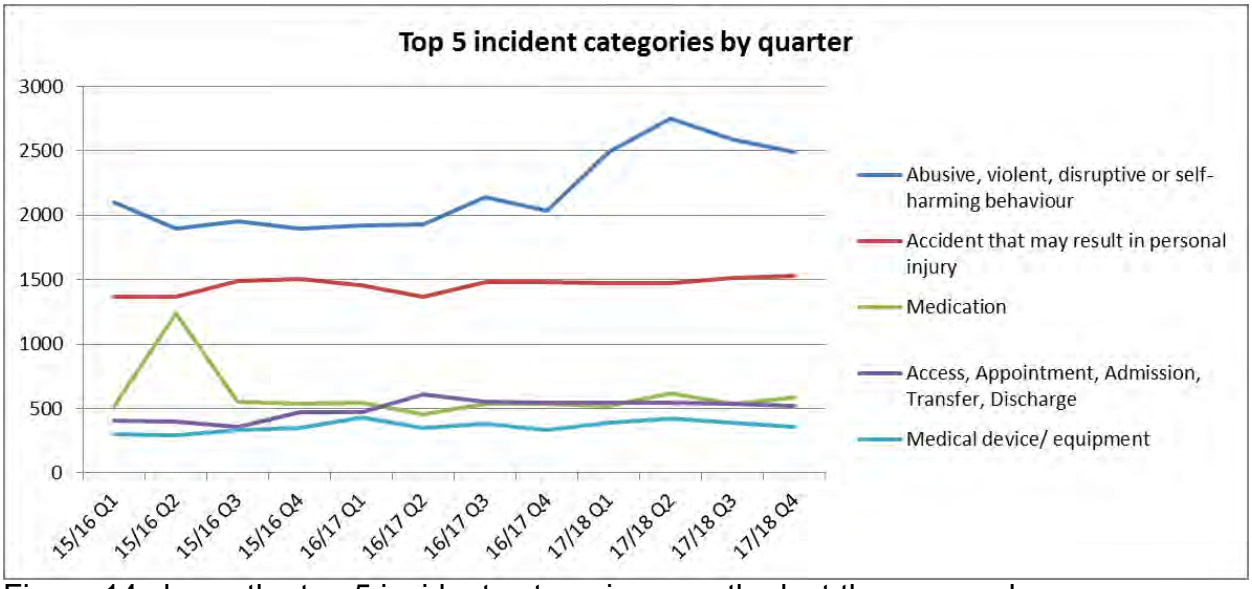
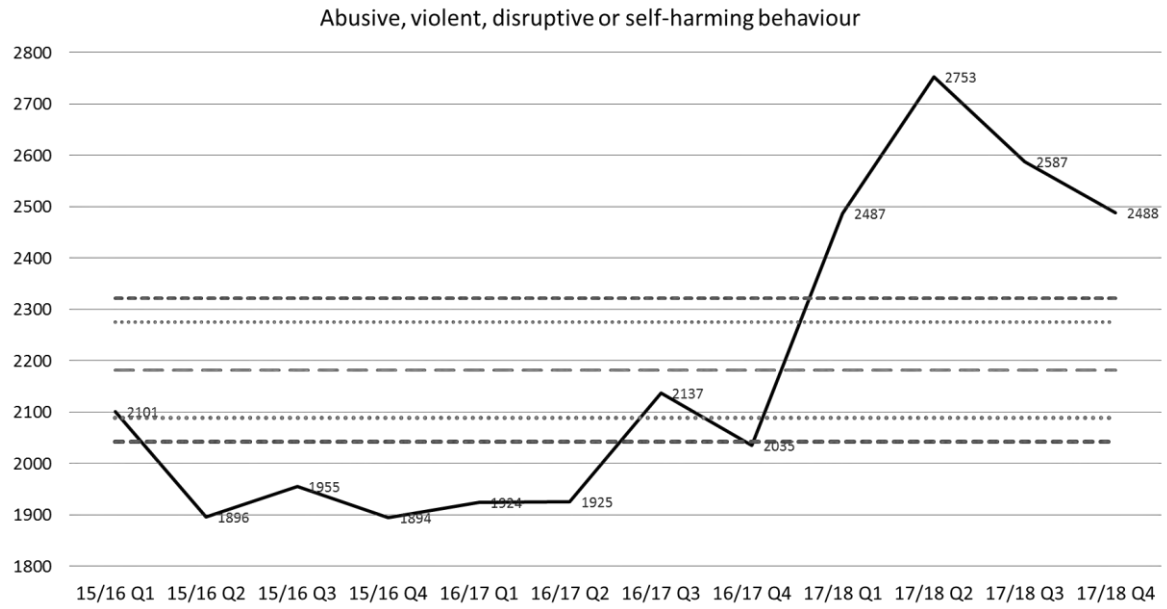


Figure 14 shows the top 5 incident categories over the last three years by financial quarter. The top 3 categories rarely change position whilst the categories taking up fourth and fifth positions have varied over time.

Figure 14 shows relatively little change in reporting trends over three years except for an increase in medication incidents during quarter 2 of 2015/16 and an increase in abusive, violent, disruptive or self-harming behaviour incidents from quarter 1 2017/18.

Individual run charts for the top 5 categories are shown in figures 15 to 21 below:

Fig. 15



The data in figure 15 has been further broken down in figures 15a and 15b below.

Figure 15a shows that the majority of abusive, violent, disruptive or self-harming behaviour incidents are reported by community and learning disability or mental health sites / facilities.

Figure 15b shows the smaller number reported in ‘acute’ hospital sites.

Fig. 15a

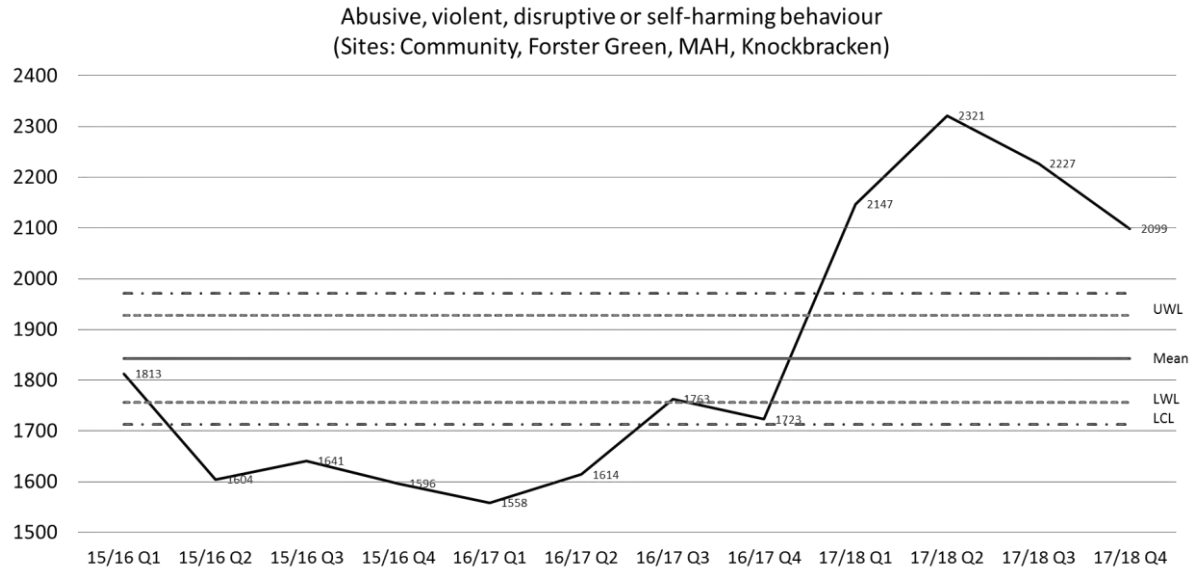


Fig. 15b

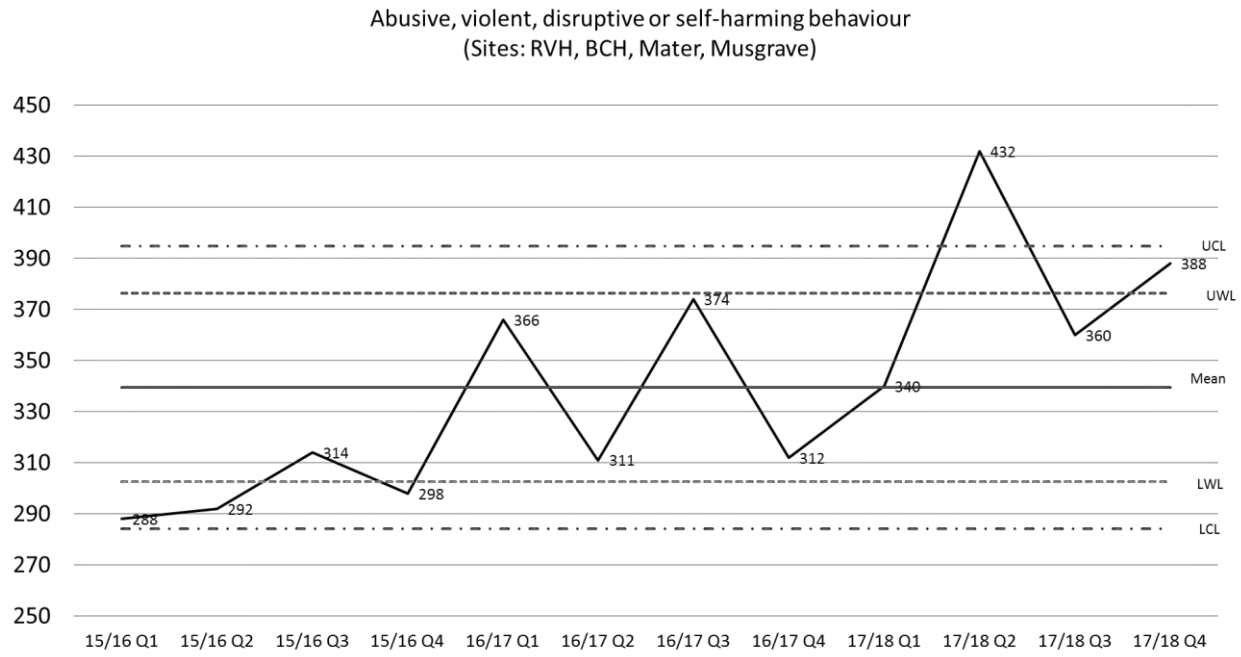


Fig. 16

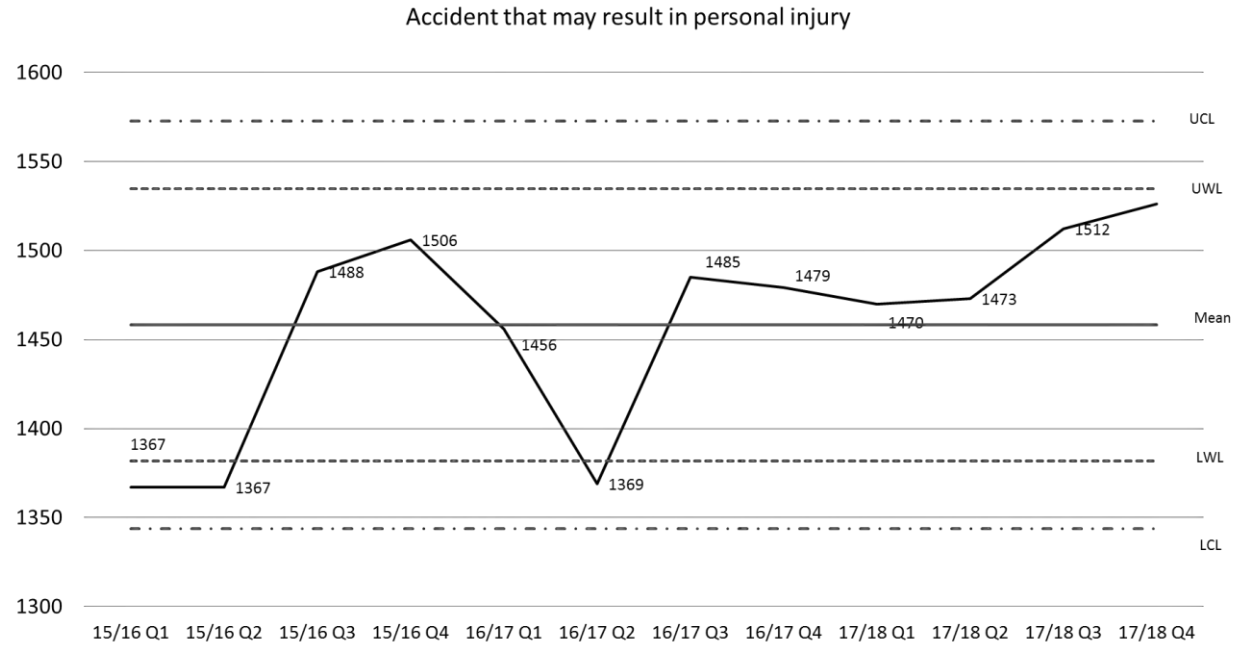
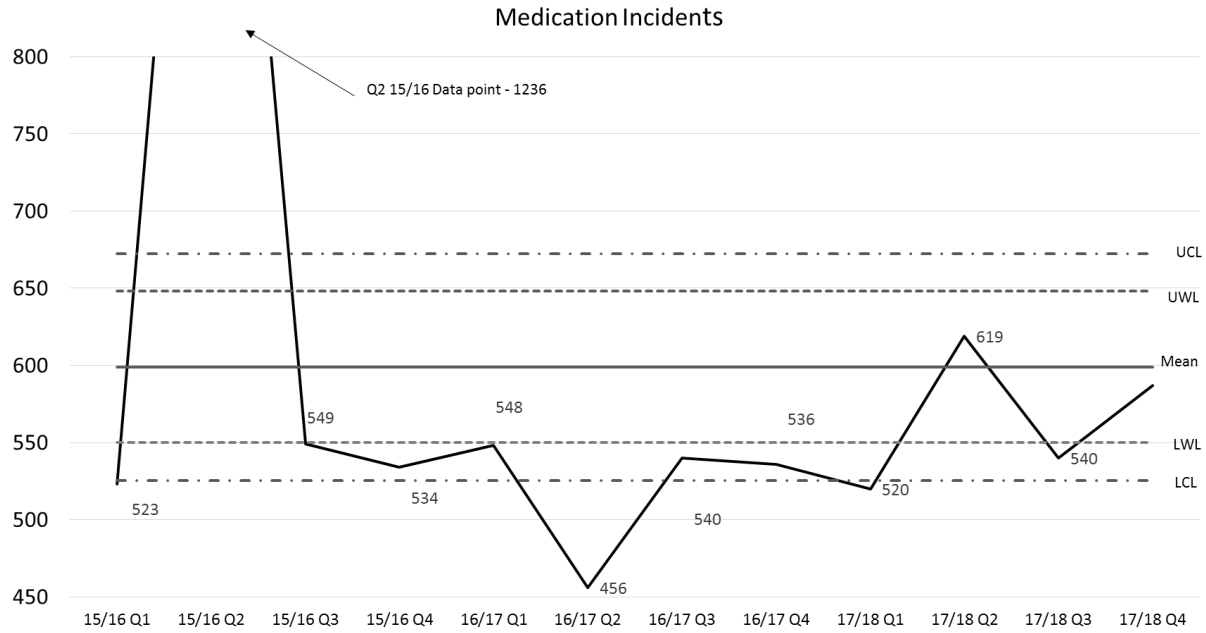
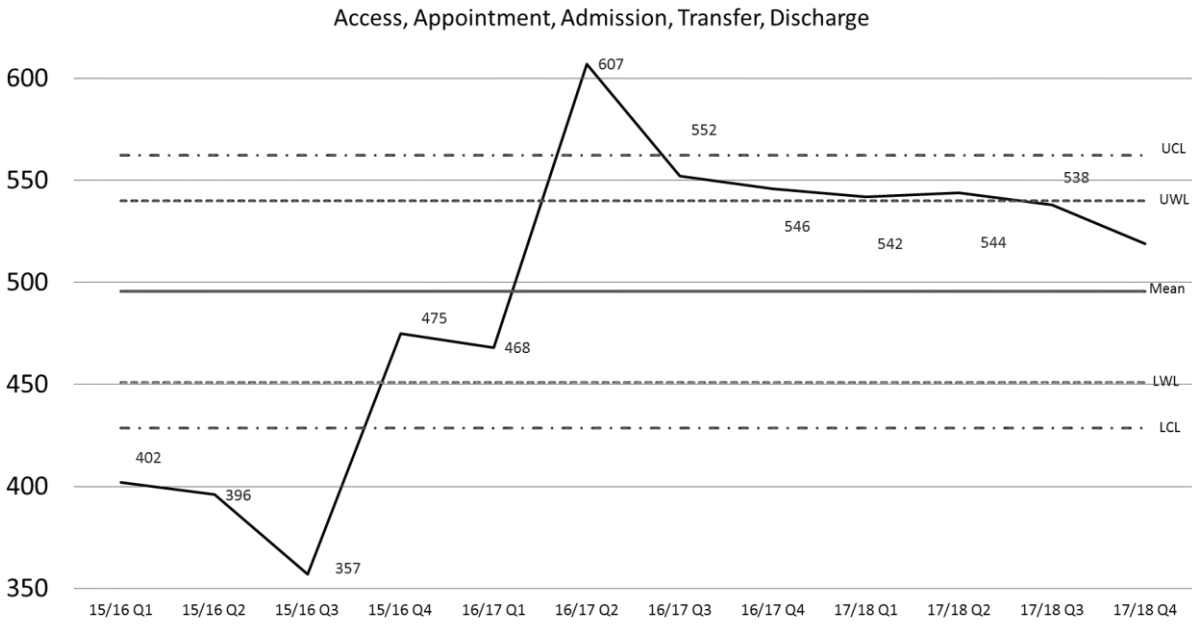


Fig. 17



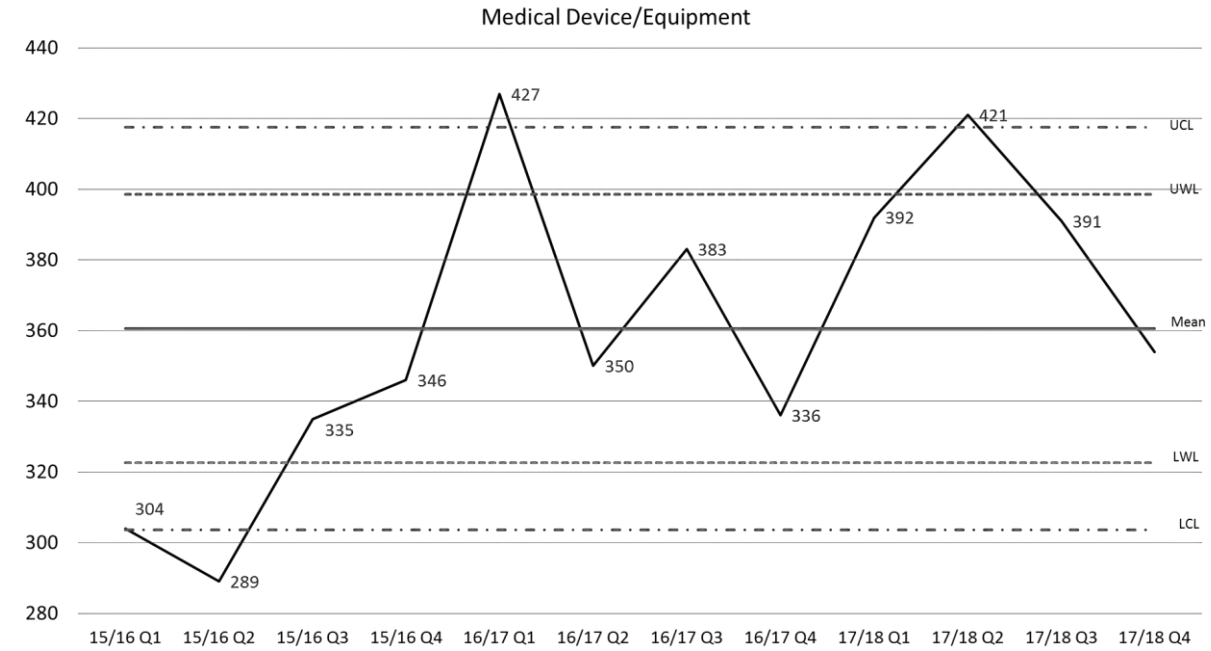
The spike in incidents in quarter 2 of 2015/16 in figure 17 was due to an intervention audit initiative where pharmacy staff recorded all discrepancies they encountered on wards or in the dispensaries as incidents on the Datix system.

Fig. 18



69% of the incidents included in figure 18 are absconder / missing patients, mostly reported by residential childrens and CAMHS units.

Fig. 19



Examples of Actions from Incident Trend Data

- **Category – Abusive, Violent, Disruptive or Self-harming**

The increase in 'abusive' incidents from quarter 1 of 2017/18 occurred predominantly in the Children's Community Services and Adult Social and Primary Care Directorates. The vast majority of these incidents were of insignificant or minor severity.

In Children's Community Services a significant number of incidents related to a small number of young people who were placed in Residential Homes as a result of a regional embargo on secure accommodation in Autumn 2017. These young people are now in more appropriate placements in the UK or ROI. A number of incidents also related to a placement of a Looked After Child (LAC) in Children with Disabilities residential facility in Q2. This LAC is now in a foster placement.
In Adult Social and Primary Care, increases tend to be because of one or two individuals with very specific behavioural challenges at a point in time. The Directorate provide monthly in-house divisional dashboards which are discussed at all divisional meetings, SMT and governance meetings. Trends are highlighted and explanations explored. In Mental Health and Learning Disability there are detailed PI (Personal Intervention) reports which highlight how many times MAPA holds have to be used and how many times seclusion is used. This provides a more detailed insight into individuals requiring extra support because of challenging behaviours.

- **Category – Accident that may result in personal injury**

In relation to incidents recorded under 'Accidents that may result in personal injury' there has been a similar number to that seen for the previous year. Within this category when this is broken down further, 77% of these incidents are linked to Slips, trips, falls and collisions. (Further detail of the breakdown and a summary of the actions taken over this reporting period to reduce this can be seen within Section 2.3.2)

- **Category – Medication**

In figures 14 and 17 the increase in medication incidents in 2015/16 was due to an intervention audit initiative where pharmacy staff recorded all discrepancies they encountered on wards or in the dispensaries as incidents on the Datix system. This cannot be achieved on a day-to-day basis due to the volume involved.

