Muckamore Abbey Hospital Inquiry

Organisational Module 9 – Trust Board

WITNESS STATEMENT OF CLAIRE CAIRNS

I, Claire Cairns, Co-Director of Risk and Governance within the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on my own behalf in response to a request for evidence from the MAH Inquiry Panel dated 13 March 2024. The statement addresses a series of questions posed to me relating to my role as Co-Director of Risk and Governance within the Belfast Trust and my involvement with the Risk and Governance Committee.

2. This is my first witness statement to the MAH Inquiry, although I contributed to MAH Inquiry Evidence Modules witness statements provided by the Belfast Trust, and I gave oral evidence to the MAH Inquiry on 21 June 2023 relating to MAH Inquiry Evidence Module 2: Health Care Structures and Governance.

3. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked “CC1”.

4. The 13 March 2024 MAH Inquiry request for evidence, with the accompanying questions, can be found at Tab 1 in the exhibit bundle.

Qualification, Experience and Position of the Statement Maker

5. I have been the Co-Director for Risk and Governance in the Belfast Trust since July 2014. Corporate Risk and Governance sits within the office of the Medical Director, to whom I report.

6. Between 2014 and 2021 I also fulfilled the role of Head of Office of the Chief Executive's office, which essentially involved responsibility for the management of various tasks in Trust Headquarters. In respect of this aspect, I reported to the Director of Human Resources.

7. From 2014, as Co-Director for Risk and Governance, I have had responsibility for provision of support to the Medical Director in meeting their accountability and responsibility to the Chief Executive for the strategic development of integrated governance and risk management arrangements. This requires that I lead a small central team in the ongoing development and delivery of an assurance framework and delivery of organisational risk management arrangements, structure and systems, which meet the Belfast Trust's statutory and legal responsibilities. This work is based on good practice and guidance from the Department of Health and other external advisory bodies and is often regionally driven and agreed.

8. As the Co-Director for Risk and Governance, part of my role is to provide and oversee support to the Assurance Committee and a number of its steering groups and sub-committees, within the Belfast Trust Integrated Governance and Assurance Framework.

9. I commenced my professional career as a student nurse, in the Royal Group of Hospitals in 1983. In January 1987, I qualified as a Registered General Nurse and entered Part 1 of the UKCC Professional Register. My first substantive post was as a Registered General Nurse in A Block theatres in the Royal Victoria Hospital, Belfast, which was then part of the Royal Group of Hospitals Trust. I rotated through Neurosurgery, Vascular & General Surgery and Orthopaedic specialities. I transferred to Gynae Theatre and Recovery in 1989 and during my time in the unit fulfilled the role of acting Sister for a period. In 1991 I was appointed as Deputy Manager within the Central Sterile Service Department of the Royal Group of Hospitals.

10. In 2001 I obtained an NVQ level 4 and certificate in management from the Institute for Supervision and Management.

11. In 2001 I was appointed as Senior Manager for Decontamination in the Royal Group of Hospitals Trust. I led on the implementation of the Regional Decontamination Strategy for the organisation. In 2002 this post transferred to the Risk Management Department, and I had the opportunity to develop further my experience in risk management and governance. In 2003 my role in this post was expanded to include management responsibility for Emergency Planning, Business Continuity and Deputising for the Risk Manager.

12. In 2007, on the creation of the Belfast Trust, I was appointed as Senior Manager in Corporate Governance Services for the Belfast Health and Social Care Trust. In this role I supported the Co-Director with the development and establishment of assurance and risk management arrangements, as well as incident reporting arrangements and systems for Belfast Trust. As the Belfast Trust introduced required savings plans, and colleagues retired, over time this role expanded to incorporate management of processes relating to Serious Adverse Incidents (SAIs), and subsequently my remit further extended to incorporate management responsibility for the Legal Services team who are responsible for Employers' & Occupiers' Liability Claims management, Clinical Negligence Claims management and Coroner's Inquest cases across the entire organisation. This reduction in available senior manager resource within the Medical Director's Office continued, and, whilst achieving cost savings, affected the central governance resource available.

13. In July 2014 I was appointed as Co-Director for Risk and Governance within the office of Medical Director for Belfast Trust and Head of Office of the Chief Executive's office. The role was split in 2021, separating the functions of Risk and Governance and Head of Office into two separate posts. I have remained in the Risk and Governance Co-Director role since that time.