Currently, medication incidents are reviewed weekly by the Medicines Governance team. Those graded as actual moderate harm and above, and potential major harm and above, are reviewed by the Medicines Risk and Safety Group and actions agreed. Current trends in medication incidents are also discussed and actions agreed. During this reporting period the group

reviewed incidents between November 2016 and July 2017. Within the last reporting period there have been a number of actions completed and further work planned. This includes:

- Agreed M&M safety messages, Safety Messages Of The Week and articles for Safety Matters newsletter
- Development of pocket sized cards detailing information about penicillin-containing antibiotics and distribution during SafeTember.
- Roll out of insulin 50units/50mL prefilled syringes across Trust.
- Dissemination of regional Medicines Governance newsletters 'Medication Safety Today'.
- Ongoing support of a number of agreed quality improvement projects ongoing across the Trust

In relation to 'Medication' incidents reducing harm can be summarized into three main aims:

1. Reducing Prescribing Errors – Improving prescribing of High Risk Medications (Insulin and Anti-Coagulants) by spreading QI projects
2. Reducing Medicines Administration Errors – Increased focus on reducing omission of medicines, particularly critical medicines. Increasing compliance with Controlled Drug policy and utilising new technology (automated CD cabinets) to aid this
3. Improving Medicines Communication between Primary and Secondary care – Improving the Medicines Reconciliation process and optimizing discharge processes

By focussing on these three aims it would be anticipated that we can achieve a 30 % reduction in harm from medications by 2020. Through inclusion within the Safety thermometer, the collection of data around these processes will be become ingrained throughout the BHSCT to allow us to measure real time improvement in medication safety.

Further breakdown of the top 2 incident categories in 2017/18 is shown in the following section. Each category is broken down by subcategory/detail and also by severity.

2.3.1. Further breakdown of 'Abusive, Violent, Disruptive or Self-harming' behaviour incidents.

Fig. 20

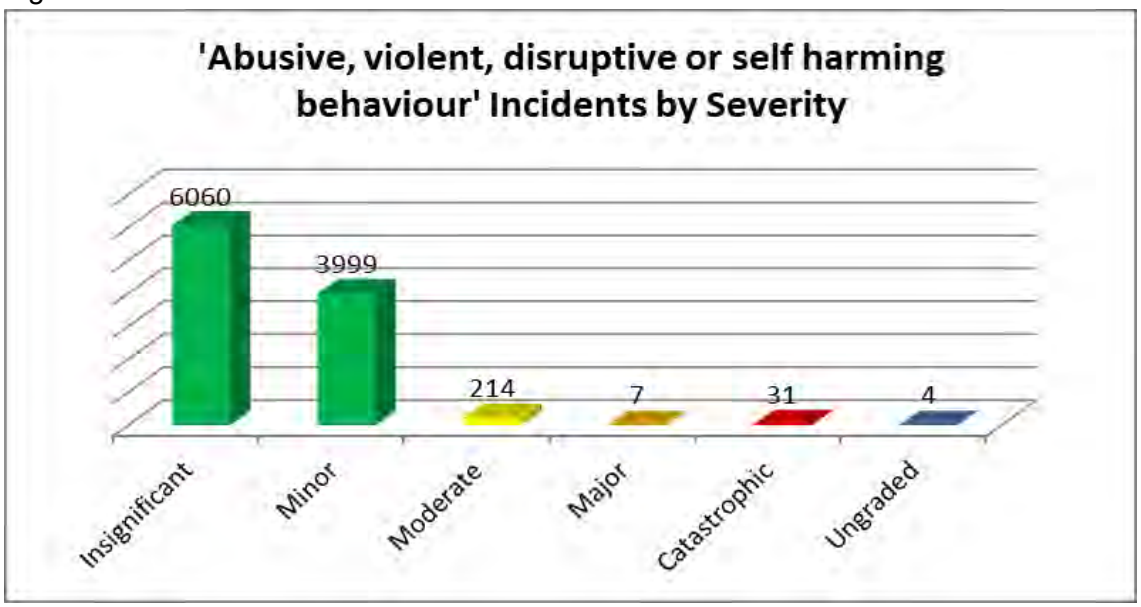


Figure 20 shows that the majority of incidents in this category (10,059 or 98%) were of insignificant or minor severity. There were 7 (0.07%) graded as major and 31 (0.3%) graded as catastrophic.

Figure 21 and 22 show run charts of these incidents by month split by 'community' and 'acute' sites.

Fig. 21

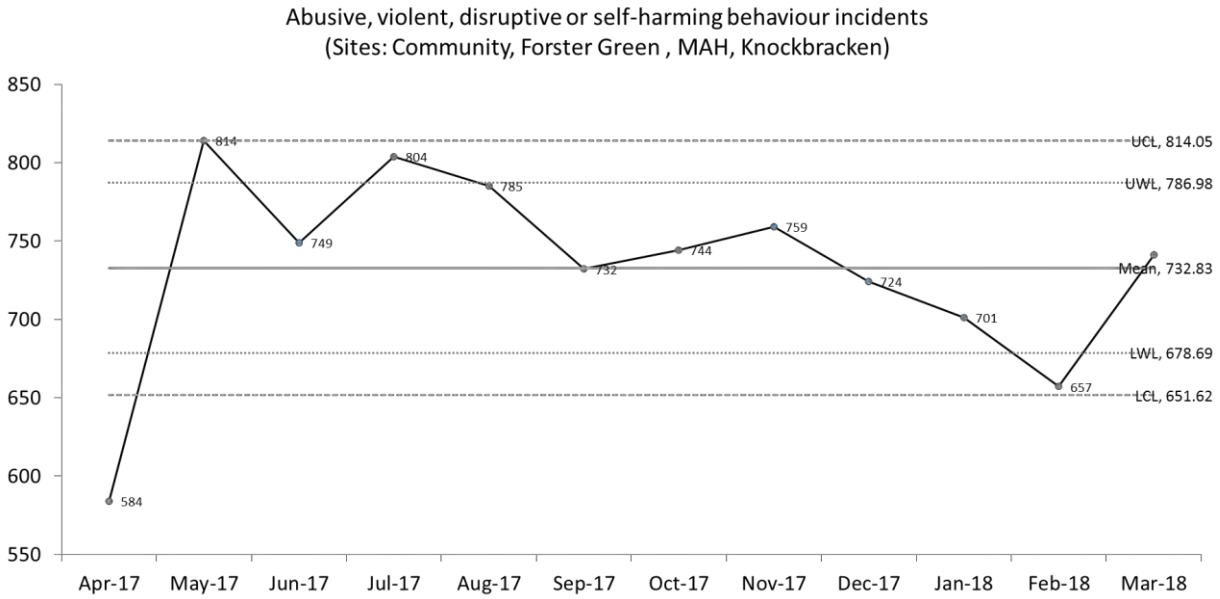


Fig. 22

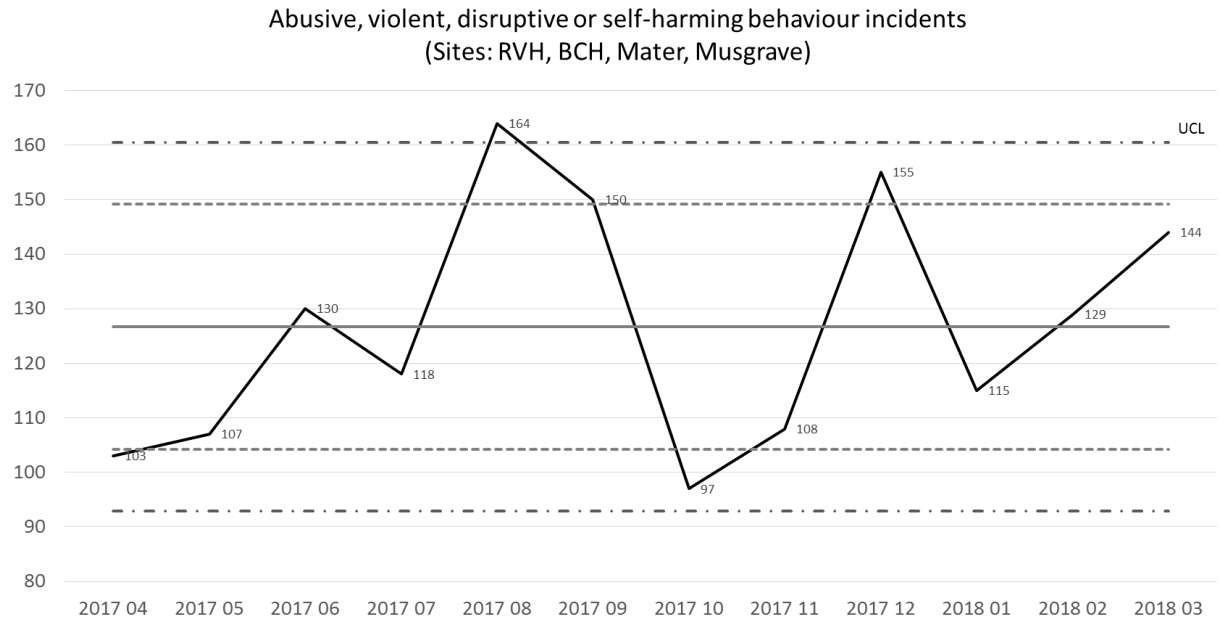
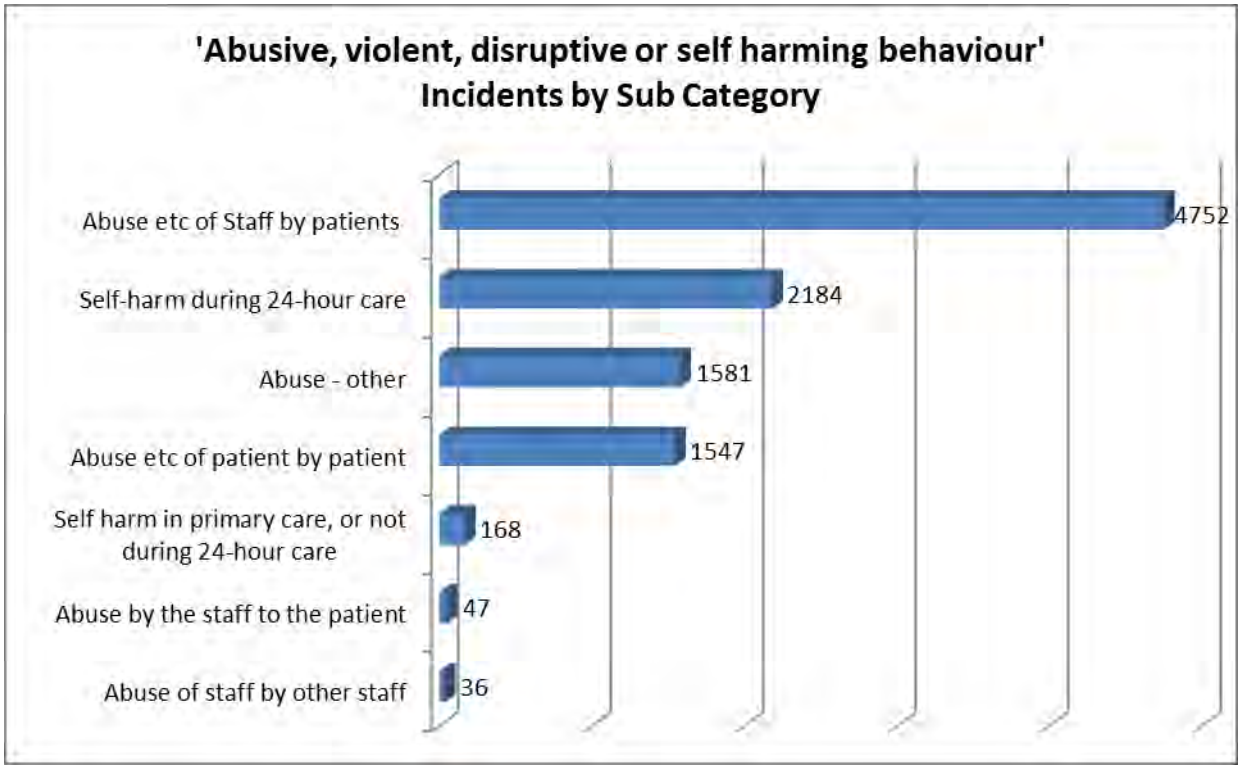

Abusive, violent, disruptive or self-harming behaviour incidents
(Sites: RVH, BCH, Mater, Musgrave)
170
160
150
140
130
120
110
100
90
80
UCL
103
107
130
118
164
150
97
108
155
115
129
144
2017 04
2017 05
2017 06
2017 07
2017 08
2017 09
2017 10
2017 11
2017 12
2018 01
2018 02
2018 03

Fig. 23


'Abusive, violent, disruptive or self harming behaviour'
Incidents by Sub Category
Abuse etc of Staff by patients
4752
Self-harm during 24-hour care
2184
Abuse - other
1581
Abuse etc of patient by patient
1547
Self harm in primary care, or not during 24-hour care
168
Abuse by the staff to the patient
47
Abuse of staff by other staff
36

Further breakdown of ‘Abusive, violent, disruptive or self harming behaviour’ incidents as shown in figure 23 shows that 4,752 (46%) of these incidents are directed by patients/clients against staff. The second highest sub category is ‘Self-harm during 24-hour care’ with 2,184 (21%) incidents.

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.

The top 3 sub categories above are further broken down by Detail in the following three graphs.

Fig. 24

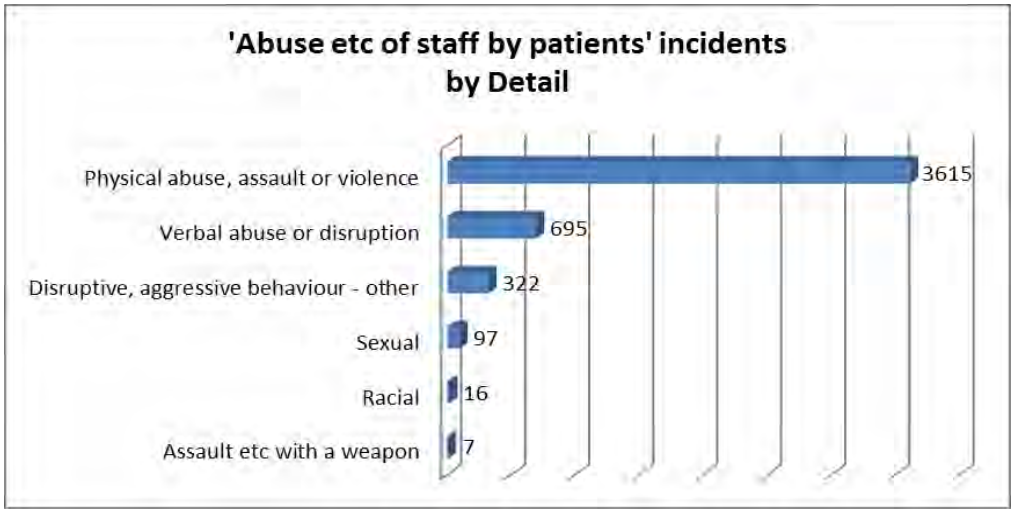
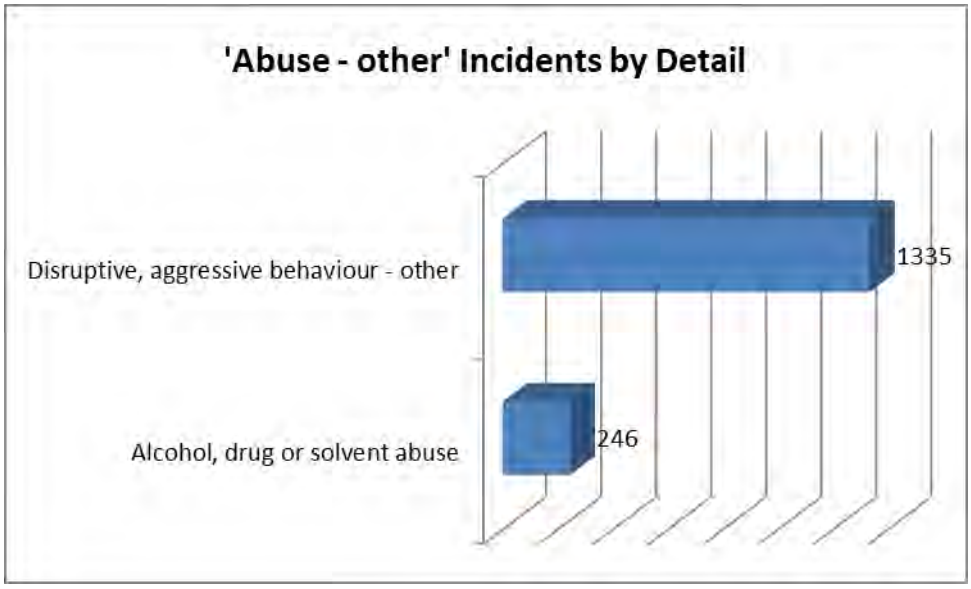


Fig. 25

Fig. 26


'Abuse - other' Incidents by Detail
Disruptive, aggressive behaviour - other
1335
Alcohol, drug or solvent abuse
246

2.3.2 Further breakdown of 'Accident that may result in personal injury' incidents

Fig. 27

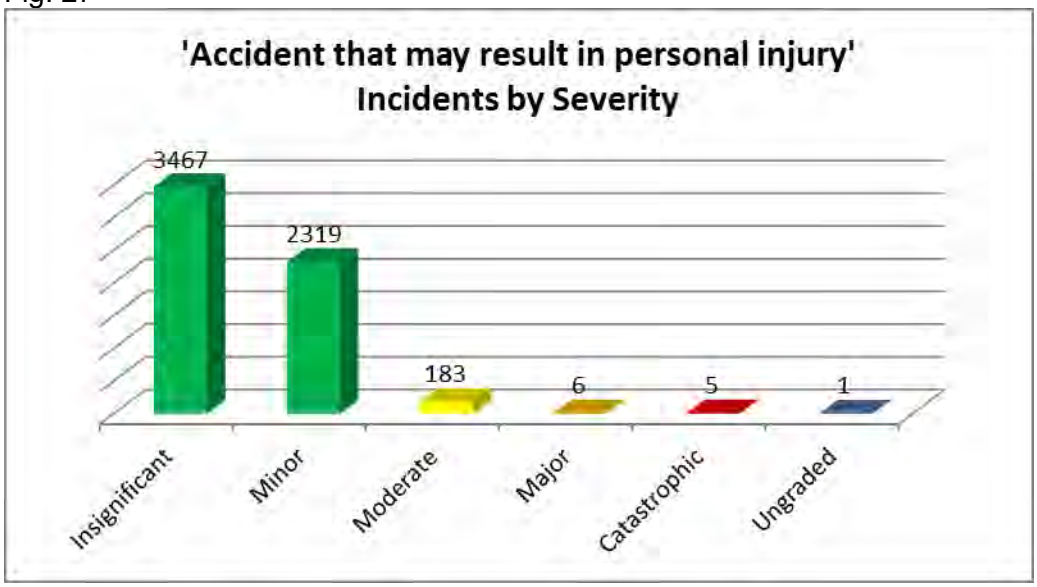
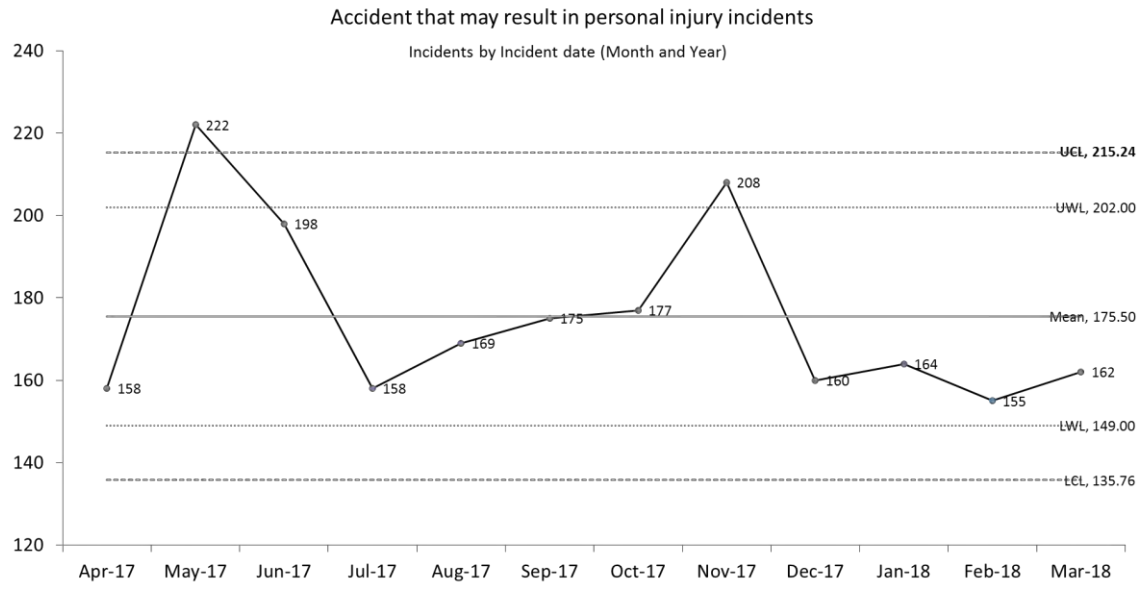


Figure 27 shows that the majority of incidents in this category (5,786 or 97%) were of insignificant or minor severity. There were 6 (0.1%) graded as major and 5 (0.1%) as catastrophic.

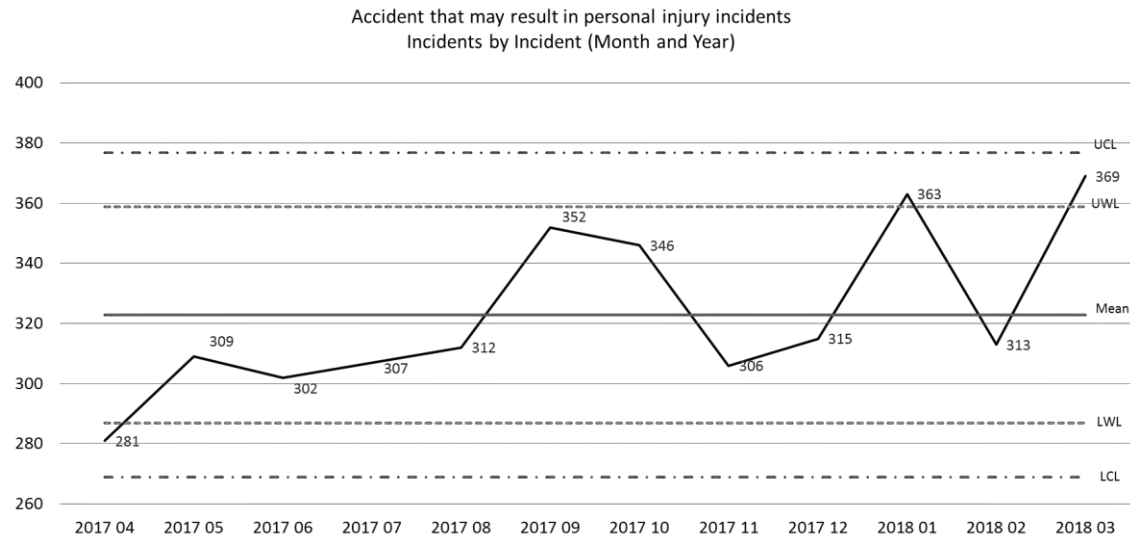
Figure 28 and 29 show run charts of these incidents by month split by 'community' and 'acute' sites.

Fig. 28



(Sites: Community, Forster Green, MAH, Knockbracken)

Fig. 29



(Sites: RVH, BCH, Mater, Musgrave)

Fig. 30

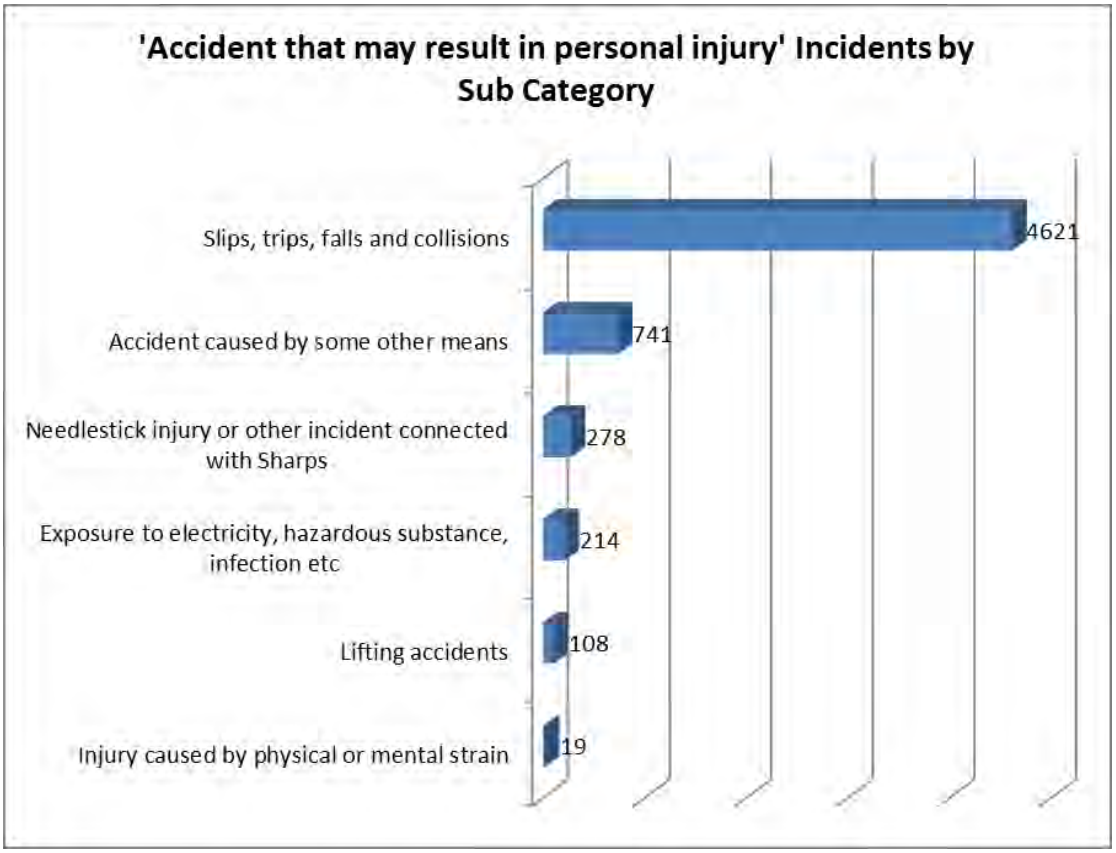


Figure 30 indicates that ‘Slips, trips, falls and collisions’ are by far the most commonly reported accident with 4,621 incidents. This represents 77% of all accidents.

Within the Trust since April 2017, in addition to ongoing training, there have been a number of actions completed to try and help reduce this. This has included

- The Fall safe project implemented in 62 wards within the adult acute in-patient setting in BHSCT
- The monitoring of falls within the adult in-patient setting via Datix and this then discussed at the Safety Improvement Team and the Falls Forum group meetings held on a 4-8 weekly basis.
- A falls awareness week held in June within the Trust, which included information stands across the sites and further information on the HUB.
- A quarterly falls newsletter for staff
- Two falls workshops for staff facilitated.

The top 3 sub categories above are further broken down by Detail in the following three graphs.

Fig. 31

Fig. 32

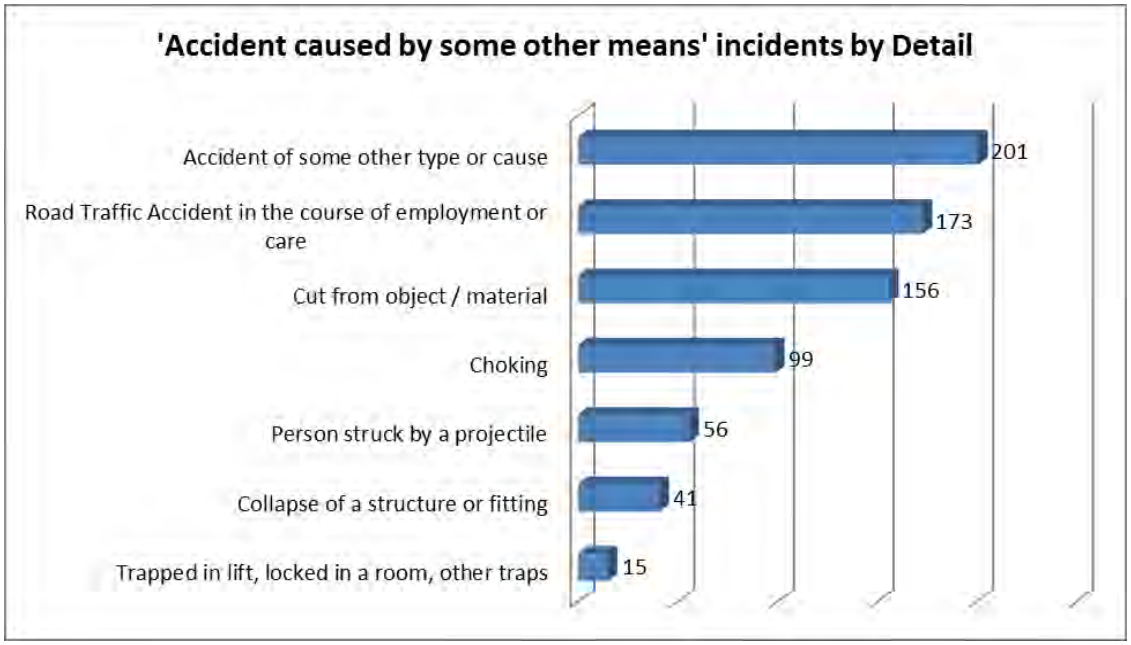
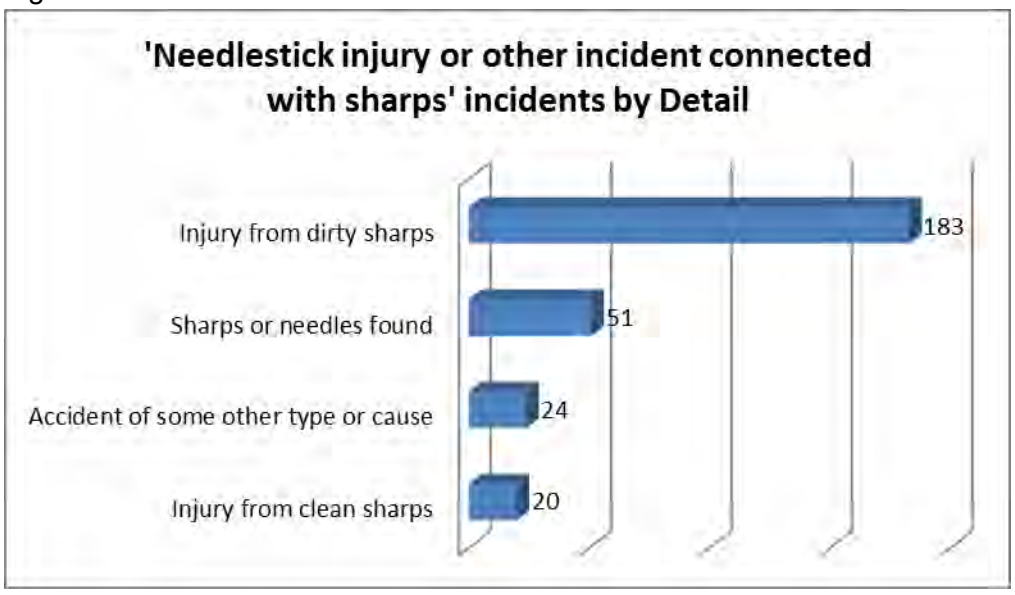

'Accident caused by some other means' incidents by Detail
Accident of some other type or cause
201
Road Traffic Accident in the course of employment or care
173
Cut from object / material
156
Choking
99
Person struck by a projectile
56
Collapse of a structure or fitting
41
Trapped in lift, locked in a room, other traps
15

Fig. 33


'Needlestick injury or other incident connected with sharps' incidents by Detail
Injury from dirty sharps
183
Sharps or needles found
51
Accident of some other type or cause
24
Injury from clean sharps
20

3. INTRODUCTION – SERIOUS ADVERSE INCIDENTS (SAIs)

During the period between 01 April 2017 and 31 March 2018 there were a total of 86 SAIs reported.

Fig. 34 - SAIs reported between April and March for the last 9 years.

Total SAIs reported for Period	Reporting Period
86	Apr 17 to Mar 18
89*	Apr 16 to Mar 17
157**	Apr 15 to Mar 16
182	Apr 14 to Mar 15
104	Apr 13 to Mar 14
95	Apr 12 to Mar 13
92	Apr 11 to Mar 12
60	Apr 10 to Mar 11
54	Apr 09 to Mar 10

**No. of SAIs excluding criterion 2 - any death of a child in receipt of HSC services (see below)*
***58 SAIs relate to the criterion of reporting any death of a child in receipt of HSC services as SAIs (see below)*

For the period in question, the following criteria determines whether or not an adverse incident constitutes a Serious Adverse Incident (SAI) as defined by the HSCB[3]:

1. serious injury to, or the unexpected/unexplained death of:
   - a service user (including those events which should be reviewed through a significant event audit)
   - a staff member in the course of their work
   - a member of the public whilst visiting a HSC facility;

3. unexpected serious risk to a service user and/or staff member and/or member of the public;

4. unexpected or significant threat to provide service and/or maintain business continuity;

5. serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

6. serious self-harm or serious assault (including homicide and sexual assaults)
   a. on other service users,
   b. on staff or
   c. on members of the public,

   by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (including CAMHS, psychiatry of old age or

[3] HSCB Procedure for Management & Follow-Up of Serious Adverse Incidents (SAIs), Version 1.1 (November 2016)

leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

7. suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

8. serious incidents of public interest or concern relating to:
    a. any of the criteria above
    b. theft, fraud, information breaches or data losses
    c. a member of HSC staff or independent practitioner.

**Please note that Criterion 2 (Child Death) has been removed from the procedure following a review in February 2016. There is now no requirement to report child deaths unless they meet one of the other SAI criteria.*

The objectives of the SAI reporting system is to encourage an open reporting and learning culture, acknowledging that lessons need to be shared in order to improve service user and staff safety and apply best practice in assessing and managing risks. It also aims to provide feedback on high level analysis and themes arising from reported incidents.

4. SAI PERFORMANCE MANAGEMENT BY DIRECTORATE

Trust performance in the management of SAIs continues to be monitored and progress reports are provided for SAI Group on all outstanding SAI investigations.

The SAI administration procedure was revised in accordance with HSCB SAI procedures (November 2016) to assist in the timely submission of investigation reports; and the HSCB highlight any overdue SAI investigations in a letter to the Chief Executive on a bi-monthly basis for urgent action.

The following tables illustrate the number of SAIs reported across Directorates and each Directorate's performance in completing investigations within the allocated timeframe as compared with the same period in the previous year.

Fig. 35

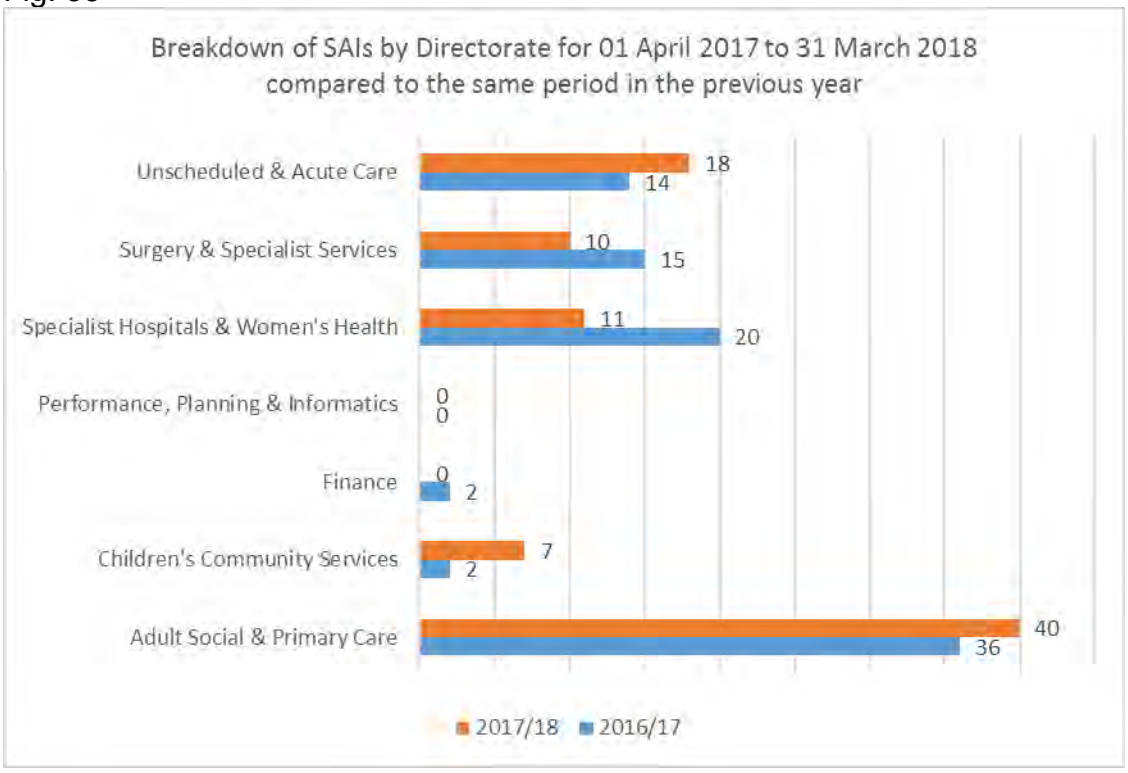


Figure 35 shows Adult Social & Primary Care, Children's Community Services and Unscheduled & Acute Care Directorates had an increase in reporting for the period 01 April 2017 to 31 March 2018; compared to Specialist Hospitals & Women's Health and Surgery & Specialist Services Directorates who both had a decrease in reporting for the same period.

Finance reported no SAIs for 2017-18 compared to 2 reported for 2016-17.

Overall there were 86 SAIs reported by the Trust during 01 April 2017 to 31 March 2018 compared to 89 SAIs reported for the same period in the previous year.

Fig. 36

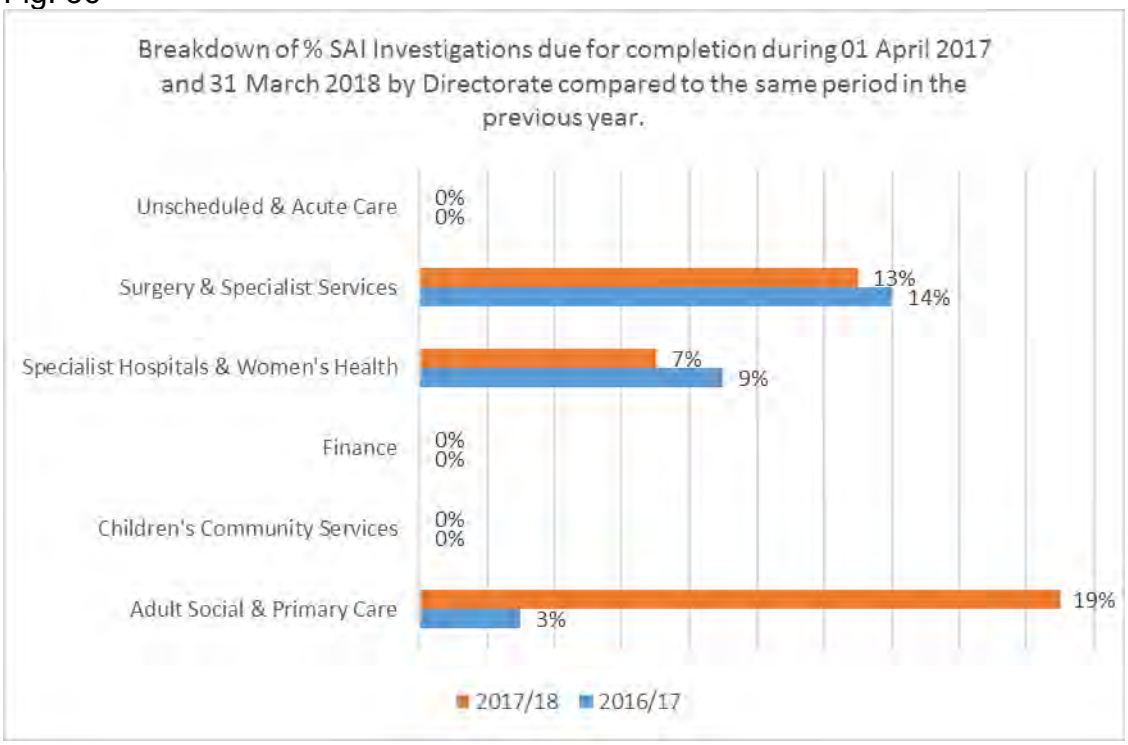


Figure 36 illustrates during 01 April 2017 and 31 March 2018 there was a marked improvement in achieving the timelines for completion of SAI investigations for the Adult Social & Primary Care Directorate from 3% in the previous year to 19% for this period.

For Specialist Hospitals & Women's Health and Surgery & Specialist Services Directorates there was a slight decrease. While for Children's Community Services, Finance and Unscheduled & Acute Care Directorates no SAI investigations were completed within the required timelines.

Where there is a delay in completion of SAI investigations the main reasons given for not being able to meet the HSCB timeframes for submission of the final report include:

- Delays with approval by Review team / Directorate
- Awaiting comments on report
- Annual leave/Sick leave/Work pressure
- Difficulties arranging Review Team meetings
- Delays obtaining input from External experts/persons
- Delays associated with completing complex investigations
- Ensuring appropriate patient/family engagement.

In addition reporting timelines are impacted when an SAI investigation is put on hold while the PSNI complete their own investigation. During 01 April 2017 to 31 March 2018 there were 10 of 86 SAI reports due that were impacted by PSNI compared to 17 of 89 for the same period in 2016.

Ongoing completion of SAI reports would be discussed as part of the monthly SAI Review Group chaired by the Medical Director.

When a SAI occurs the service will consider if any urgent action is required to make the service safe and to identify any immediate learning. The Trust has developed a guide for having a hot debrief following a SAI or an incident. The purpose of a hot debrief is to identify any urgent changes required and to remind staff of support available.

Fig. 37

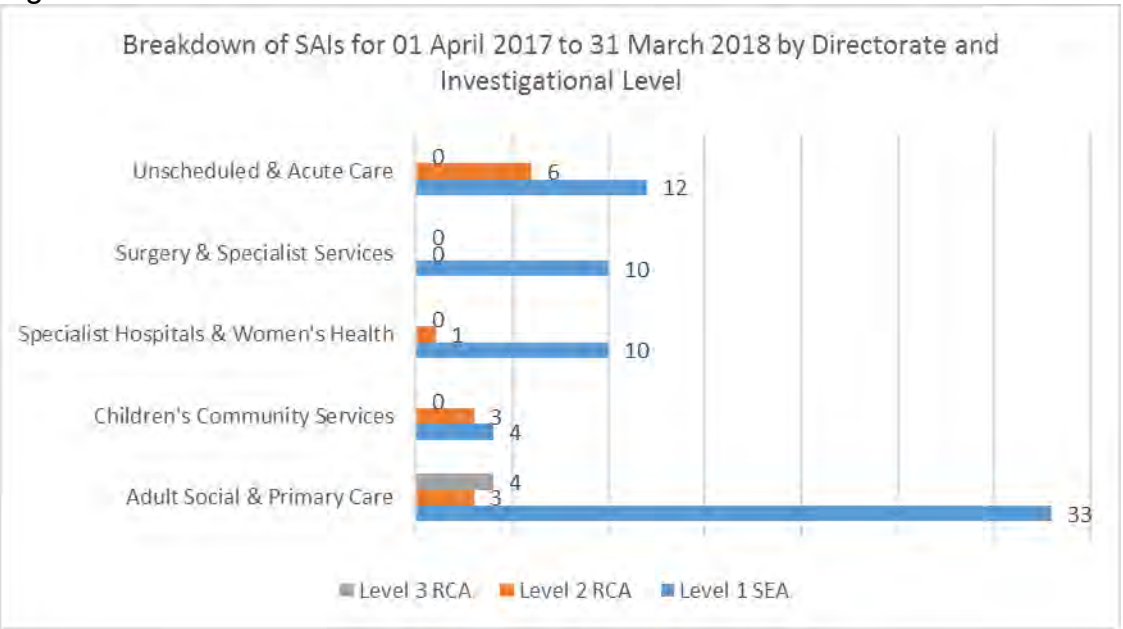


Figure 37 shows the breakdown of SAIs reported for 01 April 2017 to 31 March 2018 by Investigational Level. At a Trust level there were 69 Level 1 SEA investigations, 13 Level 2 RCAs and 4 Level 3 RCAs.

Level 3 SAIs are investigations that are considered particularly complex involving multiple organisations, have a degree of technical complexity that require independent expert advice; and/or are very high profile and attracting a high level of both public and media attention.