Questions regarding my role as Co-Director of Risk and Governance

Question 1
Please describe your role and the responsibilities you held in respect of MAH (including details of when you held such roles / responsibilities).

14. My experience is acute nursing and risk management in an acute hospital setting. I do not have any Learning/Intellectual Disability experience and never held a post with direct responsibility in respect of services provided or governance arrangements and structures in place for MAH or any service within that speciality. My Risk and Governance role involves policy that applies throughout all services within Belfast Trust, and so covers MAH as it does all other hospitals and services within the Belfast Trust.

15. In supporting the Medical Director in the Trust-wide agenda for governance arrangements, my team and I liaise with Directorate Governance Managers and their Collective Leadership colleagues in development of organisational governance arrangements seeking input, agreement and support.

16. It is important to explain that Belfast Trust has had, since early in the Belfast Trust's inception in 2007-2008, employed staff within each respective Directorate to support the relevant Director and their Collective Leadership Teams in developing their own governance committees, structures and arrangements. Each Director is responsible for their Directorate's governance arrangements and how those arrangements comply with the Trust's Assurance Framework and Risk Management Strategy. The Belfast Trust's Assurance Framework and Risk Management Strategy documents are strategic documents which map out the Belfast Trust's governance arrangements and have been developed in conjunction with the Executive Team and Trust Board on behalf of the organisation. Each Director is accountable to the Chief Executive for the arrangements within their Directorate and their responsibility is described within the Assurance Framework Document. The Assurance Framework document includes a description of the role of the collective Executive Team, each Executive Director and the Service Directors. The document is reviewed and updated annually and approved by the

Assurance Committee of Trust Board. The Assurance committee membership, between 2007 and 2023, included the Chair of the Belfast Trust and all Non-Executive Directors, with all Executive Team in attendance. I refer to the Assurance Framework document for the period 2015/2016 by way of example, which is exhibited behind Tab 2 in the exhibit bundle.

17. In my role as Co Director for Risk and Governance, I support the Medical Director by leading on the strategic development and ongoing review and update of the Trust's Assurance Framework and Risk Management Strategy. It is applicable across the entire organisation and adopted by individual Directorates within their many differing services, including those delivering direct care and those services supporting care. I lead a small corporate Risk and Governance team who provide expertise and support for a number of different governance functions, including adverse incident reporting, complaints management, claims management, Coroner's Inquests, risk management, Health and Safety, Quality Improvement, Audit and coordination centrally for dissemination of external guidance, alongside maintaining an internal intranet site housing Trust Policy, Procedures and guidelines. This corporate work includes development of organisational policy, procedures and training for staff in these Risk and Governance functions across the entire organisation, as well as systems to coordinate receipt and dissemination and monitoring of information internally and externally to the organisation. Whilst I have responsibility for the Belfast Trust's corporate arrangements supporting policy development, review and approval, I do not have ownership for policies, standards and guidelines sitting outwith these core governance functions. This responsibility rests with each identified lead Director and their teams. In addition, within the limitations of resource available, I lead centrally on the development and maintenance of the risk management software package used by the organisation, known as Datix.

18. The Belfast Trust governance arrangements mentioned above are described within the Assurance Framework, now known as the Integrated Governance and Assurance Framework. The Trust Board approved the current version of the document in July 2022. This followed extensive consultation with the Executive team, their Collective Leadership Teams and Trust Board. I exhibit the current

Integrated Governance and Assurance Framework behind Tab 3 in the exhibit bundle.

19. The Belfast Trust Assurance Framework has evolved over time and was first developed by the Medical Director and their Co-Director between 2007 and 2008. Known as the Assurance Framework Document until 2022, the document has been reviewed and updated regularly, reflecting internal and external changes affecting the arrangements it describes, including the Assurance Framework committee structure.

20. The Assurance Framework committee structure has changed throughout this period and is displayed at Appendix B of each version. While the committee structure has changed, the roles and responsibilities have remained consistent.