Of the 40 SAIs reported by the Adult Social & Primary Care Directorate 33 (83%) were carried out as Level 1 SEAs. 24 of the **33** SAIs for this Directorate related to Criteria 7 of HSCB Guidance (i.e. suspected suicide of mental health patient/client of last 12 months).

All SAIs reported by Surgery & Specialist Services were investigated as Level 1 and all apart from one SAI was investigated as Level 1 for Specialist Hospitals & Women's Health (the other one was investigated as a Level 2).

For the 18 Unscheduled and Acute Care SAIs, a third where investigated as Level 2 RCAs, while 3 of 7 SAIs reported by Children's Community Services were investigated as Level 2 RCAs.

5. SUMMARY OF SAIs BY CRITERIA

Of 86 Serious Adverse Incident (SAI) notifications, 41 (48%) involved the death of service users. Of which 26 in total across all Directorates (30%) relate to Criteria 7 of HSCB Guidance (i.e. suspected suicide of mental health patient/client of last 12 months) two of which were investigated as Level 2

Figure 38 shows a breakdown of all SAIs reported for the period 01 April 2017 to 31 March 2018 by SAI criteria.

Fig. 38

SAI Criteria	No. SAIs
1. Serious injury to, or the unexpected/ unexplained death	24
3. Unexpected serious risk to service user and / or staff member	26
4. Unexpected or significant threat to provide service	1
5. Serious self-harm / assault within Healthcare facility	1
6. Serious self-harm / assault by Service user in the community	5
7. Suspected suicide of MH Client/ Patient of last 12 months	26
8. Serious incidents of public interest or concern	3
TOTAL	**86**

Child Death Notification (CDN)

The Department of Health (DoH) agreed a new process for reviewing and reporting child deaths. This process includes a multidisciplinary review of all child deaths at local Mortality and Morbidity (M&M) meetings and all child deaths are reported to the Public Health Agency (PHA).

There was one child death reported under Criteria 1 for the period 01 April 2017 to 31 March 2018. The investigation for this SAI is currently ongoing and the final report will be submitted to HSCB once it has been completed.

6. SERVICE USER / FAMILY ENGAGEMENT

The Procedure for the Reporting and Follow up of SAIs (revised November 2016) and the Trust SAI Procedure, make clear the importance of appropriate engagement with service users, relatives, carers and the Coroner.

Figure 39 provides a breakdown of the level of notification to service user/family/carer of all SAIs reported during this reporting period 01 April 2017 to 31 March 2018.

Fig. 39

Was Service User / Family / Carer notified of SAI?*	
Advised of SAI	76
Not appropriate	1
Not applicable	1
Awaiting confirmation**	2
Not contactable	4
Not informed	2
TOTAL	**86**

**Data correct as of 25/06/2018*

***Awaiting confirmation from the Service Directorate. Service User/Family/Carer engagement can happen at different stages of an SAI Review.*

7. SHARED LEARNING FROM SAIs

The Trust Procedure for sharing learning governs how learning from SAIs should be shared throughout the organisation and beyond. In support of this process Learning Templates are produced where learning has been identified from SAI investigations and after approval at SAI Group are shared to Directors for cascading as appropriate.

Figure 40 shows a breakdown of Shared Learning Letters (12) issued from SAIs for the period 01 April 2017 and 31 March 2018.

The Trust Policy applies to learning from any source including:

- An incident or Serious Adverse Incident (SAI)
- A complaint or compliment
- A morbidity / mortality review case (including Cardiac Arrest reviews)
- A litigation case,
- An audit,
- Events in other Trusts sometimes result in a learning letter from that Trust, the Health and Social Care Board (HSCB) or the DHSSPS.

In the period the following learning alerts have been shared. These are available on the Belfast Trust Hub via the following link:

http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Shared%20learning/Serious-Adverse-Incident.aspx

Shared Learning Letters are discussed at speciality Morbidity & Mortality and Patient Safety meetings.

Fig. 40

Reference	Theme	Date Shared
BHSCT/SAI/15/138	The results of all tests carried out must be reviewed.	May 2017
BHSCT/SAI/16/054	Importance of Safe prescribing and Continuity of Care	May 2017
BHSCT/SAI/16/049	Management of Retained Foreign Bodies in Theatre Environment.	May 2017
BHSCT/SAI/16/083	It is important to ensure that routine recording of clinical observations is undertaken when managing patients with epidural analgesia in situ.	August 2017
BHSCT/SAI/16/072	All Interventions must be Recorded in the Clinical Records	Sept 2017
BHSCT/SAI/17/013	Pulmonary embolism is important to consider within the differential diagnoses for unexplained new onset of seizure activity.	Sept 2017
BHSCT/SAI/14/185	Before prescribing or administering a loading dose of a medicine, staff must check if the patient has already been prescribed that medicine by an alternative route eg oral/ enteral or has already received a loading dose.	Sept 2017
BHSCT/SAI/16/066	Patients with severe AKI should be discussed at an early stage with a Consultant Nephrologist particularly if urgent dialysis may be required.	November 2017
BHSCT/SAI/16/037	Multi-disciplinary discussions should be formally documented in the clinical records as outlined in the Clinical Record- Keeping policy and professional guidelines.	December 2017
BHSCT/SAI/17/033	On discharge, staff must ensure that a referral/re-referral is made to all necessary services. E.g. District nursing.	December 2017

Reference	Theme	Date Shared
BHSCT/SAI/17/048	An effective triage process must be in place to consider incoming referrals	January 2018
BHSCT/SAI/17/066	A thorough check of a patient's clinical records must always be made prior to surgical arrangements being made or carried out.	February 2018

In the period the Trust also published edition 13 and 14 of Safety Matters. Safety Matters Newsletters are available on the hub via the following link http://intranet.belfasttrust.local/Directorates/medical/riskgovernance/Pages/Home.aspx

8. NEVER EVENTS

Figure 41 shows the list of Never Events that the Department of Health introduced in October 2016 via Circular HSC (SQSD) 56/16. Information relating to these events will be captured as part of the SAI process and the patient/service user and/or their family will be informed that the incident is a never event.

Fig. 41

Never Events
1. Wrong Site Surgery
2. Wrong Implant / Prosthesis
3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium containing solution
5. Wrong route administration of medication
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or next entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso - or oro - gastric tubes
14. Scalding of patients

During the period 01 April 2017 to 31 March 2018 there was 1 Never Event reported. This relates to wrong site of injection and an SAI was reported & investigated during the period. This investigation was carried out as Level 1 and learning has identified the need to review WHO checklists, especially for minor procedures.

9. SAIs RELATED TO EMERGENCY DEPARTMENTS

Figure 42 shows that the Trust reported 3 SAIs occurring in Emergency Department (ED) for the period 01 April 207 to 31 March 2018. This was the same number of SAIs reported for the Trust for the same period in the previous year.

Fig. 42

Incident Type	ED	Current Status
Access, Appointment, Admission, Transfer, Discharge **Discharge**	RVH	Final report sent to HSCB
Accident that may result in personal injury **Slips, trips, falls and collisions**	RVH	Final report sent to HSCB
Treatment Procedure **Treatment, procedure – other**	MIH	Final report overdue

*Data correct as at 24/04/2018

NB: SAI Investigation reports outstanding are routinely followed-up at monthly SAI Review Group meetings as part of the agenda.

10. ACUTE HOSPITALS INDEPENDENT SECTION PROVIDER (ISP)

Figure 43 shows a breakdown of SAIs reported for the period 01 April 2017 to 31 March 2018 for Independent Sector Providers (ISPs).

During the period 3 SAIs were reported for the independent sector. 2 of these SAIs occurred in the Unscheduled & Acute Care Directorate and 1 occurred in the Adult Primary & Social Care Directorate. Table 7 provides further detail.

Fig. 43

Incident Type	ISP	Current Status
Clinical assessment (investigations, images & lab tests) **Failure to act on adverse test results or images**	Private Healthcare	Final Report sent to HSCB
Treatment, Procedure **Treatment/procedure – inappropriate/wrong**	Private Healthcare	Report overdue
Implementation of care or ongoing monitoring / review **Concerns raised about implementation of care or ongoing monitoring/review**	Private Nursing Home	Final Report sent to HSCB

11. SAIs REPORTED TO OTHER ORGANISATIONS

RQIA

The Regulation & Quality Improvement Authority (RQIA) continues to require incidents to be reported to it in accordance its statutory responsibilities. All mental health and learning disability SAIs are reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986 AND any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation. 26 suspected suicides were included in the SAIs reported to RQIA and HSCB over the reporting period 01 April 2017 to 31 March 2018.

Early Alert notifications

Since June 2010, the Trust is required to make the Department (and thus the Minister) aware of those events (which may include potential SAIs) which may require urgent attention or possible action by the Department. The Department issued guidance outlining seven criteria which may trigger an “Early Alert” notification.

The HSCB have a process for requesting Early Alerts to be considered for reporting as SAIs. As a result the Trust Early Alert protocol was circulated to all Directors to provide clarification in facilitating prompt notification and follow up where required.

The Trust has made 34 Early Alert notifications during this period; 9 were also reported as SAI's in the period 01 April 2017 to 31 March 2018..

Northern Ireland Adverse Incident Centre (NIAIC)
The Northern Ireland Adverse Incident Centre (NIAIC), part of Health Estates, exists to record and investigate reported adverse incidents involving medical devices, non-medical equipment, plant and building items used in HPSS and to issue warning notices and guidance to help prevent recurrence and avert patient, staff, client or user injury.

3 SAIs (1 electrical failure, 1 staff injury and 1 equipment not effective) was reported to NIAIC for this period. For all such incidents, normal NIAIC procedures are followed. NIAIC on conclusion of their investigation would share their findings with the incident reporter.

Health & Safety Executive (under RIDDOR).
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR) require employers and others to report accidents and some diseases that arise out of or in connection with work. These reports enable the enforcing authorities to identify where and how risks arise and to investigate serious accidents. 4 SAIs (2 patient falls, 1 physical abuse, assault or violence; and 1 exposure to hazardous substances) met the requirement for reporting to Health & Safety Executive (HSE) under RIDDOR for this period.

Interface Incidents
Interface incidents are incidents that have occurred in another organisation, which may be reportable as SAIs. During the 2017/18 period the Trust reported 15 interface incidents to HSCB.

12. SAI RECOMMENDATIONS FROM THE O'HARA REPORT

Following issue of the O'Hara report and the recommendations issued around the SAI process BHSCT have undertaken an initial gap analysis and in the interim of new guidance issued by the HSCB are reviewing existing arrangements to help further increase the robustness of the assurance linked to this process.

Work is underway across a range of themes arising from the O'Hara Report. One of the workstreams will deal with Serious Adverse Incidents (SAIs). A Regional Governance Leads Group is being established and Belfast HSC Trust Co-Director for Risk & Governance has been identified for membership.

13. SEA & RCA METHODLOGY TRAINING

Significant Event Audit (SEA) and Root Cause Analysis (RCA) methodologies are routinely used as part of the SAI investigation process. To help ensure that SAI investigations are robustly carried out the Trust has secured formal

training for the 2018 period to enable key staff across Directorates to be trained in these methodologies.

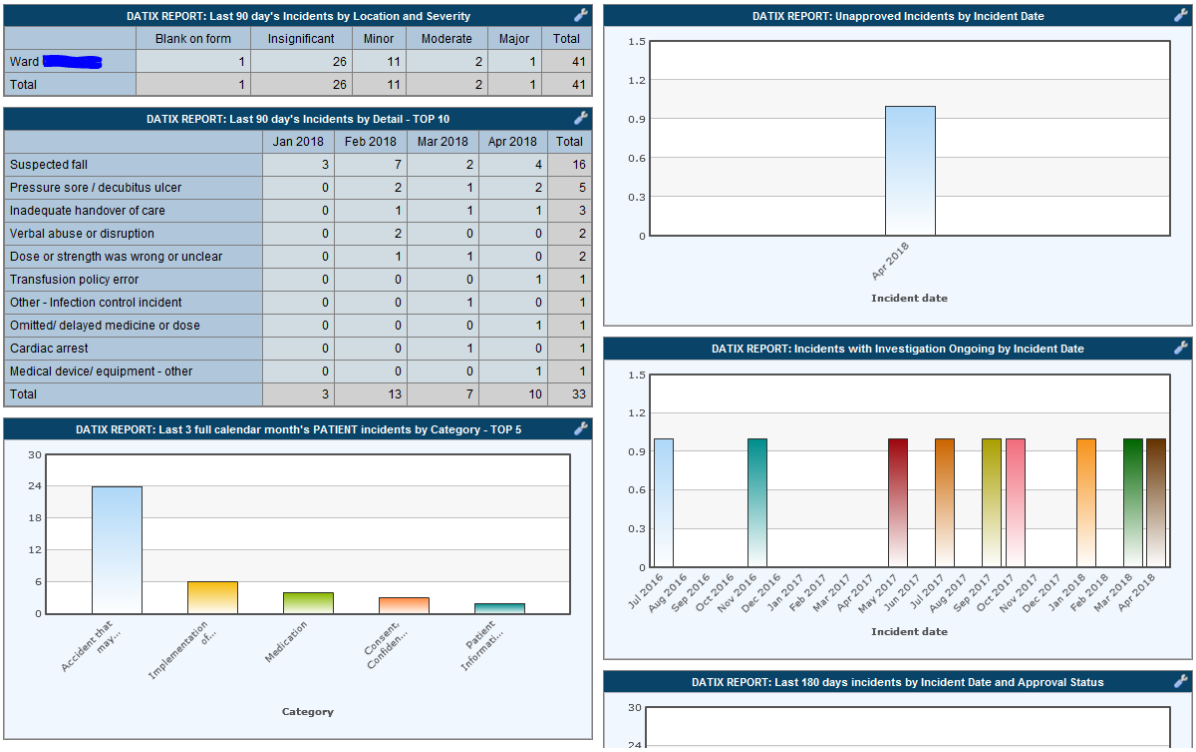
14. LEARNING FROM INCIDENTS

Incidents are investigated locally and learning is shared with teams and across the Trust if applicable. Incident reports are provided to specialist teams upon request and quarterly and monthly to Directorates to enable identification of trends and to inform improvement work.

Datixweb Incidents Dashboards have been rolled out to all users from September 2017. This provides easy access to local trend information.

A quality improvement project looking at governance data provided to ward staff was undertaken with the gynae and vascular wards to look at what data is relevant for front line staff. This data report is being rolled out across further wards in surgery in a phased approach. This work is co-ordinated by the Data Triangulation Group.

Sample Datixweb Incident Dashboard:



DATIX REPORT: Last 90 day's Incidents by Location and Severity

	Blank on form	Insignificant	Minor	Moderate	Major	Total
Ward [redacted]	1	26	11	2	1	41
Total	1	26	11	2	1	41

DATIX REPORT: Last 90 day's Incidents by Detail - TOP 10

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Total
Suspected fall	3	7	2	4	16
Pressure sore / decubitus ulcer	0	2	1	2	5
Inadequate handover of care	0	1	1	1	3
Verbal abuse or disruption	0	2	0	0	2
Dose or strength was wrong or unclear	0	1	1	0	2
Transfusion policy error	0	0	0	1	1
Other - Infection control incident	0	0	1	0	1
Omitted/ delayed medicine or dose	0	0	0	1	1
Cardiac arrest	0	0	1	0	1
Medical device/ equipment - other	0	0	0	1	1
Total	3	13	7	10	33

A quality improvement project is underway to reduce needlestick injuries in the Trust. This group, involving Occupational Health, Health & Safety and service area representatives, have to date completed:

PDSA Cycle 1- Sharps Improvement Tool

- Developed a "Sharps Improvement Tool" (This Tool is completed on a weekly basis in Ward 6A Royal Hospital and NICU, RJMS in conjunction with the Ward/Unit).
- Feedback report provided to the Ward- good practice, issues identified and points of learning included in the daily safety brief communicated to staff.
- This Tool will be completed on a weekly basis until end of April 2018.

PDSA Cycle 2- Improve the quality of local investigation of all sharps incident.

- A sharps investigation template has been drafted and is currently being finalised. This template will be trialed in the event of an incident in either service area.

And plan to proceed with other planned PDSA Cycles:

- Increase attendance at relevant training programs – clinical practice/safe use of medical sharps, IP&C and Waste Management.
- Improve the quality of training programs e.g. to include a focus on personal impact/ experiences and lessons.

In relation to SAIs, (separate to the information covered under Section 7 'Shared Learning from SAIs') identified learning as part of this process is progressed via the Shared Learning Review Group (SLRG). This group would review and quality assure shared learning letters with potential learning at Trustwide/Regional level prior to submission to the relevant Assurance Framework Group for their approval. A copy of the approved learning letter would also be forwarded for regional sharing if appropriate.

15. 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 (including SAIs) 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.

16. APPENDIX 1: Serious Adverse Incidents (SAIs) by Sub Category and Directorate

Serious Adverse Incidents (SAIs) by Sub Category and Directorate grouped by Category from 01 April 2017 to 31 March 2018.

	ASPC	CCS	FIN	PPI	SHWH	SSS	UAC	Incident Type	Total
Access, Appointment, Admission, Transfer, Discharge	**1**	**1**	**0**	**0**	**2**	**1**	**1**		**6**
Appointment	0	0	0	0	0	1	0	Failure in outpatient referral	1
Discharge	1	1	0	0	0	0	1	2 inappropriate discharges and 1 Absconder	3
Transfer	0	0	0	0	2	0	0	2 unplanned transfers	2
Abusive, violent, disruptive or self-harming behaviour	**36**	**3**	**0**	**0**	**0**	**0**	**0**		**39**
Abuse by the staff to the patient	3	1	0	0	0	0	0	4 Alleged assault on patient by staff member	4
Abuse of patient by patient	3	1	0	0	0	0	0	4 cases of physical abuse, assault or violence	4
Abuse of staff by patients	1	0	0	0	0	0	0	Physical abuse, assault or violence	1
Self-harm during 24-hour care	3	0	0	0	0	0	0	2 attempted suicide and 1 other	3
Self harm in primary care, or not during 24-	26	1	0	0	0	0	0	26 deaths of clients known to MH/CCS and 1 client known to MH self-	27

	ASPC	CCS	FIN	PPI	SHWH	SSS	UAC	Incident Type	Total
hour care								harm/stabbing	
Accident that may result in personal injury	**0**	**1**	**0**	**0**	**1**	**1**	**3**		**6**
Exposure to electricity, hazardous substance, infection, etc	0	1	0	0	1	0	0	1 equipment system was not effective and 1 hazardous exposure to smoke or fire	2
Slips, trips, falls	0	0	0	0	0	1	3	1 suspected patient fall and 3 patient falls	4
Clinical assessment (investigations, images and lab results)	**0**	**0**	**0**	**0**	**1**	**0**	**1**		**2**
Images for diagnosis (scan / x-ray)	0	0	0	0	0	0	1	1 CT scan	1
Laboratory Investigations	0	0	0	0	1	0	0	1 Development of immune AntiD	1
Infrastructure or resources (staffing, facilities, environment)	**0**	**0**	**0**	**0**	**0**	**0**	**1**		**1**
Environmental matters	0	0	0	0	0	0	1	1 Electrical Failure	1
Diagnosis, failed or delayed	**0**	**0**	**0**	**0**	**0**	**0**	**1**		**1**
Diagnosis, failed or delayed	0	0	0	0	0	0	1	1 failure to act on adverse symptoms	1
Medication	**0**	**0**	**0**	**0**	**0**	**1**	**2**		**3**
Administration or supply of a medicine from	0	0	0	0	0	1	1	1 Delay and 1 Infusion Error	2

	ASPC	CCS	FIN	PPI	SHWH	SSS	UAC	Incident Type	Total
a clinical area									
Preparation of medicines / dispensing in pharmacy	0	0	0	0	0	0	1	1 Medication error	1
Implementation of care or ongoing monitoring/ review	**1**	**0**	**0**	**0**	**1**	**2**	**4**		**8**
Possible delay or failure to Monitor	0	0	0	0	0	2	3	4 Delay/Failure to monitor and 1 Failure to follow-up	5
Infection control	0	0	0	0	1	0	0	1 Infection Control issue	1
Other type	1	0	0	0	0	0	1	1 delay in escalating deterioration and 1 concerns raised	2
Other - please specify in description	**1**	**2**	**0**	**0**	**0**	**1**	**1**		**5**
Other	1	2	0	0	0	1	1	3 unexpected deaths, 1 unexplained injury and 1 cardiac arrest	5
Treatment, procedure	**0**	**0**	**0**	**0**	**5**	**4**	**3**		**13**
Connected with the management of operations / treatment	0	0	0	0	4	3	2	3 Delay/Failure to monitor, 1 Failure to follow-up, 1 wrong site, 1 radiology incident, 2 inappropriate/wrong treatment, 1 Adverse event after treatment and 1 delay in treatment	9

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	ASPC	CCS	FIN	PPI	SHWH	SSS	UAC	Incident Type	Total
Delay in treatment, other	0	0	0	0	1	1	2	2 delay, 1 treatment/procedure inappropriate, and 1 treatment/procedure other adverse event	4
	ASPC	**CCS**	**FIN**	**PPI**	**SHWH**	**SSS**	**UAC**		**Total**
TOTALS	40	7	0	0	11	10	18		86

Belfast Health and Social Care Trust
caring supporting improving together

TRUST BOARD
SUBMISSION TEMPLATE

MEETING	**Trust Board - Confidential**	**Ref No. 3.a i.a**
DIRECTOR	**Interim Director Adult Social and Primary Care**	**21 September 2020**
Muckamore Abbey Hospital - Update		
Purpose	This paper provides an update in respect of Muckamore Abbey Hospital.	
Corporate Objective	• Safety and Quality	
Key areas for consideration	1. Safe care in Muckamore Abbey hospital 2. RQIA Inspections 2019 and Improvement Journey Appendix 1 - Actions for the Muckamore Management Team arising from the Recommendations of the Leadership and Governance Review	
Recommendations	• For Information	

Briefing for Extraordinary Trust Board – 21 September 2020
Muckamore Abbey Hospital

Patient Numbers

At 16 September 2020, there were 49 patients in residence in Muckamore Abbey hospital and 1 patient on trial resettlement. Two of the 49 patients remain on home leave at the request of families in light of the Covid-19 pandemic.

Table 1.1 : Inpatients (inclusive of patients on home leave) and Patients on Trial Resettlement

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	21	0
Belfast HSC Trust	18	1
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	1	0
Total	**49**	**1**

Patient Safety

A weekly Safety Report sets out performance against a range of patient safety metrics. This Report is reviewed by the senior management team in Muckamore Abbey Hospital, shared with the multi-disciplinary team and shared and discussed at the fortnightly Directors' Assurance Meeting, chaired by the Chief Executive. There is also a weekly Live Governance call for all clinical areas to feedback on the previous week's incidents and any other governance issues. The Safety Report and the Live Governance calls have continued during the Covid-19 pandemic.

The most recent Safety Report, Report No 77, week ending 2 September 2020 is enclosed.

Leadership

The Leadership and Governance Review into Muckamore Abbey Hospital 2012 – 2017 was published on 5 August 2020.

A process to seek feedback on factual accuracy of the report from those who were interviewed by the Leadership and Governance Review team is underway.

Work is progressing in relation to the Recommendations for the Trust, which are summarised below.

The Belfast HSC Trust

1. The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.

2. The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.

3. Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

4. The complaint of P96's father of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.

5. In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

6. The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

Appendix 1 sets out the current position in respect of recommendations 2, 3, 4 and 5.

Staffing

Current nurse staffing levels, with the combination of substantive nursing staff, long-term agency staff and nurse bank staff, are currently providing a safe level of care, supported by use of the nursing model. This remains under regular review as it has been and remains a very challenging period due to staff absence and vacancies.

The fundamental vulnerabilities of the workforce remain which are the temporary (agency) nature of 40% of the workforce, combined with an ongoing PSNI investigation which may result in further substantive staff being suspended. It is imperative that Muckamore Abbey Hospital can continue to be supported to reduce its bed numbers on site in order to achieve a more sustainable staffing model. The Trust continues to actively pursue all avenues of recruitment.

As at 16 September 2020, there are 62 members of nursing staff who are precautionary suspended - 30 are registrants, and 32 are non-registrants. There have been 2 further arrests associated with Muckamore Abbey Hospital, the total is now 9.

Covid-19

There have been no further patients test positive since the outbreak was stood down on 12 May 2020, and no staff have tested positive. The management team and staff in Muckamore Abbey Hospital continue with their focus on the protection of patients and staff from Covid-19, including the safe management of family visiting on site.

Carers and Families

Contact has been maintained between families and patients via ward teams using the telephone, photographs and/or FaceTime or zoom. In addition, visiting is being supported in line with the current Trust guidance.

Section 2

RQIA Inspections and Associated Improvement Journey
Muckamore Abbey Hospital

RQIA Inspections 2019 and 2020

RQIA placed 3 Improvement Notices on Muckamore Abbey Hospital on 16 August 2019 in respect of failures to comply with minimum standards across 3 areas : Staffing, Adult Safeguarding and Financial Governance. The date given for the Trust to demonstrate compliance was 15 November 2019.

Inspection : 10-12 December 2019
The RQIA carried out a 3-day unannounced inspection of the hospital from 10 – 12 December 2019. Verbal feedback from this inspection was given on 16 December 2019 and RQIA followed this up in writing on 19 December 2019. In summary, they lifted the Staffing Improvement Notice in full with immediate effect, and lifted all bar one aspect of the Adult Safeguarding and the Financial Governance Improvement Notices.

Improvement Notice – Staffing

The Belfast Health and Social Care Trust must :

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH which

a) Is based on the assessed needs of the current patient population; and
b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements

2. Implement an effective process for oversight and escalation of challenges relating to staffing across the hospital site; this should include Ward Sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate

3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of the current staffing model and associated escalation measures

4. Engage the support of, and work in partnership with, other HSC organisations (including the HSCB, the PHA and HSC Trusts) to define future model(s) for nurse staffing in mental health and learning disability inpatient services/wards.

The inspection found significant progress had been made with respect to staffing and RQIA lifted the Improvement Notice in full.

Progress was summarised by RQIA as follows :

- Required model of staffing has been mapped out and defined
- Effective escalation arrangements in place
- A robust action plan to continue to manage staffing on site is in place

Key actions undertaken by the Trust :

- Work progressed to determine safe staffing levels through an assessment of patient acuity and dependency. Acuity and dependency determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels.
- This triangulated approach resulted in a nursing model which can describe what safe staffing levels are in each ward, and for each patient. The model was developed by the senior team, in conjunction with Ward Managers and ASMs, and has been approved by the Executive Director of Nursing and the then Expert Nurse Advisor, DoH
- The model is used by Ward Managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.
- Ward staffing levels are reviewed on a daily basis, Monday to Friday, and at the weekly Ward Managers meeting (Friday) for the weekend.
- ASMs are on site Monday to Friday and review the requirements daily and there is a now a daily staffing huddle with each ward represented.
- The OOH Co-ordinator also reviews staffing levels on site in the OOH period. Any issues of concern are raised by the wards to the ASM/OOH Co-Ordinator to Service manager and then to the collective leadership team.
- In the OOH period, there is a 1:6 senior manager on call rota in place to provide additional support to staff on site as required.

Improvement Notice – Financial Governance

The Belfast Health and Social Care Trust must ensure:

1. **That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.**

2. **In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.**

3. **Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes that:**
   a) appropriate records of patients' property are maintained;
   b) staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

c) audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy;
d) there is a comprehensive audit of all financial controls relating to patients in MAH.

The inspection found significant improvements and lifted all but one aspect of the Improvement Notice.

Progress was summarised by RQIA as follows :

- Effective management and oversight of patients' finances
- New Trust policy and procedure
- Staff are aware of the new policy and procedures
- Staff have received training relevant to their role with respect to the management of patient finances
- Staff now have a clear understanding of their roles and responsibilities at ward level, managerial level and at a governance level
- Decisions relating to patient finances are now being made on an individual and supportive basis and in consultation with patients and their next of kin, best interests decision making was evident

RQIA determined to lift all elements of the Improvement Notice relating to Financial Governance in MAH except for the action relation to there being a 'comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.'

An audit of financial governance throughout the hospital had already been scheduled for February 2020 and therefore RQIA extended this element of the Improvement Notice for 3 months to enable full completion and reporting of the audit.

Following the BSO Internal Audit of Financial Governance in February 2020, BSO provided a final report with the outcome of 'Satisfactory'. On 14 April 2020, RQIA wrote to Dr Jack to confirm that the Improvement Notice for Financial Governance had been lifted.

Improvement Notice – Adult Safeguarding

1. The Belfast Health and Social Care Trust must :

Implement effective arrangements for adult safeguarding at MAH and ensure:

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;
b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;
d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved.

2. **Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate.**

3. **Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.**

The inspection found significant improvements and lifted all but one aspect of the Improvement Notice.

Progress was summarised by RQIA as follows :

- Effective deployment of safeguarding referrals
- Evidence of learning from safeguarding investigations being implemented
- Outcomes from safeguarding investigations are positively impacting patient well-being
- Good multi-disciplinary working between professional staff
- Meaningful implementation of protection plans being achieved
- Quality and timeliness of information on safeguarding concerns shared with relevant stakeholders
- Service improvements being developed through meaningful engagement with patients and carers
- Staff have a clear understanding of their roles and responsibilities in respect of safeguarding practices at ward level, managerial level and at a governance level
- Monthly auditing of adult safeguarding procedures in place

RQIA determined to lift all elements of the Improvement Notice relating to Adult Safeguarding in MAH except for the action to '**implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital**.' RQIA extended this element of the Improvement Notice for 3 months to enable the Trust to embed improvements across the safeguarding arrangements and to ensure systems/processes are robust.

At a meeting with RQIA on 2 April 2020, MAH staff presented the improvement work on safeguarding practices. RQIA said they were assured with the progress in this area. As they were unable to carry out a site visit (due to lockdown) to test what had been presented, they asked for some further evidence by way of audits etc. which were subsequently provided. **On 22 April 2020, RQIA wrote to Dr Jack to confirm that the Improvement Notice for Adult Safeguarding had been lifted.**

Since 22 April 2020, there have been no active RQIA Improvement Notices for Muckamore Abbey Hospital. However, the Trust has ongoing work to do associated with Quality Improvement Plans submitted following 2019 inspections, including the 3 day inspection in December 2019 and the virtual April 2020 inspection. The QIP is an extensive document and can be shared if required. For the purposes of this report, the actions required as a result of the December 2019 inspection are summarised below :

Improvement 1
The Belfast Health and Social Care Trust must

- implement effective arrangements for the management and monitoring of CCTV within MAH and ensure:

    i. that all staff understand the procedures to be followed with respect to CCTV;
    ii. that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively;

- Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.

Improvement 2
The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas:

- Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time.

- Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy.

- Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.

Improvement 3

- The Belfast Health and Social Care Trust shall complete a review of how seclusion is provided on the site taking into account the safety of both patients and staff. The Trust should also take into account the dignity of patients and best practice guidance.

Improvement 4

- The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the

required standards and best practice guidance and ensuring the safety of patients and staff.

Improvement 5

- The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks.

Improvement 6

- The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient.

OTHER IMPROVEMENTS

This section summarises a range of improvements and developments which have been undertaken in relation to Muckamore Abbey Hospital. A number of these are ongoing, and are reflected in the work required as part of the RQIA Quality Improvement Plan.

Enhanced Governance and Assurance Arrangements

Enhanced governance and assurance arrangements are now in place, key points below :

- Weekly Safety Report – detailed data/safety metrics for MAH
- Learning Disability Governance Committee
- Daily Executive Team Huddle – high level metrics
- Safety Report on MAH monthly to Trust Board
- Safety Report on MAH monthly to Directors Assurance Group
- Muckamore Abbey Hospital Departmental Assurance Group

Weekly Safety Report

A weekly Safety Report provides assurance on patient safety metrics which is reviewed by the senior management team in MAH, shared with the multi-disciplinary team and shared and discussed at the monthly Directors' Assurance Meeting, chaired by the Chief Executive.

This report is underpinned by the use of data an demonstrates a transparent and accountable approach to care.

Live Governance

There is also a detailed weekly Live Governance call for all clinical areas to feedback on the previous week's incidents and any other governance issues. These calls give an opportunity to review safety parameters as well as having relevant ward specific and site wide clinical and adult safeguarding discussions where necessary, which are often supportive to the ward teams. There is also sharing of good practice and important learning form SEA reviews.

Purposeful Inpatient Admission (PIpA)

The introduction of the PIpA model was one of the most constructive and innovative changes undertaken to improve MDT care on site. The way patients' needs are being met are clearly visible to relevant individuals and for external scrutiny. This is extremely useful both for defining and ensuring quality and safety of care (through a task focus), in ensuring efficient use of MDT time, daily and timely support for all disciplines and timely decision making for patient and families. PIpA also informs the safety mechanism in relation to evaluating adult safeguarding issues and incidents on site.

Reduction in Restrictive Practices

The hospital management team measure and monitor the use of restrictive practices on site. Use of restrictive practices with patients is included in the weekly Safety Report, discussed at weekly Live Governance, discussed at the ward MDT meetings and reviewed at the monthly Governance Committee. Discussion on restrictive practices includes the use of seclusion, voluntary confinement, physical intervention and the use of rapid tranquilisation and PRN medication.

Audits are ongoing to ensure that any use of seclusion and voluntary confinement is conducted in accordance with Trust policy, for example, that patient observations are carried out at the appropriate frequency and are documented. The finding and actions from the audits are shared and discussed across the site.

A Restrictive Practice Working group has been set up to provide a strategic direction for the work to reduce the use of these practices. The group has representation from medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy.

The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, and an overarching Restrictive Practice Policy has been developed in line with best practice across the UK.

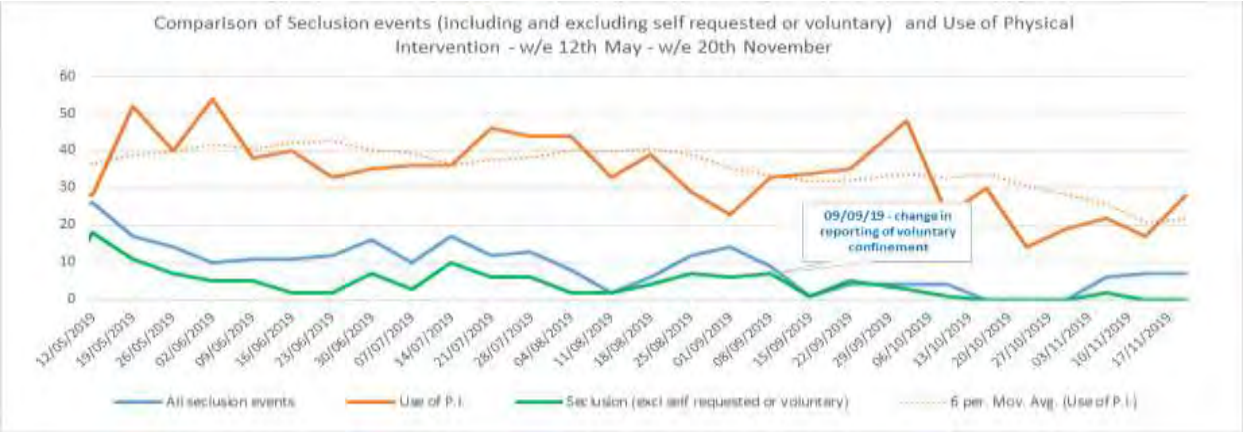
In summary, the use of Seclusion is monitored as follows :

- **Ward Staff** : Immediate and ongoing monitoring of patient, documentation in the seclusion record
- **MDT**: Review of seclusion for individual patients (daily PIpA report out) and for identification of learning across the system. Discussion at ward level.
- **Live Governance**: Instances of seclusion are discussed to confirm the clinical rationale
- **Collective Leadership Team**: Seclusion records will be subject to a continual review process comprising weekly Safety Reports, analysis at Live Governance and analysis of audits
- **Executive Team**: Safety Report presented at the Muckamore Directors Operational Group; elements of the Safety Report included in daily dashboard
- **Trust Board** : Summary of safety metrics provided to Trust Board bi-monthly including latest version of Safety Report

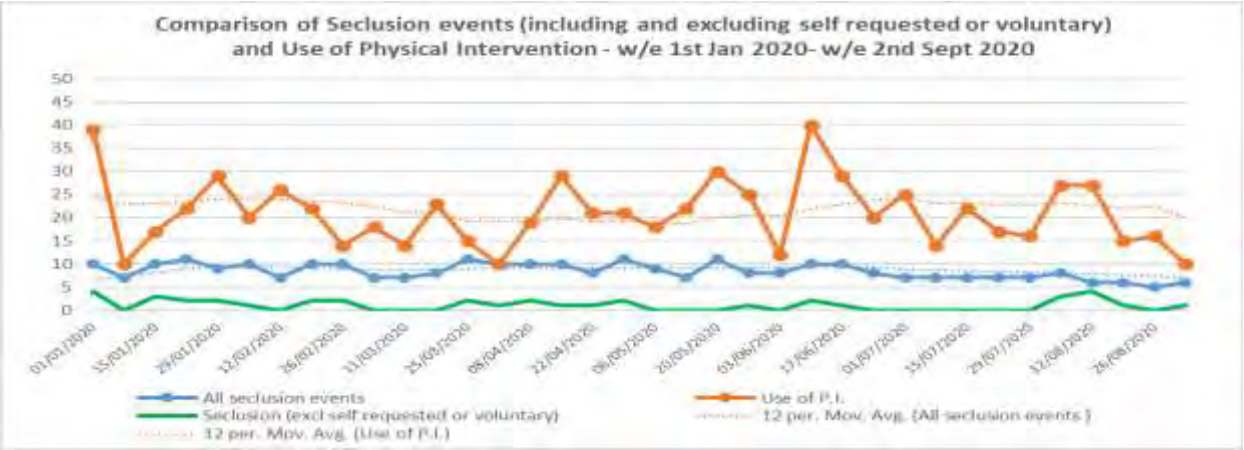
The Use of Seclusion and Voluntary Confinement

There has been a sustained reduction in the use of restrictive practices on site, notably seclusion, and a reduction in the use of physical interventions on site.

Seclusion Events and use of Physical Intervention – w/e 12 May 2019 to 20 November 2019



Seclusion Events and use of Physical Intervention – w/e 1 January 2020 to w/e 2 September 2020



The blue line above represents the combined use of seclusion and voluntary confinement, 'seclusion events' – as well as the use of physical intervention, the orange line. There is one patient who avails of voluntary confinement on a regular basis and this is agreed as part of his ongoing care plan.

There has been a sustained reduction in the use of seclusion events over the last 2 years. For example, there were 23 seclusion events in September 2019 compared to 120 seclusion events in September 2018, 10 seclusion events in October 2019 compared to 107 seclusion events in October 2018 and 41 seclusion events in November 2019 compared to 104 in November 2018.

Number of Times Seclusion Used Daily – w/e 1 January 2020 to w/e 22 July 2020

Culture

Positive Behaviour Support is a culture. We are influencing this culture through:

- Behaviour Assistants (Band 4) : in post from August 2019 across all clinical areas. Part of MDT and patients with most challenging behaviour have a PBS plan based on a traffic light system.
- PBS Training
    - Principles of PBS being instilled by training and practical engagement of staff in PBS Plans for patients
    - Introduction of PIpA has further embedded a psychology formulation approach for each patient
    - Ongoing use of low stimulus areas
    - Autistic Spectrum Disorder (ASD) Training – considering how best to tie in this training with existing training opportunities. Could be added to PBS training in relation to challenging behaviour in LD with autism.

We are working hard to change our culture. This involves a whole range of measure, including but not limited to :

- Training and education for staff
- Patients and carers at the heart of what we do
- Spirit of inquiry at all levels
- Developing leadership at all levels across the hospital
- Embedding a QI approach
- Embedding a clinical governance framework including robust and timely ASG processes
- Robust discharge planning and collaborative MDT working

Use of CCTV

Weekly review of contemporaneous CCTV is ongoing and used to provide feedback to staff on good practice, as well as providing an overall assurance to the management team that care continues to be safe.

A CCTV Working Group has been set up (representation from ward staff, safeguarding staff, management, litigation and Trade Unions) to review the current use of CCTV and the development of its use within the hospital. A range of improvements to the process have been implemented.

Work is underway to review and update the CCTV Policy and to include the option to use CCTV for training and incident debrief. This is now also reflected in a recommendation from the Leadership and Governance Review.

Surveys have been designed to gather feedback on the current use of CCTV and the potential for its use to be widened, eg. for reflection and incident debrief, training etc. Feedback will be sought from staff, families, carers, advocates and patients at the end of September 2020.

Management of Physical Healthcare

In previous RQIA inspections the Trust were asked to develop and implement a systemic approach to the identification and delivery of physical healthcare needs.

The following improvements have been made in this area :

A locum Speciality Doctor with an interest in Physical Healthcare has been recruited to the hospital to focus on physical health checks for all patients.

A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population - cervical cancer, bowel screening, mammograms, AAA and diabetic eye.

Six monthly (March and September) checks in line with Maudsley Guidelines are carried out; this includes bloods, ECG and all other relevant physical checks. Where relevant, patients now have an annual chronic health condition review - eye exams, asthma review, epilepsy review, hypertension review, testicular exams, breast exams and cervical screening. A review of all patients' health checks in regards to antipsychotic medication has been carried out. In addition, each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist.

Physical Healthcare on Admission

- All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). ECG machines, physical observation equipment and venepuncture facilities are available on site.
- Past medical history and medicines reconciliation are confirmed within the first week by a ward junior doctor and the pharmacist
- Any initial concerns about physical health are followed up accordingly (ward trainee)

Ongoing Management of Physical Healthcare

- For non-urgent physical concerns on the ward, the ward junior doctor is called
- For urgent physical concerns, a duty bleep system operates on site and staff are aware to also contact NIAS in emergencies (there are limited resuscitation facilities on site).
- Mandatory training for staff includes Life Support Training, at various levels depending on the grade/role of staff
- Ward rounds (PIpA model) operate across all wards, with focus days, one per week is health promotion. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring.
- All material pertaining to physical healthcare concerns are kept in manual files on the wards for easy access at PIpA and for out of hours doctors
- Podiatry, dietetics, SALT, physio and OT are available on site and there is a visiting dentist.
- Future plans include the development of an 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for patients with complex co-morbidities.

Management of Medicines

This forms part of our Quality Improvement Plan with RQIA. A number of areas of improvement have been implemented:

- There has been an increase in the amount of pharmacy hours provided on site, from 0.5wte to 0.8 wte from April 2020. A pharmacy technician post is still required, and options for funding are being explored.

- The pharmacist reviews the kardexes for omitted doses and completion of administration records at the PiPA rounds and any omissions or areas of concern are raised at that time. With the increase in pharmacy input, a more formalised approach is being developed.

- A POMH audit on antipsychotic prescribing in people with a learning disability under the care of mental health services has been carried out (4/2/20-27/3/20) - this included all MAH inpatients and a sample of community patients.

Maintenance of Safe Staffing Levels (Nursing)

While recruitment and retention remains a challenge for Muckamore Abbey Hospital, we have a number of checks and balances in place which work robustly to ensure that staffing levels remain safe on site :

- At 08:00, 7 days/week, there is a site wide call which has representatives from across the site. Staffing is reviewed and staff relocated if required. IPC guidance is followed in respect of any staff movement.
- Nurse staffing rotas are completed for each ward with the BHSCT nurse bank to ensure there are appropriately skilled staff to meet the needs of our patients.

Staff have an RNLD or RNMH registration. There is a competency framework in place to support agency staff to take charge of shifts if required.

- There are a high proportion of our agency staff who are long term bookings with us, and many who have now been on site 18 months or longer.
- Weekend staffing is reviewed every Friday and a Senior Nurse is identified who is in charge of the site over the weekend and contactable if there are any staffing issues or concerns.
- Any staffing concerns are escalated by Ward Sister/Charge Nurse to the Assistant Service Manager, the Service Manager and to the Divisional Nurse when required.

Recruitment and Retention of Staff

There is a Muckamore Abbey Hospital specific rolling advert for both RNs and SNAs. There were 6 successful candidates for SNA positions and 6 successful candidates for RN positions from our most recent recruitment exercise. The next step is to advertise and create a waiting list for Band 6 Deputy Ward Sister and Charge Nurse positions.

Enhanced Management Support and Management Stability

There is now a permanent Co-Director and Service Manager (April 2020) in Muckamore Abbey Hospital. In addition :

- There has recently been successful permanent recruitment into the two vacant Assistant Service Managers position. Both have an RNMH background and one appointee comes to us from outside the Trust.
- Assistant Service Managers are visible on the wards, and have their offices in the ward blocks (adjacent to but outside the clinical environment).
- Out of Hours Coordinator positions (similar to Patient Flow or Senior Nurse roles across the acute setting) are in the process of being recruited in order to expand the existing team. There have been welcome applications from a number of our agency staff.
- All Band 7 Ward Sister/Charge Nurse posts on site are permanently recruited to.

There is a 1:6 Senior Manager on call rota for Muckamore Abbey Hospital out of hours who is available for escalation of issues and support as required.