21. As previously described, responsibility for implementation of the organisationally agreed governance and risk management arrangements within individual service areas, for example MAH, is the responsibility of the Director of the directorate in which that service falls, their Collective Leadership Team and the Governance Manager for the service. Accountability for those governance arrangements sits within the management structures for the respective leadership team and their governance manager, accountable to their Service Director, who is accountable to the Chief Executive. The Assurance framework document describes these roles and responsibilitie**s.**

22. Risk and Governance does not directly scrutinise or oversee individual Directorates' risk management arrangements. The role of Risk and Governance is to inform Trust-wide risk and governance policies, and it is then left to individual Directorates to implement those policies on a local level and to provide assurance through separate systems. Directorates can of course ask for any guidance or assistance they require in respect of the policies and procedures.

23. Assurance around implementation of risk and governance arrangements is obtained internally by use of the Belfast Risk Audit Assessment Tool (BRAAT). This is a Belfast Trust designed audit tool. It is monitored as part of the business

of the Belfast Trust Health and Safety Committee, jointly chaired by the Medical Director and Union representation. Each Directorate is represented at this Committee by its Directorate governance manager. Each Directorate provides a report to the Committee, including an update regarding progress on these self-audits. A Directorate's self-assessment using BRAAT occurs on an approximately 3-yearly cycle. A Directorate's progress regarding BRAAT is a form of data provided to Planning and Performance for Directorates to use within their own QMS reporting, alongside other risk and governance information.

24. External assurance on risk and governance arrangements is provided by Internal Audit, which is part of the Business Services Organisation. Internal Audit carries out scheduled reviews of services within the Belfast Trust, which may include audits of risk management, control and governance arrangements. The reviews are carried out according to periodic audit plans. Internal Audit supports risk management, control and governance within the Belfast Trust by providing line managers with recommendations in relation to matters such as risk management or governance.

25. Risk and Governance assist and facilitate the Internal Audit plan pertaining to risk management and governance arrangements. The Medical Director and myself, together with other Directors, will meet with the Head of Internal Audit to agree areas to be reviewed within the Internal Audit cycle. Once the plan is finalised, it has been considered and approved by the Audit committee, Risk and Governance will provide corporate-level information, access to Datix information and will provide contact details of Directorate staff to assist Internal Auditors in the review process associated with the core risk and governance related audits. The subsequent report provided by Internal Audit provides a level of assurance alongside recommendations to address identified gaps. The overall outcome will be monitored via the Belfast Trust Audit Committee and any elements within the corporate Risk and Governance remit will be followed up with updates on progress, supported by evidence provided to Internal Audit until it is agreed that the recommendation has been satisfactorily addressed. If a recommendation relates to a corporate issue, the plan to address the matter, associated actions, along with evidence to support implementation, will be provided by Risk and Governance.

Where there are recommendations specific to an individual service, then risk and governance matters, follow up action, and provision of evidence is provided by the service in question. This schedule of audits may include MAH as one of many services complying with Trust risk and governance arrangements.

26. My role in relation to MAH was therefore limited to involvement in the risk and governance functions that applied to all services within the Belfast Trust and therefore applied to MAH.

Question 2

What regular risk and governance meetings took place in relation to MAH? In answering this question please provide an explanation of

- i. **How often meetings occurred.**
- ii. **Who attended meetings?**
- iii. **Who decided the agenda for meetings?**
- iv. **What regular reports were provided to meetings?**
- v. **How reports were prepared and by whom?**
- vi. **Who reports were sent to?**

27. I am not aware as to what regular risk and governance meetings taking place in relation to MAH prior to 2017. This would be the same for all services within Belfast Trust. Risk and Governance meetings in relation to a speciality or service such as MAH could be expected to occur at Divisional and/or Directorate level, but such meetings would not ordinarily take place at a Trust-wide level, and my role did not include involvement in such Directorate governance meetings.

28. As previously stated, responsibility for implementation of Trust risk and governance arrangements within individual service areas, for example MAH, is the responsibility of the Director, their Collective Leadership Team and the Governance Manager for the service. As Co-Director Risk and Governance, I do not have oversight of these arrangements. Accountability for Directorate governance arrangements sits within the management structures of the respective directorate leadership team and their governance manager, with accountability to their Service Director, who is accountable to the Chief Executive.

29. To explain further, each Directorate has appointed a governance manager to assist with their governance arrangements. These managers organise and oversee provision of governance information to committees within their Directorate, and support those committees. The detail of how this is organised can differ from Directorate to Directorate due to the diversity of services across a large, complex organisation. The directorate governance manager reports through Directorate structures and not corporately. This means the local Directorate governance arrangements, including its committees, and the information they consider, are agreed between the Director, the collective leadership team and their governance manager.