Gillian Traub
Interim Director
Adult Social and Primary Care Directorate

Appendix 1
Actions for the Muckamore Management Team from the Recommendations of the Leadership and Governance Review Recommendations 2, 3, 4 and 5

Recommendation	Context and Work to Date	Next Steps	Timeline
The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services	The managerial arrangements for Muckamore Abbey Hospital, introduced in October 2019, comprised an Interim Director for Muckamore Abbey Hospital, and an Interim Co-Director and Divisional Nurse dedicated to Muckamore Abbey Hospital. Managerial arrangements in respect of the Director and Co-Director roles have in large part reverted back to 'normal business'. There remains a dedicated, but Interim, Divisional Nurse. There has been significant success in recruiting substantively into the local management team for Muckamore Abbey Hospital. In October 2019, there was a vacant Service Manager position and two vacant Assistant Service Manager positions. These three posts have now been filled substantively. In October 2019, all bar one Ward Manager position in Muckamore were filled on a temporary basis; these positions have now all been filled substantively.	Interim Director for LD Services to review the existing managerial arrangements and develop proposals for enhancing the current arrangements pending the wider Departmental review of the location of MAH services. This will contribute to the proposed Chief Executive led review of Directorate and Divisional structures which will commence in October 2020.	End October 2020

	The Chair of Division post has been vacant for over 12 months and remains vacant although the Clinical Director for Learning Disability is providing additional support to the service. This remains an area of risk – the medical staff team within Learning Disability is a small team (less than 5wte).		
Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.	The BHSCT has a long-standing advocacy contract with Bryson House for patients with a learning disability across hospital and community settings. The current term of the contract is to the end of March 2021. Mr Bingham has offered the view at a recent MDAG meeting that advocacy services contracted by the Trust are not seen as sufficiently independent of the Trust which may be a factor in families not feeling confident with advocacy arrangements. However it is of note that the Leadership and Governance Review spoke to <5 families and there are a number of families who appear to have long standing advocacy arrangements with the existing provider. Consideration needs to be given as to how to improve arrangements recognising there are long term advocacy arrangements in place meaning some families have developed relationships with advocates.	Re-engage with the Patient Client Council regarding the original remit and to clarify if they are able to support the Trust in evaluating its existing arrangements. Consider other mechanisms to seek feedback from families about their experiences of advocacy to inform an overall decision about the future of the existing contract.	**Step 1** Meeting with Patient Client Council to be set up in September 2020

	Prior to Covid-19, the Patient Client Council had been engaged by DOH to recruit a dedicate advocate for Muckamore families and the Trust had asked also that the advocate seek feedback from families on existing advocacy arrangements. This process was put on hold due to Covid-19.		
The complaint of [redacted] of 30 August 201 7 should be brought to a conclusion by the Trust's Complaints Department	Letter from Mr Martin Dillon, Chief Executive of 5 April 2019 following a meeting held with P96's father, Mr Dillon, Mr McNaney, Mrs Heaney and Mr Sean Holland. This letter outlined the actions agreed at the meeting. From a review of emails and other correspondence, as well as feedback from staff, it appears that the actions agreed at the meeting and set out in the letter of 5 April 2019 were completed. It is clear from a review of the complaints file that the Complaints Department were not involved with P96's father complaint after 31 August 2017 as the Complaints Department were advised that the issues being raised by P96's father would be taken forward as an adult safeguarding procedures. A closure letter was sent to [redacted] on 31 August 2017. The issues were	Telephone call to P96's father on 28 August 2020 by Miss Traub to clarify P96's father outstanding issues. P96's father described these as follows : • To confirm whether or not a risk assessment was completed about P96 risk of absconding prior to his move from PICU to Cranfield 2 in December 2018. • Confirmation of whether the CCTV footage for the afternoon of 21.12.18 is available – he does not believe the Trust feedback that he got in 2019 that the footage is no longer available, is correct. • To confirm why the number of incidents of P96 absconding on 21.12.18 were not investigated as an SAI	October 2020

	then handled by the management team, outwith the Complaints Department.	• To confirm whether minutes of a meeting he attended with B.Mills and C.Close are on PARIS	
In addition to CCTV safeguarding function it should be used proactively to inform training and best practice developments	A CCTV Working Group was established in December 2019 to oversee issues associated with CCTV on site. The management team are fully supportive of the option to use CCTV to inform training and best practice developments and these discussions had already commenced within the Working Group. For example, identifying good practice around MAPA is an area that CCTV could really help with. MAPA training does not represent real life situations and being able to show staff how MAPA is used well in practice through CCTV examples would enhance the quality of training being given. Initial work of the CCTV Working Group which ahs been completed to date includes: • Additional training/support and discussion with CCTV reviewers (contemporaneous viewing) • Clarification and refinement of CCTV viewing template for contemporaneous CCTV viewers • Introduction of a QA step with management and safeguarding	• Family/carer and staff questionnaires have been developed to seek feedback and engagement around the use of CCTV. These questionnaires are with the CCTV Working Group for comment and sign off at the next meeting on 24.09.20. Once signed off these will be sent out w/c 28.09.20. • Use of CCTV Policy (Muckamore Abbey Hospital) has been reviewed and revised to incorporate contemporaneous viewing and also the option for footage to be used for training. This draft policy is with the Co-Director for review. • Feedback from the questionnaires will inform any other amendments to the revised policy. Important that we have policy cover in respect of this work moving forward.	**Step 1** Policy to Standards and Guidelines November 2020

	representatives to review the contemporaneous CCTV viewing feedback and identify immediate actions • Engagement with Trade Unions (ongoing) re staff concerns with remit of CCTV contemporaneous viewing • Retention of CCTV footage – scoping of improvements required to CCTV system on site to improve robustness and retention of system and footage		

Muckamore Abbey Hospital Weekly Safety Report 77
For Chair / Co-D Sign-off – 02/09/20 – Draft

Belfast Health and Social Care Trust
caring supporting improving together

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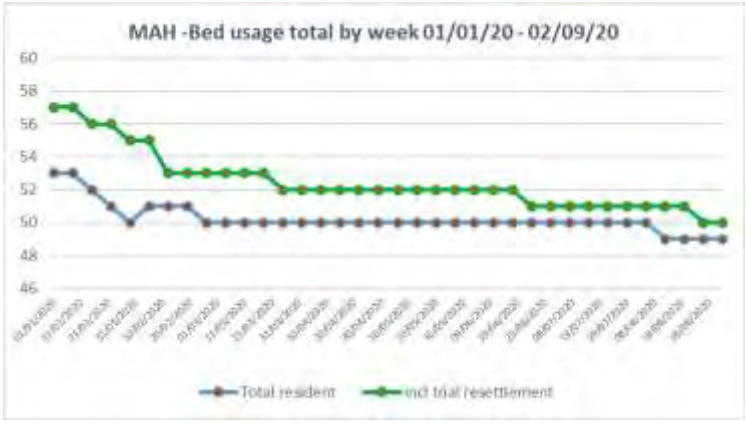
Weekly Report Number - 77

1) Key Patient Activity Issues

1.1 MAH Inpatient Numbers

The number of patients in residence remains at 49. The number of patients on trial resettlement remains at one with the discharge of one patient in the previous period. Two patients are on extended home leave at the request of families. The graph below displays the number of inpatients resident in Muckamore Abbey Hospital and the number of patients on trial resettlement. –

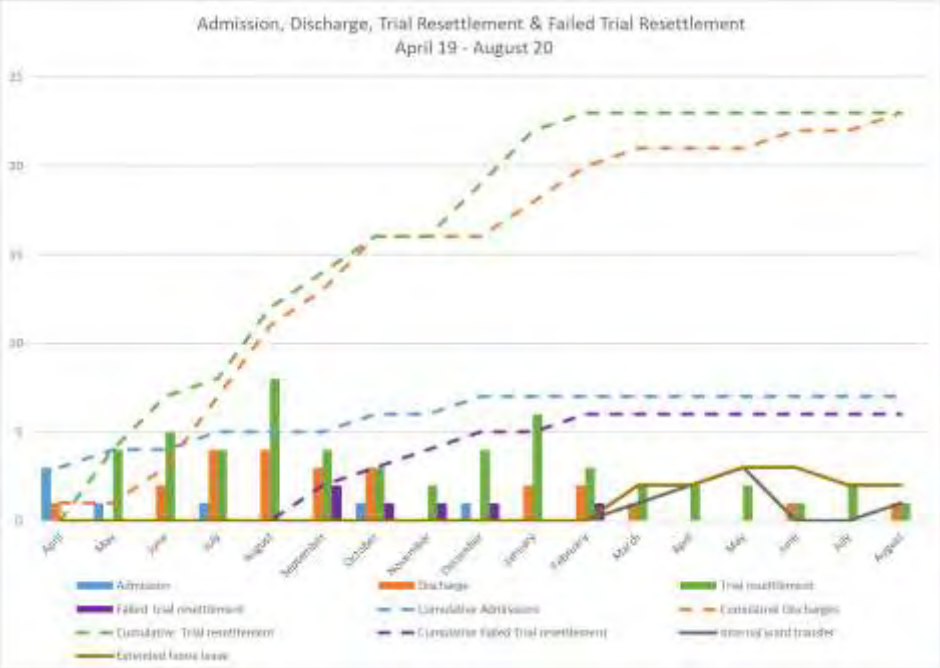


Patients in Muckamore Abbey Hospital by Trust of Residence are as follows :

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	21	0
Belfast HSC Trust	18	1
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	1	0
Total	**49**	**1**

1.2 Monthly MAH Admissions, Trial Resettlements and Discharges

The graph below plots the monthly, and year to date, number of patients admitted, discharged, on trial resettlement or having returned from an unsuccessful trial resettlement.



Admission: admitted during month
Discharge: discharged during month
Trial resettlement: pts on TR on last day of month (not included if discharged/failed trial resettlement during the month)
Failed TR: Returned to MAH during the month
Cumulative Admissions: Number of actual patients
Cumulative Discharges: Number of actual patients
Cumulative Trial resettlements: Number of actual patients
Cumulative failed TR: Number of actual patients
Internal ward transfer: No of pts transferred within the month
Extended home leave: Pts on EHL on last day of the month

1.3 Failure Rate of Resettlement – 2020/21 updated

The failure rate of resettlement in the year 2019/20 was 23%. The table below shows the year to date position for 2020/2021 :

	2020/21			
	Successful Resettlement - patient discharged	**Failed Resettlement** - patient returned	**Ongoing Resettlement**	**Success Rate**
BHSCT	1	0	1	**100%**
NHSCT	0	0	0	**N/A**
SEHSCT	1	0	0	**100%**
WHSCT	0	0	0	**N/A**
Total	**2**	**0**	**1**	

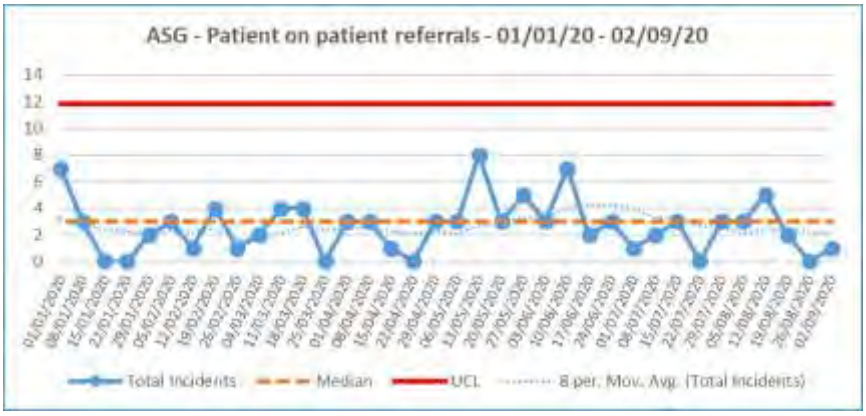
(2) Current Safeguarding Referrals

2.1. Patient on Patient Adult Safeguarding Referrals – w/e 02 Sep 2020

There was one patient on patient ASG referral reported during the period.

02/09/2020								
Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
Ardmore	Dayspace	1	30/08/2020	5-6pm	same day	same day	ASGR(PP)	Physical

Trend Analysis for Patient on Patient ASG Referrals, Jan 2020 to date :



2.1 Staff on Patient Adult Safeguarding Referrals – w/e 02 Sep 2020

There was one staff on patient ASG referral reported during the period, and one reported which related to an unspecified date in July..

previous period								
Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
CF 1	Dayroom	1	July	n/a	28/08/2020	same day	ASGR(PP)	Psyc
02/09/2020								
Ward	Location	Victim	Date	Time	ASP1	DAPO	Outcome	Type
CF 1	Bathroom	1	28/08/2020	n/a	same day	same day	ASGR(PP)	Phys/Sexual

(3) Weekly governance review - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.

3.1 Incidents

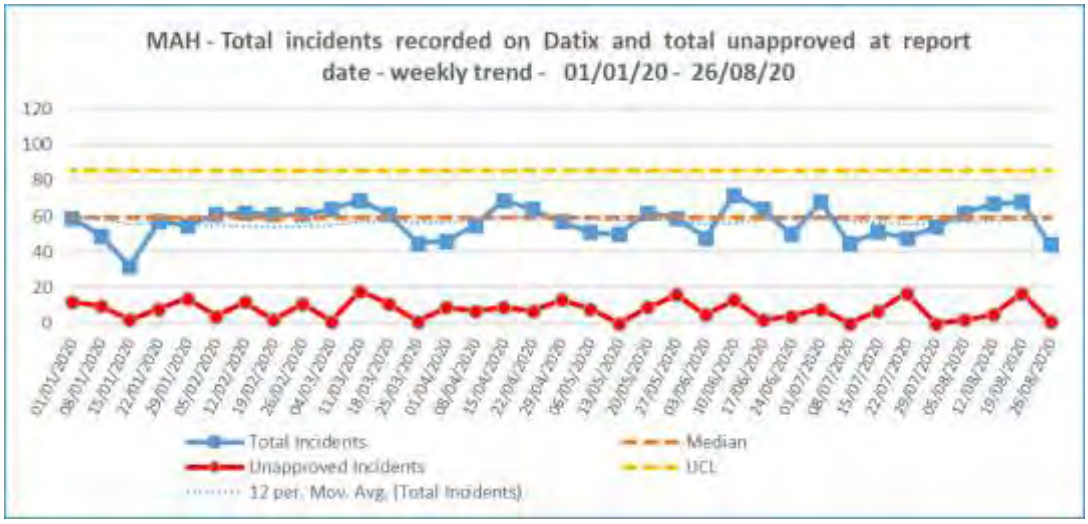
Incident reporting relates to the period week ending 26 Aug 2020, as approved at 03 Sep 2020.

A total of **44** incidents was recorded, of which 1 across all wards / areas remains unapproved. This analysis covers the **43** approved incidents.

The following table shows approval status by ward / location of incident:

Approval status 20/08/20 - 26/08/20 (app. 03/09/2020)	Ardmore	CF 1	CF 2	Erne	Sixmile A	Sixmile T	Moyola Day Care	Total
Unapproved, viewed	0	0	0	1	0	0	0	1
Approved, investigation ongoing	0	1	0	0	0	0	0	1
Approved, investigation complete	12	11	9	5	3	1	1	42
Total	**12**	**12**	**9**	**6**	**3**	**1**	**1**	**44**

The chart below shows incidents recorded on Datix from 01 Jan 2020 to date.



Only the **51** 'approved' incidents can be further categorised by **those affected in the incident, by severity, by day of the week and by category/ type of incident.**

a) Those Affected

Those affected 20/08/20 - 26/08/20 (app. 03/09/2020)	Patient	Staff	Total
Actual self harm	2	0	2
Witnessed Slips/Trips/Falls (includes faints) - Involving furnishings	1	0	1
Other self harming behaviour	1	0	1
Physical	6	0	6
Physical contact	4	20	24
Physical threat (no contact)	2	3	5
Workplace Stressors/Demands - Staffing levels	0	1	1
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	2	0	2
Witnessed Slips/Trips/Falls (includes faints) - Walking with assistance	1	0	1
Total	**19**	**24**	**43**
	44%	56%	

Highlighted incident types with >3 incidents per category

Incidents are discussed at Ward level PIPA Meeting and weekly Live Governance chaired by the Clinical Director.

b) Severity

The classification of the approved incidents for the period is shown in the table below.

Incidents by Severity 20/08/20 - 26/08/20 (app. 03/09/2020)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total
Totals:	21	22	0	0	0	43
	49%	51%	0%			

c) Incidents by Day by Location

Incidents by day of the week - 20/08/20 - 26/08/20 (app. 03/09/2020)	Ardmore	CF 1	CF 2	Erne	Sixmile A	Sixmile T	Moyola Day Care	Total
Thursday	5	3	1	2	0	0	0	11
Friday	0	2	1	2	2	0	0	7
Saturday	0	0	2	0	0	0	0	2
Sunday	3	0	1	0	0	0	0	4
Monday	0	3	2	1	0	0	0	6
Tuesday	2	3	1	0	1	0	1	8
Wednesday	2	1	1	0	0	1	0	5
Total	**12**	**12**	**9**	**5**	**3**	**1**	**1**	**43**

Highlighted locations with >3 incidents in a day

d) Type / Location / Severity

Incidents by Severity 20/08/20 - 26/08/20 (app. 03/09/2020)	Insig-nificant	Minor	Moderate	Major	Cata-strophic	Total	% Incidents
Ardmore	**7**	**5**	**0**	**0**	**0**	**12**	**28%**
Physical contact	1	3	0	0	0	4	
Physical threat (No contact)	2	0	0	0	0	2	
Physical	2	1	0	0	0	3	
Other self harming behaviour	1	0	0	0	0	1	
Actual self harm	0	1	0	0	0	1	
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	1	0	0	0	0	1	
Cranfield 2	**5**	**4**	**0**	**0**	**0**	**9**	**21%**
Physical contact	2	4	0	0	0	6	
Witnessed Slips/Trips/Falls (includes faints) - Involving furnishings	1	0	0	0	0	1	
Physical threat (no contact)	1	0	0	0	0	1	
Workplace Stressors/Demands - Staffing levels	1	0	0	0	0	1	
Cranfield 1	**4**	**8**	**0**	**0**	**0**	**12**	**28%**
Physical contact	2	7	0	0	0	9	
Physical threat (No contact)	1	0	0	0	0	1	
Physical	0	1	0	0	0	1	
Actual self harm	1	0	0	0	0	1	
Erne	**2**	**3**	**0**	**0**	**0**	**5**	**12%**
Physical	1	1	0	0	0	2	
Physical contact	1	2	0	0	0	3	
Sixmile Assessment	**2**	**1**	**0**	**0**	**0**	**3**	**7%**
Witnessed Slips/Trips/Falls (includes faints) - Walking unassisted	0	1	0	0	0	1	
Physical contact	1	0	0	0	0	1	
Physical threat (no contact)	1	0	0	0	0	1	
Sixmile Treatment	**1**	**0**	**0**	**0**	**0**	**1**	**2%**
Physical contact	1	0	0	0	0	1	
Moyola Day Care	**0**	**1**	**0**	**0**	**0**	**1**	**2%**
Witnessed Slips/Trips/Falls (includes faints) - Walking with assistance	0	1	0	0	0	1	
Totals:	**21**	**22**	**0**	**0**	**0**	**43**	
	49%	51%	0%				

Moderate + detail 13/08/20 - 19/08/20 (app. 03/09/2020) - not approved at the time of the previous week report

Detail copied from Datix incident form

Moderate x1

Inappropriate/Aggressive Behaviour towards Staff by a Patient - Physical contact

Erne

19/08/2020

Incident description

When staff entered patients apartment patient immediately ran towards her. Without time to react patient grabbed staffs arm and bit her to left inner arm causing extensive bruising.

Corrective action taken at time if incident

Staff went to Accident and Emergency for treatment and vaccination No Jacket worn as stepped into to speak to a member of staff.

Outcome of review/investigation

Patient has a history of challenging behaviour - and staff member did not put on a antibite jacket as they were only going to speak with a staff member for a couple of minutes.

Lessons learned

None recorded

Investigation complete

3.2 Medication Incidents

There were no approved medication incidents

3.3. Use of Rapid Tranquilisation during Physical Intervention.

=0 use of rapid tranquilisation reported during the period w/e 02 Sep 2020.

3.4. Use of Prone Restraint

=0 use of prone restraint reported during the period w/e 02 Sep 2020.

3.5 Use of Supine Hold

=0 use of supine hold reported during the period w/e 02 Sep 2020.

3.6 Incidents of Physical Intervention (PI)

There were 10 incidents involving the use physical intervention w/e 02 Sep 2020, equating to 37% of all incidents.

Use of Physical Intervention 27/08/20 - 02/09/20 (based on all incidents - approved/not approved 03/09/2020)	NO - None used	YES - Holding only	YES - Dis-engagement only	YES - Dis-engagement and Holding	Total	% use of P.I. by location
Ardmore	3	6	0	0	9	67%
Cranfield 1	3	1	1	1	6	50%
Cranfield 2	3	0	0	0	3	0%
Erne	7	0	0	0	7	0%
Sixmile Assessment	1	1	0	0	2	50%
Total	**17**	**8**	**1**	**1**	**27**	
	63%	30%	4%	4%		

Highlighted locations with >3 incidents of use of P.I. in a location

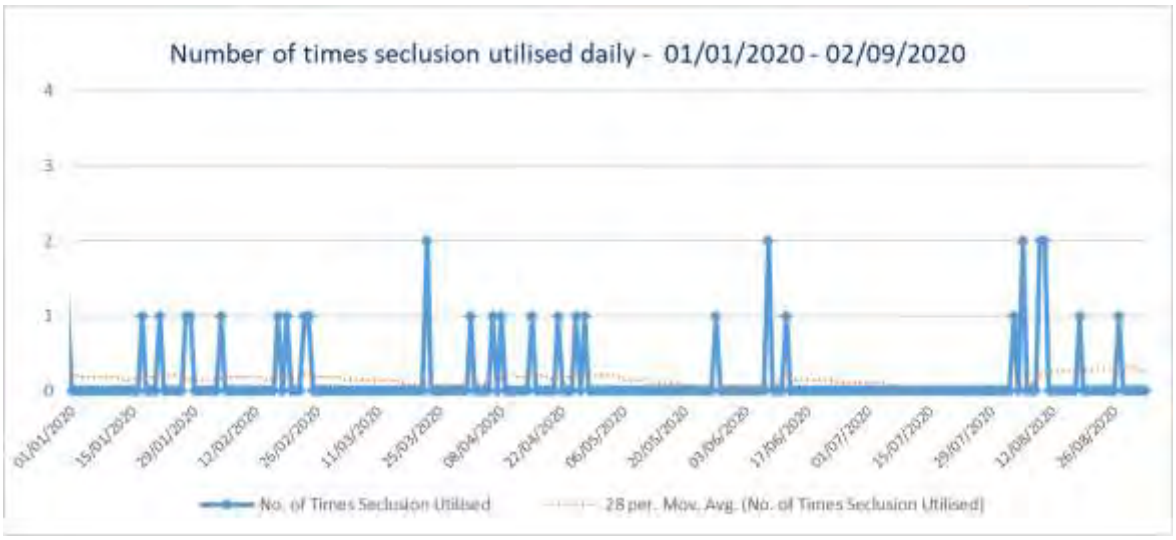
3.7 Seclusion and Voluntary Confinement

3.7.1 Seclusion

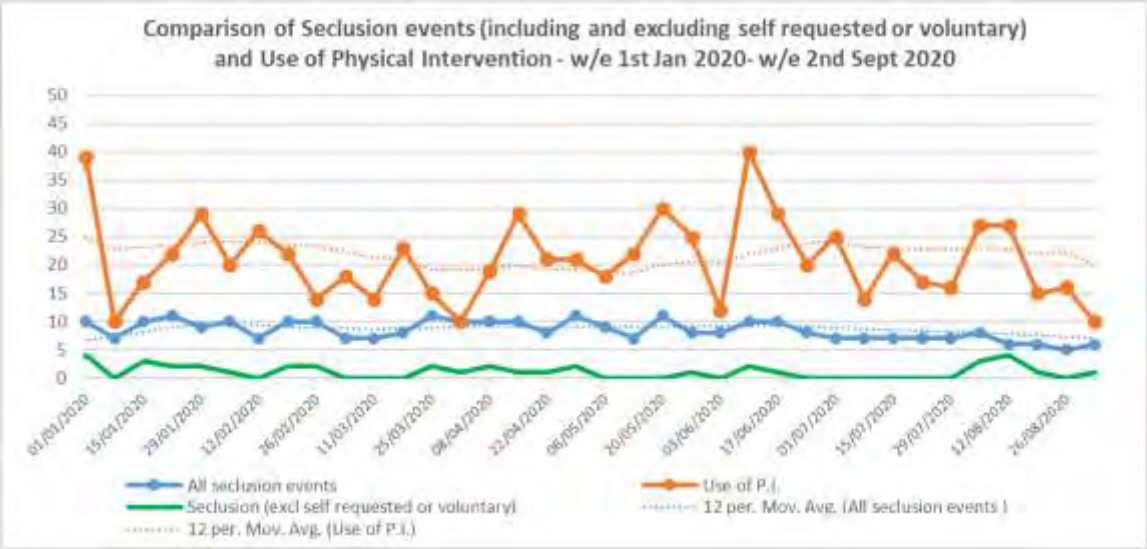
Seclusion was utilised once in this period (MMcC - Sixmile Assessment).

Seclusion took place on the 27th Aug between 11:03-11:15am in the patient's bedroom. Observation compliance arrangement were not applicable as the time was less than 15 mins.

Daily Seclusion Trend (excludes voluntary confinement)



Comparison of Seclusion Events and Use of Physical Interventions



Seclusion Review Compliance

Seclusions with Average Weekly Seclusion Time

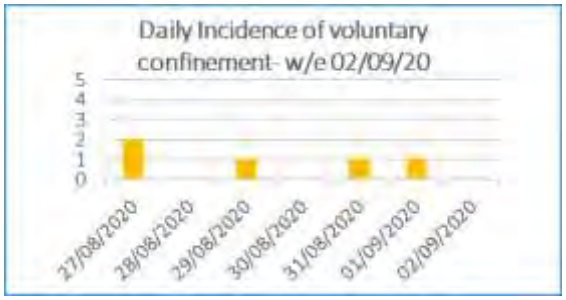
The graph below shows the trend of average weekly time in seclusion, per seclusion event :

3.7.2 Voluntary Confinement

Voluntary Confinement was utilised on **5 occasions** in this period**,** in the management of 1 patient (MMcC) in Sixmile Assessment:

- Shortest duration of voluntary confinement – **15 minutes**
- Longest duration of voluntary confinement – **1 hour 27 minutes**
- Earliest commencement of confinement was **09:35am**
- Latest conclusion of confinement was **11:45pm**

Instances of Voluntary Confinement per Day of Week



Analysis by Patient of Voluntary Confinement

02/09/2020				
Patient ID	**Ward**	**Confinement Area**	**Reason**	**No. of VC's**
P60	Sixmile A	Patients bedroom	Voluntary	5

Number of Episodes

No episode ended later than **11:45am** and the earliest episode started at **09:35am**.

02/09/2020					
Time Vol Confinement Ended	7am - 12noon	12 noon - 5pm	5pm - 11 pm	11pm-7am	**Total**
No. of VC's	5	0	0	0	5

Length of Time of Voluntary Confinement

In terms of the length of time voluntary confinement occurred, the table below details for each patient the length of time confinement lasted on each occasion by time band. The average time was **54 minutes** for the period.

02/09/2020							
Pt. ID.	<30mins	30 mins - 1 hr	1 - 2 Hrs	2 - 3 Hrs	3 - 4 Hrs	> 4 Hours	Total
P60	1	3	1	0	0	0	5
Total	**1**	**3**	**1**	**0**	**0**	**0**	**5**

Observation Compliance

Voluntary confinement Observation compliance - w/e 02/09/2020				
Total Vol Confinement	15 min obs	4 hr medical assess	1 hr medical assess	Issue
5	5 of 5	n/a	n/a	

3.8 Complaints

There has been 1 formal complaint from a patient family member that is being responded to. There has been 1 informal complaint that is being managed through local resolution.

3.9. Risk Register Position

No change.

3.10. CCTV Viewing
(*References to Cx relate to camera numbers, e.g. C28)*

The CCTV system is monitored 24/7 by the external provider who installed the cameras as part of the contract. Any camera faults are identified in real time and the Ward area are advised. This then generates a maintenance request to follow up which includes an out of hour's service. Most faults are screen issues that don't effect the ongoing recording onto the hard drives meaning coverage is not lost at these times. It is rare for a fault to be a physical camera issue but in these instances it would affect recording from that camera at that particular time until the fault was fixed.

Please note that all CCTV viewing is now reviewed prior to publication in the Safety Report. On a weekly basis, an Assistant Service Manager and a Designated Adult Protection Officer will review the CCTV viewing reports to determine if any action is required – this is a new step, called the CCTV Viewing Quality Assurance (QA) Review Process.

The QA Review Process was completed on 7 September 2020 for the viewing reports included below, and comments are included.

Sixmile Assessment 12/08/20	**Viewer 1** - Patients assisted with general care needs. 5 patients observed throughout this time frame, who mostly walked around ward area, sat chatting to staff members in day

07:00 – 15:00	space and spent time in garden smoking. There appeared to be a good staff to patient ratio. General nursing care needs provided to patients. **Viewer 2** – Good staff engagement between staff and patients noted. 4 patients observed during this period, spending time in day space, garden and going to their bedroom. Ward Sister and 5 staff members observed talking to and observing patients. (14:28) one patient appeared very restless pacing around day space, frequently going out to garden and back in again. Ward Sister followed patient out to garden and sat on bench beside him interacting with him on 1:1 basis. Patient returned to day space and appeared more settled. Ward Sister closely observes patient as he walks around day space. When patient was in garden talking to Ward Sister, 2 other nurses observed from a close distance.	
Ardmore 2 13/08/20 08:00 – 15:00	**Viewer 1** - Very busy wards. 5 patients observed. Staff well engaged with patients. Good staff to patient ratio. Some structured activity observed with one patient, which patient responded well to. 1 patient very unsettled and agitated during period observed. Patient pacing, running and lying on floor and outside in garden area. Staff worked with patient to engage her. A 10:11:33 (C51 garden area) patient observed to run towards student nurse who was supervising patient. Patient appeared to grab staff member's arm and pull her. Situation culminated in staff member and patient falling to the ground. Staff responded quickly and appropriately to this situation, assisting staff member and talking to patient. Patient eventually becomes less agitated, 2 staff members supervising. Patient responds to 1:1 attention. Staff were well engaged with patients who appeared to respond to this. 1 staff member (male) was particularly engaged with patient who was very unsettled and agitated. Cameras freezing at times. **Viewer 2** – Good interaction observed between staff and patients. Staff observed in day space with patients, in garden with patients and nurse observed in Flat 1 living room with patient. Another nurse observing patient in Flat 3 living room, from doorway. Student nurse observed doing practical activity with patient at table in day space. (C29 11:56), patient appears restless at staff base. Appears to be shouting at staff. Nurse takes patient out to garden and brings chair for her to sit down. Nurse stays in garden with patient until 12noon when student nurse comes out to sit with patient. Student nurse involved in patient care. Staff observed to spend time interacting 1:1 with patients. Ward Sister visible throughout this time frame in patient areas e.g. Staff base, day space and garden.	
Ardmore 2 17/08/20 15:00 – 21:00	A number of staff and patient interactions noted. Nursing staff observed engaging with patients to avoid and diffuse episodes of aggression. Nursing staff managed effectively to interact with patients to engage, support and avoid potential episodes of aggression. Experienced nursing staff used their skills very effectively e.g. management skill, communication and interactive skills to keep ward relaxed and free of any misunderstanding between patients. Nursing staff observed playing games, hugging, talking to patients throughout the session. The above mentioned activities helped keep patients occupied and focused.	
Cranfield 1 18/08/20 15:00 – 21:00	Restless ward today, but appeared to be very well managed. No incidents as staff were constantly vigilant and attentive to needs. One gentleman was getting very restless/ agitated and his protective head gear was put on. Yes good recognition of need. As detailed above one gentleman became very restless – staff used calming and defusing techniques very well.	

Erne 1 19/08/20 21:00 – 07:00	Period of night duty in Erne 1. I found the camera positions and viewing slightly difficult in this ward. As far as I could see very little happened during this shift – patient went to bed, were checked and got up again. Viewed the different corridors and bed areas here possible, but very little activity during the night. Patients checked regularly. I think Erne 1 is one of the more difficult wards to observe as there appears to be limited cameras and their positions give limited viewing. *Service Manager comment: There are 66 cameras in Erne. The SM will review camera positions in response to this observation.*
Moyola Day Care 19/08/20 13:00 – 16:00	Patients observed in Day Care (C36, 37, 38 between 13:19 – 15:33). On all occasions at least one staff member present. Staff observed playing snooker with patient (C36 13:23), engaging in artwork (C38 13:58 – 14:55) with another patient. A further patient did not appear to engage in any activity with staff, but verbal interaction observed (C37 13:19). Staff observed providing all personal care needs as required. C38 14:55 – 15:33 – Staff observed positively engaging with patient, encouraging her to converse, sing and take an interest in written material. Patient appeared to enjoy this and in my subjective opinion, presented as being more relaxed than previously observed.
Covid 19 20/08/20 13:00 – 16:00	One patient observed in ward. Patient observed by 1 nurse throughout. Nursing staff rotated for this role. At 13:00 patient sitting inside staff base playing play station and checking his phone. 14:00 – Patient went to his bedroom, nurse checked room every 5-10mins. 15:30 – Patient came out to day space. Nurse sat beside him on sofa interacting on 1:1 basis. Staff wearing masks at all times.
Ardmore 1 21/08/20 21:00 – 07:00	Generally a quiet night shift. Two patients observed throughout. Patient sitting in smoking room (C19). Appeared to be checked regularly by staff members and had supper/refreshments provided. Other patient got up at 04:35 and 05:34 and received appropriate supervision from staff. Staff members visible on ward throughout night shift. Patients checked and supervised appropriately throughout shift.
Ardmore 2 21/08/20 21:00 – 07:00	Night shift with patients in their bedrooms from approximately 21:45. One patient was up several times through the night, sitting in the day space near the staff base. Staff observed completing night checks in bedroom corridors.
Cranfield 2 21/08/20 15:00 – 21:00	Staff visible in all public areas. A total of 5 patients observed during this period of time. Good interaction observed between staff and patients during meal times and when patients in day space. Staff observed checking bedroom corridors. C21 17:05 – Nurse assisting patients with his evening meal at table in day space. Nurse stayed with patient after meal time and interacted on 1:1 basis with him. 18:10 C21 – Nurse observed doing board game with patient at table in day space. C45 16:18 – 16:22 – visiting professional in mask and scrubs observed talking to patient at staff base.
Cranfield 1 22/08/20 21:00 – 07:00	Generally a quiet night shift. Three patients observed throughout this time frame. General nursing care needs provided when required. One patient walked around ward until after 00:00 and received assistance and supervision as required. Another patient rose early at 06:00 and received breakfast /fluids and medication. Staff members visible on ward throughout shift and patients appeared to be checked on a regular basis. A patient got up at 04:59 (C32, 35, 29) and appeared upset and briefly unsettled, throwing items at nursing station. Appropriate space/supervision/reassurance given to patient who appeared to return to his bedroom shortly after incident.
Sixmile Assessment	4 patients observed, 3 active on ward day space area. Good ration of staff to patients. 2 patients spent time pacing about ward, going out for a smoke. Whilst male staff did

22/08/20 15:00 – 21:00	engage with patients, there were no activities and patients looked bored. Low level engagement overall. Patients appeared very independent. Basic care and nutritional needs met. 2 female staff were engaged with 1 patient (15:22 C10). This patient responded well to this interaction and seemed very animated. Male staff observed chatting amongst themselves and at nurses' station. 2 female staff engaged well with patient who responded positively to this connection.
Sixmile Treatment 25/08/20 07:00 – 15:00	Ward appeared quiet and calm. Patients observed mostly walking around ward day space, standing at nurses' station chatting to each other or staff members, making coffee or smoking in garden area. Some patients did appear to go off ward. One staff member observed playing pool with patient. General nursing care needs/monitoring provided to patients. Staff members visible on ward, verbally interacting with patients. Other patients appeared to spend time in bedrooms. C25 not working. System displayed "running error" and cameras froze, necessitating turning off and rebooting system. *Service Manager comment:* *This was an issue in the viewing room and not a hard drive issue. Rebooting in the viewing room resolved the issue.*
Covid + Cohort ward 28/08/20	One patient observed who engaged in own activities such as watching programme on laptop and using iPhone. 2 female staff members observed positively engaging with patient i.e. chatting to patient, sitting with patient, taking an interest in patient's programme and bringing drinks/food. Male staff members appeared to keep a distance from patient. As above. Female staff members appeared more responsive to patient's emotional and practical care needs. Male staff members observed sitting behind or standing at nursing station with minimal interaction with patient. Female staff members demonstrated humane and compassionate care towards patient; ensuring his comfort and general care needs.
Cranfield 2 29/08/20 21:00 – 23:30 V1	**Viewer 1** – 2 patients observed during time period. 1 patient went to his room early, 2nd patient spent his time pacing/sitting in day space area drinking coffee/smoking outdoors. Very minimal engagement between staff and this male patient. Other patients were checked in their rooms by staff. 5 staff observed on ward. Minimal engagement observed between one patient who was awake + active on ward & staff. As noted other patients in their rooms were checked by staff.
Sixmile Treatment 30/08/20 15:00 – 21:00	Ward intermittently interactive and busy. When not in their bedrooms, patients observed socially engaging with each other over coffee/food or smoking in garden area. Patients also observed engaging in own activities such as drawing, listening to music or using iPhones. Same patients seemed to spend time off ward. Staff members observed verbally interacting with patients in day space and garden area. One male staff observed playing pool with 2 patients. General care needs provided. A female staff member observed positively engaging with patients – such as making food with patient in life skills room and sitting with patient who was eating alone in dining area. Female staff member visible on ward positively engaging with patients.

(4) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback

4.1. Safety Brief
Ongoing on a daily basis on each ward, using agreed template.

4.2. Safety Quality Visits
The Assistant Service Managers have virtual catch up with ward teams.

4.3 Weekly Live Governance meetings ongoing
Chaired by Clinical Director and involving all wards.

4.4 Monthly ward clinical improvement groups
These have been stood down during the coronavirus pandemic.

4.5 Patient Experience Feedback
This work is currently paused as part of containment measures for the coronavirus pandemic.

(5) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.

5.1. Staff Counsellor Sessions – 12 Sessions offered per week.

This service continues to offer support to staff.

5.2 Information from MAH Senior Nursing Team

The Senior Nursing Team continues to maintain a focus on workforce recruitment and retention. In addition the Senior nursing Team has been contributing to Resettlement discussions focussing on how to make the process even more patient focussed.

5.3 Lead Nurse/ASM recruitment
Appointment of 2 lead Nurse /Assistant Service Managers. One successful candidate from within Belfast Trust and the other from an external Trust.

5.4 **Safetember – "Knowing Me Knowing You"- Staff Engagement Project**

This short life project is being piloted with the intention to roll out for all patients on evaluation of the Pilot. This initiative is directly aimed at staff providing a practical tool for day to day care and support for our Patients at MAH. A pro forma has been developed to assist all care and support staff write down things (no matter how small) that contribute to the wellbeing of their patient.
It is planned that this information can be interpreted and used to better inform our knowledge of our patients across the whole staff care group measured against a set of successful outcome indicators that includes reduced patient on staff incidents. This Project is supported by the newly appointed Quality Improvement Manager. It will "go live" on 7 September 2020. It is also intended that this tool will assist when patients are going through the resettlement process.

2 other projects will be highlighted through the Safetember platform, one in relation to Fire awareness and the other focussing on staff safety and the use of personal protective equipment.

(6) Emerging issues

Covid-19 Update at Time of Report Submission
Muckamore Abbey Hospital has raised the profile of Covid-19 awareness across the Site. Updated guidance has been developed in relation to considering a Patient activity. An Action Card have been updated in respect of the "The Symptomatic Patient" and "Testing Guidance".

Staff Absence in Erne Ward

Increased staff absence in Erne Ward. A range of options are being reviewed. Estates review of building environment in relation to standards for facilities of people with Learning Disability and wheelchair users has been commissioned and report is expected in October. Successful recruitment has been made for additional Band 5 and Band 7 nursing staff.

Review of Leadership and Governance Muckamore Abbey Hospital 2012 – 2015
The report was published on the evening of 5 August 2020. Staff Briefings took place on 5 August and 6 August, and a conversation with patients in Sixmile Ward on 6 August. A further 2 briefings took place w/c 10 August 2020 with staff.

RQIA Whistleblowing
A number of concerns have been raised with RQIA anonymously in relation to Erne recommendations in a clinical care plan for two patients in Erne Ward, and the communication of the same to staff. RQIA have been provided with a response which includes that specific action plans have been formulated by the MDT in relation to both patients which were initiated on 23 and 24 July 2020 respectively. Care plans have been fully updated for Patient 1 and are in the process of being updated for Patient 2.

Request for admission from WHSCT
A request has been made from the WHSCT for a Northern Trust patient to be admitted to the MAH site. It is understood that this patient requires a high level of staffing support to maintain safety**.** An initial meeting to discuss this case took place on 14 August 2020 with a follow up meeting held on 21 August 2020

Trade Unions
Trade Unions are highlighting concerns regarding the increasing number of physical assaults on staff and support to staff and discussion with the management team are ongoing.

(7) Media and communications – FOIs, media enquiries etc.

As of 2 September 2020

- No media enquiries outstanding - *However there is a media enquiry in relation to psychiatric facilities and CCTV. It does not mention Muckamore specifically but Muckamore will be included in the response.*
- No constituency enquiries outstanding

- No Departmental enquiries outstanding
- 7 FOI requests outstanding (1 started as media but transferred to FOI)

(8) Financial Governance

BSO Internal Audit have provided a final audit report with an outcome of 'Satisfactory' and on 14 April 2020, RQIA wrote to the Trust to advise that the Improvement Notice had been lifted. An Action Plan is now in progress.

An unannounced Finance Audit was completed on 15 July 2020. Generally there was a satisfactory outcome to how Patient finances are managed in line with Hospital Policy and Procedure. Audit outcome was shared with the ASM group and with the Ward Managers Group on 22 August 2020. Individual Action plans are being compiled between the Auditor and each ward management team for feedback and learning points.

(9) Next Steps/forward look – wider strategy update

Review of Leadership and Governance Muckamore Abbey Hospital 2012 – 2017
Following publication of this review, it is planned to seek feedback from those who participated in the review process in order to inform an overall response from the Trust to the Review.

(10) Other Issues requiring escalation for advice and senior decision making

None.

Templer, Sara

From: Carson, Eileen
Sent: 21 June 2024 11:42
To: Templer, Sara
Subject: FW: Re: Meeting with Family Liaison Officers (FLO) MAH
Attachments: Prep for FLSW meeting with Chairman_09.02.23.docx; Meeting with Family Liaison Officers 9 February 2023.docx

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From: Carson, Eileen **On Behalf Of** McNaney, Peter
Sent: 08 March 2023 16:12
To: Jack, Cathy <cathy.jack@belfasttrust.hscni.net>; Reid, Tracy <tracy.reid@belfasttrust.hscni.net>
Cc: Kelly, SharonA <sharona.kelly@belfasttrust.hscni.net>; McGuinness, Claire <Claire.McGuinness@belfasttrust.hscni.net>; OReilly, Anne <Anne.OReilly@belfasttrust.hscni.net>; Bradley, Martin <Martin.Bradley@belfasttrust.hscni.net>; Carson, Eileen <Eileen.Carson@belfasttrust.hscni.net>
Subject: Re: Meeting with Family Liaison Officers (FLO) MAH

Sent on behalf of Mr Peter McNaney

Hi Cathy/Tracy

As you are aware Martin Bradley and I met with the FLO team on 9 February 2023.

I have already given you both a copy of the document that they gave to Martin and I at the visit but I attach a further copy for ease of reference. I have also now had my notes of the meeting typed up and enclose a copy herewith.

I have highlighted a number of issues of concern and suggested a number of actions which I think we should undertake in response to these concerns. I would appreciate your and Tracy's response on how we will deal with these issues.

We have already discussed at Trust Board the introduction of a pilot of body cameras in MAH but perhaps you would advise me whether this will be sufficient to address the concerns the FLOs raised about the adequacy of CCTV coverage.

We have also discussed at Trust Board the need for the development of an Assurance and Inspection Framework for resettlement homes but again I think it is important to update the Board on this work once it has been further progressed.

The Board also received a paper from the meeting Medical Director on our approach to the Duty of Candour consultation and we have commissioned Peter McBride to conduct an exercise into obstacles to openness and transparency in the organisation. It might be useful to specifically review our experiences at MAH as part of this work.

I was struck by the comment that families do not believe they have been updated by the Trust in relation to the action it has taken since the CCTV was viewed back on 2017. I believe it would be important that we write to all affected families to advise them of the suspensions, investigations and disciplinary action taken against staff so far.

There are a number of other issues raised in the FLO's document which I would also like you to comment on but I am particularly concerned by the comment made at point 10 in the "what can we do better" section which says that "we are raising a red flags with you about creeping apathy" to staff who raise issues and poor engagement with families.

Obviously we need to assess and respond to this observation. I would therefore welcome your views on how you intend to review the issues set out by the FLOs. I also think it would be important for someone to meet the FLOs to provide feedback on the actions already taken by the Trust and intended to be taken in the future in relation to the issues they have highlighted.

Kind Regards

Peter

Belfast Health and Social Care Trust
caring supporting improving together

Trust Headquarters
2nd Floor
Non Clinical Support Building
Royal Victoria Hospital
Belfast, BT12 6BA

Tel: 028 9504 7542

What is the Family Liaison service?

The means through which the Trust informs, supports and listens to the families of MAH patients who have been identified within the time frame of the historic (CCTV) safeguarding investigation.

FLSW service is an important Trust service that enables the BHSCT to visibly demonstrate its meeting of 3 main obligations.

1. Statutory responsibilities.
2. Duty of Candour and openness.
3. Responding to families through Trauma informed care

To elaborate:

1. **Statutory responsibilities:**

   - ✓ Statutory obligations under PPI [Personal and Public Involvement (PPI) which is the active and effective involvement of service users, carers and the public in Health and Social Care (HSC) services.

   - ✓ Stat obligation under carers legislation (2002) – i.e. We have a stat duty to regard the rights, needs, wishes, views of carers and they have the legal right to have their carer support needs be assessed by the Trust.

   - ✓ Obligations under the Regional ASG Policy to inform families of accurate information in a timely manner. To involve, collaborate with families and keep them up to speed (as long as it is safe to do so).

   - ✓ Art 8. Right to Family Life – the Trust has a legal obligation under the Human Rights Act 1998 to regard the family rights and needs of the NOK of our patients (esp. when the patient is a child or adult lacking capacity)

2. **Duty of Candour and Openness:**

   - ✓ Trust staff have a professional duty of candour to be open and transparent with the people using their services, whether or not something has gone wrong. AND whether or not the person/patient/NOK asks the question.

   - ✓ Openness and honesty is a Trust core value – we promise …We are open and honest with each other and act with integrity and candour.

   - ✓ There are two types of duty of candour, statutory and professional.

   - ✓ In Northern Ireland we do not have legislated Stat Duty of candour – we only have professional Duty of Candour which is carried by our registered health professionals. Although there is currently no statutory duty of candour in Northern Ireland, as

recommended by the Donaldson (2014) and O'Hara reports (2018), the suggestion has been endorsed by previous Northern Ireland health minsters

- ✓ Trust Policy: 'Being Open Policy – saying sorry when things go wrong' – Our policy states; "Saying sorry is: always the right thing to do / is not an admission of liability / acknowledges that something could have gone better / the first step to learning from what happened and preventing it recurring."

Additionally, Check out these relevant reports below, which highlight the necessity (and statutory duty upon the Trust) of involving service users, carers and the public.

- o Department of Health: Systems, Not Structures – Changing Health and Social Care, 2016
- o Department of Health: Health and Wellbeing 2026, Delivering Together, 2016
- o Northern Ireland Human Rights Commission: Inquiry into Emergency Health Care, 2015
- o Department of Health: The Donaldson Review -The Right Time, The Right Place, 2014 Page 34 states *"Openness is not something that can simply be demanded. It needs the right conditions in order to flourish. The enemy of openness is fear".*

  Good governance arrangements alone are a blunt tool – it needs many other things (Leadership, people, role modelling, active demonstration of values, teach peer governance from day 1 and reinforce at team meetings, training, and supervision)

- o P36 of the Donaldson report states in regards to Duty of candour –

  "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***"

- o Also the BHSCT knows only too well that - **The introduction of a statutory Duty of Candour for Northern Ireland was one of the key recommendations arising from the Inquiry into Hyponatraemia Related Deaths (IHRD) (O'Hara 2018).**
- o The duty of candour was introduced in England in 2014 in response to concerns raised following investigations into Mid Staffordshire NHS Foundation Trust.
- o The Mid Staffordshire NHS Foundation Trust: The Francis Inquiry, 2013

  It is not missed by FLSWs that the Lead Barrister to the Mid-Staff Inquiry was none other than Mr Tom Kark QC, who is now the Chair of the MAH Public Inquiry. We suspect that Mr Kark might feel he will be repeating much of what he learned and stated in 2013.

- NHS Resolution is the organisation that manages clinical negligence claims against the NHS. Their 'Saying Sorry' leaflet confirms that apologising will not affect indemnity cover:

3. Trauma informed lens:

- Looking through a Trauma Informed lens means being sensitive to the impact of trauma on our families and understanding / utilizing tools to support families navigate this ASG investigation and the fall-out from it. We support all services within the Trust and any we come into contact outside the Trust to work in a manner that is sensitive to the needs of our families.

- FLSW believe that the Trust has a wider responsibility to understand, as well as identify and support change needed in Learning Disability services to reduce the risk of re-traumatization.

- Trauma-informed care shifts the focus from *"What's wrong with you?"* to *"What happened to you?"*

- The Trauma-Informed Care in Action - Trauma-Informed Care Implementation Resource Centre (chcs.org) recommends that the following;
  "A trauma-informed approach to care acknowledges that health care organizations need to have a complete picture of a patient's life situation — past and present — in order to provide effective health care services with a healing orientation.
  Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness.
  It can also help reduce avoidable care and excess costs for both the health care and social service sectors".

What is the Learning (obtained from FLSW with families)?

1. Families have been traumatised by the failures in duty of care to their loved ones.

2. Most families believe this trauma is not regarded or respected by the Trust sufficiently.

3. Most families believe that that they will never know the full extent of the harm caused to their loved ones whilst in the care of Muckamore.

4. In terms of Health & Social care services: Most families believe that having a child with a learning disability renders them to lifetime (especially when they transition to adult services) of sub-standard opportunity to thrive and leaves them vulnerable to abuse and poor care standards. And that this is the norm.

5. Families tell us that processes involved in the 2017 investigation are taking too long to show results. (This causes mental distress and suffering / some carers have died without knowing any outcome)

6. We are still not involving the affected patients sufficiently in the adult safeguarding process (some patients who had capacity to access PIA or ABE have died without being interviewed). This is not **just** a Trust responsibility, this is also a police responsibility.

7. Families feel that Feedback on progress is unsatisfactory / is too limited / too constrained by 'process confidentiality' / the last official Trust correspondence to families was July 2020 Cathy Jack's letter / which was received well by many but also some families voiced "it's just words" and questioned "do they really mean it"? Where is the proof that they mean it? / And because the words were not followed up with action it feeds into the suspicion that the latter were correct.

8. Most affected-families still feel like an after-thought rather than central stake-holders.

9. When families are offered adequate information and explanations for delays or mishandled care – they are often very accepting and the relationship with families is maintained and /or repaired. Taking the time to listen and pro-actively support carers who have felt 'wronged' by the Trust is an effective remedy. This is what FLSW does and it actively puts the remedy into the 'sorry'. It is a visible demonstration of the Trust's apology to families and the Trust promise to investigate and learn and make things better. FLSW is a visible representation of the Trust's promise to respect the hurt caused to families and be open and transparent with them.

10. There are a number of agencies (and teams) with varying roles and remits involved in the Investigation (2017 / Historical/ contemporaneous) and families find this confusing to navigate. Teams and agencies could do much better to explain their roles and how they fit into the ASG world.

11. Most families do not believe they will get justice for their loved ones – but are holding out that the 'system' might change enough to benefit future boys/girls with LDs.

12. Too many families believe that what is known to have occurred is the only the tip of the iceberg – "it didn't just happen when the cameras were recording in 2017"

13. CCTV is a good thing and should be brought in more widely.

14. (Learning from FLSW/DAPOs) Current use of CCTV in MAH is not as per the Trust Assurance – the level of monitoring, the method of monitoring, the method of randomly selecting dates, the technology, the processing of concerns is all terribly problematic and lacks robustness. FLSWs believe this will not stand up to Public Inquiry scrutiny. There are also still patient/staff areas that are not adequately covered by CCTV.

15. The Trust promise and offer of psychological services /support for families was delayed unreasonably – to a degree we are sure will be criticised by the Public Inquiry at a future point. Psychological services came too late – and was too little (too little too late).

16. Many families believe that Multi-Disciplinary Team working is set up primarily to meet the needs of the professionals and not the patient or family. FLSWs have seen much evidence of this. But when active effort is made to include families it is always well received.

17. Nearly all families believe it (the abuse) was caused by a cultural failure, a culture of apathy and a lack of leadership in the Hospital. There is not much faith in the theory of "a few bad apples" which was initially put forward by MAH and remained a commonly purported theory until the PI started and media reporting of negative stories escalated.

18. Nearly all families believed there was poor leadership in Muckamore and in the Belfast Trust that led to the failings, and this has created a legacy of mistrust for the current leadership team. This has created on-going challenge for the current leadership teams to rebuild credibility and Trust with the families. FLSWs have encountered that when members of the new collective leadership team have taken time to meet with families and listen and respond to their individual concerns that this has largely been received well.

19. Nearly all families believe that people in management positions in the Trust should have their roles and decision-making scrutinised and examined, and in the event that failings are discovered that they are held to account, as well as the staff seen on CCTV directly ill-treating their loved ones.

20. There is anger with many families that many senior people in MAH either retired or moved away from that part of the Trust and have not/will not be held to account for their actions and decision-making. Families that express this say this is grossly unfair.

21. There is a common view held by families that the Belfast Trust suffers from a kind of 'Corporate cognitive dissonance' – i.e. what we say and what we do too often does not align / does not match up.
    Cognitive dissonance is ***a mental conflict that occurs when your beliefs don't line up with your actions.***

22. We know that as per the Belfast Trust policy - **"Saying sorry is:**
    Always the right thing to do / is not an admission of liability / acknowledges that something could have gone / the first step to learning from what happened and preventing it recurring."
    BUT although we have implemented the first bit, i.e. we have said 'Sorry' but we are not implementing the last bit (learning and remedying). We are not doing the latter part of that sufficiently or adequately.

23. Many families believe that even with Muckamore closing and service delivery being relocated to the community it is a transference of the problem and not a solution to the problem. This view was most vocally expressed to DoH reps in October 2022.

24. Many families have expressed their belief that closing Muckamore is Belfast Trust's way of off-loading the problem to the home-trusts. That the resources, collaboration with families and resettlement care-planning that is needed will not be sufficiently supplied by the Trust to enhance the chance of resettlement success.

25. Many Families say they are still not being involved sufficiently in resettlement planning.

26. Many families cite the lack of money and lack of resources being invested in community LD services and say that this is evidence that the DOH is not serious about remedying the failure at Muckamore.

27. Most families consistently complain about the lack of Trust responsiveness to their needs and views. Despite the Trust giving assurances that it is committed to Family/patient collaboration (as well as it statutory obligations). Most families assert this is not their lived experience. Many have stated that the first time this changed was when they encountered their allocated FLO, who as a single point of contact to try to be effective and cut through all the levels of perceived bureaucracy / people / time delays etc.

What we can do better?

1. Involve families in consistent, meaningful engagement in the care planning and service delivery to their loved ones.

2. Saying sorry is a start but it is not enough – involve the families and listen to what their most pressing concerns are and then pro-actively try to remedy those problem.

3. Give our affected families an official update. Write out to them (last correspondence was July 2020). FLSWs have suggestions in terms of reviewing the communication strategy with families.

4. Share the learning that we have gathered so far. Example; where has the learning gone from the Leadership & Governance Report 2020?

5. Use what we've learned so far to do better now (and not just wait for the PI to make recommendations). Learning should also be disseminated to our community partners and key service providers in the independent and private sectors.

6. Leading on from point 5 above, we are not doing enough in terms of trauma-informed care of our affected patients or our affected families. In relation to the affected-families a trauma informed lens would inform and improve how staff respond to carer anxieties.

7. Require all staff involved in the care and LD service delivery to a family to take responsibility for their part and pursue solutions.

8. Creeping apathy – listen to your staff who raise 'red flags' and point towards poor engagement of families and intervene early to protect against creeping apathy. We are raising a red flag with you today.

9. Lead with the DOH by pressing the Health Minister for statutory Duty of Candour to be introduced to Northern Ireland.

10. Seek engagement with the IHRD Bill Team around the continuing development of the policy 'Being Open' framework – make sure you involve your staff in this consultation. I.E. Pro-actively engage with the IHRD Bill Implementation team in Stormont and involve our staff in the next stage of exploring how a DOC would impact on our work.

11. Ask the staff who have been involved in the investigation (all the staff) for their views – what went well/ / where did we drop the ball / if we could start again what would we do differently?

12. Invest in embedding 'psychological safety' as the only model for staff engaged in MDT working in Learning Disability inpatient services.

13. Invest in eradicating ‘group think’ within MDT’s and disrupt the medical model of ‘consultant hierarchy’ in Learning Disability inpatient care.

14. Peer governance – invest in training our staff to identify, challenge and respond to poor practice and ASG concerns in teams (Whistle blowing is not sufficient/ Current ASG training is not sufficient).

15. Require nurse/medical education organisations such as QUB/UU to take more of an active role in preparing staff to understand poor practice, safeguarding, disclosing and reporting.

Family Liaison Officers (FLOs) Meeting – Muckamore Area Hospital (MAH)

9 February 2023

1. Martin Bradley and I met with:

   Lindsay Bell – Manager

   RO4

   for 2 hours at McKinney House on 9 February 2023.

2. At the commencement of meeting I said we had constantly at Board level received positive feedback on the work of the FLO team and the appreciation by families of their efforts. I said Martin and I were keen to hear their frontline experiences of their work with families and any concerns they might have in relation to MAH revealed by their work.

3. RO4 gave us a document the FLOs had prepared entitled "Prep for FLO's meeting with Chairman" which contains 3 main elements:

   (a) An outline of the Trust's statutory responsibilities, the need for the introduction of a Duty of Candour and the need for the use of a trauma informed lens in dealing with the families.

   Action: Collate Trust's response to Department and IHRD working groups consultation on Duty of Candour. Highlight work we are doing with Peter McBride on Being Open and Transparent. Can this work incorporate learning from MAH regarding obstacles, and assurances.

   Action: Review use of trauma informed practice.

   (b) An outline of what the FLOs have learnt by working with the families which details inter alia:

(i) That families have been traumatised by what has happened to their loved ones and that this trauma is not regarded or respected sufficiently by the Trust.

(ii) Families feel the investigation process of the 2017 CCTV findings are taking too long to show results.

(iii) Families feel that feedback on progress is unsatisfactory. Last official correspondence from the Trust was Cathy Jack's letter to them in July 2020.

Action: Trust need to send an update to families of what present state of play is in relation to ASG/Disciplinary Investigations from 2017 CCTV incidents – from Chief Executive and review its communication strategy with families.

(iv) CCTV is a good thing and should be more widely used however current use of CCTV is not operating as per Trust Assurance due to level of monitoring, method of monitoring, method of randomly selecting dates, current technology. Also patient/staff areas not covered by CCTV.

Action: Current use of CCTV should be reviewed. How does body cameras pilot impact on this.

(v) The delay of psychological support services to families.

Action: Review psychological support services and engage with families.

(vi) Families believe there is a cultural failure, culture of apathy and lack of leadership at MAH. Want those in leadership position held accountable – not just front facing staff. Believe Trust suffer from "cognitive dissonance" – ie Trust beliefs don't line up with actions

(vii) FLOs say – Trust have said sorry but we are not learning and remedying.

(viii) Families don't want a transference of problem – to resettlement homes. Families don't believe involved enough on resettlement planning. Insufficient resources being applied to solve problem.

Action: Need a plan of inspection and assurance for resettlement homes and need to review family involvement on resettlement planning.

3. Final element of FLO paper sets out what they say we can do better.

(a) FLO team set out 15 bullet points on what they think Trust can do better.

Broken into broad themes the issues are: a meaningful family involvement and engagement in core planning, service delivery and resettlement. Such engagement to be informed by a trauma informed practice approach – a meaningful attempt to remedy their problems.

Action: get a review done on our approach to family engagement and trauma informed practice.

Note Point (8) "We are raising a red flag with you today about "creeping apathy" – you need to listen to staff "who raise red flags" and point towards poor engagement of families and intervene early to protect against creeping apathy.

Action: Peter McNaney - Write to Cathy Jack, Tracey Reid and Anne O'Reilly as Chair of Social Care Committee and Learning Disabilities Champions to highlight issues and for a time scale around actions.

(b) How do we demonstrate learning from our experiences/reviews and how have we shared learning – eg Learning & Governance Report 2020. Trauma informed practice in dealing with families. Ask staff involved in investigations for their views on mistakes and different options.

(c) Lobby for a Duty of Candour as a Trust and engage with IHRD team.

(d) Ask staff involved in CCTV investigation for their learning.

(e) Disrupt medical model of consultant hierarchy in LD care.

Introduce peer governance

Invest in embedding psychological safety and input to future medical education.

4. In addition to their paper the team made the following comments:

- They regretted Natalie Magee leaving she was a breath of fresh air. Their fear is a return to “collective apathy”.
- They have witnessed tension on the ground between MAH staff and ASG staff. They believe there is a whole lot of collective group thinking led by consultant psychiatrists.
- They gave a number of examples of lack of empathy by MAH staff eg when P60 died and his family were invited up to pick up his things they were presented to them in black plastic bags.
- In their view families should be allowed open access to the wards when they visit without having to wait. They gave an example of Mother of P77 and her boys trying to visit her son P77 on Christmas Day. She had to wait 20 minutes before he was presented with his nappy hanging down to his knees, with greasy unwashed hair. When her boys tried to look through the window to speak to him they were told to go away by staff.
- They do not believe that the vast majority of agency staff are LD trained – there is too much standing off.
- They also mentioned one patient who lives in a pod P248 P248 and expressed the view that they were not convinced by the quality of care he was receiving.
- We enquired whether parents/family had free access to the wards and they said not universally and that many families have to wait outside until their loved one is brought to them.
- We asked whether management were engaging with the issues they were raising and they replied they were “not sure”.

- They did say that Ciara Rooney the present ASG lead was excellent and when an issue was raised it was investigated and sorted out but they had a feeling that apathy was creeping back in to the Senior Nurse roles.
- They believed that a closed culture had existed in MAH for too long and that there was a complete disconnect between what Sean Holland says to the families on their involvement and how they were actually treated with consultants telling them their input would not be required in the development of patient care plans.
- We asked whether they were involved with resettlement and had they met Patricia Donnelly who is overseeing the exercise. They had met Patricia but were unconvinced that without proper assurance similar problems might occur in the resettled properties.
- In relation to Operation Turnstone they all expressed the view that some staff were being referred for criminal investigation on a very low threshold. They were unaware of what social worker advice the PSNI/PPS were receiving and believed that the PSNI had decided to report every possible offence to build a pattern of behaviour to support neglect. Lindsey Bell said she would not have referred some staff.
- In terms of supporting the work of the Public Inquiry they had met the Chair and members of the Inquiry Panel when they had visited MAH and had asked them would the Inquiry be looking at how the Trust had responded to Operation Turnstone and the Chair had said they would look at what the Trust had done from when the allegations were known to the present day.

Templer, Sara

From: Mc aney, Peter
Sent: 21 June 2024 11:39
To: Templer, Sara
Subject: FW: Follow up FLSW meeting with Chair

From: Reid, Tracy RO1
Sent: 0 A ril 2023 12: 0
To: McNaney, Peter <RO1 ; Jack, Cathy RO1 >
Cc: Sloan, Peter <RO1
Subject: F : Follow u FLS meeting with Chair

Peter and Cathy

By way of u date in relation to the meeting held by Chair and NE s with FLS , lease see key actions agreed with FLS s last week, when met with them

Ha y to discuss further

Tracy

From: Reid, Tracy
Sent: 0 0 2023 12:3
To: Bell, Lindsay <RO1 , RO4 RO4 RO4
Cc: Mckay, Eileen <RO1 ; Sloan, Peter <RO1
Subject: Follow u FLS meeting with Chair

ear all

Thank you for meeting with me last week in which we discussed a number of matters arising from your meeting with the Chair and Non E ecuti e irectors in relation to your su ort to families

e ha e agreed a number of key actions in the first instance

1) Eileen McKay is to meet with you as a grou , to go through the issues that you ha e raised to the Chair and Colleagues, to establish further detail e idence around the matters that ha e been raised and which issues are current, re iously dealt with or outstanding and what the escalation has been around these matters

2) Eileen McKay will summarise findings, including actions that are outstanding and are not addressed and share this with Peter Sloan and , within 6 weeks, with immediate escalation by Eileen of any s ecific unaddressed concerns

3) FLS ha e ad ised Chair that we should send a u date communication letter to families, and ha e ad ised that the Chief E ecuti e has re uested a s ecific and ersonalised letter, but u on discussion with you, you feel that this is not ossible. ha e asked you to set out a ro osed communication strategy for families and can ask you to ha e this with me by Monday 1 th A ril 2022, as it is im ortant that we make rogress. As e lained that it had already been agreed by Trust Board earlier in the year, that we should rogress this

) e also discussed shared learning and ad ised that we will utilise a worksho to ull together learning from Lindsey Marie Jac ui and Glenn with learning identified by FLS will contact the Leadershi Centre for a facilitated worksho in May 2023. As ha e ad ised it is im ortant that learning addresses matters that su ort the Trust internally to learn and informs the de elo ment of a iece of work that L are already doing around Assurance Framework for Commissioned Ser ices and those who are re settled

) e discussed the sychological su orts a ailable to families and atients. ad ised that there should no im ediment to accessing this, and asked that you ro ide a sco e of the need. Can ask that you ha e this with me by Monday 1 th A ril 2023. will then s eak with Peter Sloan as to who we take this forward

6) e also discussed some s ecific cases, which will ick u with Lindsey at su er ision

) e also agreed that at the end of the in estigation that there should be a thematic re iew of the harm caused to each of the atients, and this to be shared with families, with a trauma informed recommendation for future atient care. asked that you would set out a rocess for this and can ask that you submit this to me by Tuesday 2nd May 2023

know that had re iously re iewed the FLS rotocol and had submitted comments, can ask that these amendments are with me by Tuesday 2nd May 2023

Many thanks

Tracy

Tracy Reid

Interim Executive Director of Social Work

Sometimes I e-mail outside of normal working hours. I never ask or expect that you will read, respond to, or action the email outside of the hours that you work.

A Floor | Belfast City Hospital | 51 Lisburn Road | Belfast | BT9 7AB | Tel: RO1 [redacted] |
email: tracy.reid RO1 [redacted]