30. As Co-Director for Risk and Governance, I am not part of this structure and colleagues from the service should be able to describe what regular meetings took place in relation to MAH and the detail about these.

31. I oversee the strategic governance and assurance committee structure known as the Assurance Framework committee structure and I would not expect to see specific risk and governance meetings regarding an individual service within this structure, unless the service required additional support or monitoring. No such arrangement was in place for MAH prior to 2017. The Assurance Framework committee structure deals with governance information globally from all directorates in the Trust.

32. The Assurance Framework is underpinned by Directorate governance arrangements; in keeping with roles and responsibilities as described within the Assurance Framework document, Directors are responsible for establishing these structures and for escalating any issue requiring consideration within to Executive Team or Trust Board.

33. To the best of my knowledge, the Assurance Committee, its steering groups or any of the sub committees within the Assurance Framework, did not deal specifically with Risk and Governance issues at MAH (just as they would not for other specific hospitals or services); however the committee structure is designed to seek assurances about all services delivered by the Trust, which includes MAH.

34. It may be helpful to the Inquiry Panel if I go through a standard agenda for an Assurance Committee meeting. I will attempt to describe the opportunities each agenda item provides for consideration of matters from any service, division or directorate requiring the committee's consideration regarding assurance. A typical Assurance Committee agenda would contain the following items:

    a. Apologies;

    b. Minutes of Previous meeting – the minutes of the previous meeting are checked to ensure they are a true and accurate record of the meeting;

    c. Matters arising - allows follow up of actions from the previous meeting;

    d. Chair's Business - this concerns items the chair wishes to discuss and routinely includes the following:
        i. Conflicts of interest
        ii. Emerging issues – this item accommodates any developing issues needing brought to the attention of the committee, in written briefing or verbally, dependent on the timing. Any Director can propose and agree items for inclusion here. It is my experience the discussions as to what was included may involve the Chief Executive, Executive Team and the committee chair (who was until 2022 also the Chair of Trust Board).

    e. Assurance Framework - It is at this item that the quarterly update to the Board Assurance Framework and Corporate risk documents is presented. The Board Assurance Framework 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 that 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 paper includes

all identified Board Assurance Framework (BAF) risks and an extract of the corporate risk register incorporating any corporate risks not covered by the BAF. A briefing paper will confirm any new or de-escalating risks. Approximately three BAF risks are considered in detail at each meeting, with the discussions led by the lead Director for each. A schedule is maintained to ensure all risks are covered in detail during the year. All risks included on this document will be updated and available to the committee, who can raise queries regarding any risk. Newly added risks and those proposed for de-escalation will also be discussed in detail. This approach has scheduled SQ44 (Risk of Harm to vulnerable patients in Muckamore Abbey Hospital whilst Historical investigation is ongoing) for discussion five times since it was added to the BAF January 2019.

f. Quality Management System (QMS)presentation. This item was introduced in February 2021 and covers a schedule of presentations; each director brings their sense of the risks and challenges to the attention of the Assurance Committee, with an assurance map flagging areas of concern. Since introduction, the Directorate of Mental Health and Learning Disability has presented in February 2022, July 2022, May 2023. I believe that The Executive Director for Social Work presented in November 2021 and November 2023, also providing information relating to MAH.

g. Risk and Governance Report. This is a high-level data report covering Incidents including SAIs, Complaints, Legal Services and Coroners services. The report provides trend analysis of the entire organisation. The corporate Risk and Governance team have been working to improve the information provided, focusing on triangulating information and bringing to the attention of the committee work to improve safety using governance information. To do this the team seek updates from governance personnel across the organisation, and, in particular, incident trend information, seeking to understand and asking for assurances on these changes. In addition, between 2019 and 2022 the team developed and introduced infographic directorate governance

reports. The concept required the central Risk and Governance team to collate governance information from our systems and provide it to each Directorate for their analysis. The Director would then discuss the finalised report with Assurance Committee. The introduction was in addition to the well-established quarterly reporting, and, whilst a positive innovation, it was very labour intensive to collate, format and manage analysis of information with Directorate colleagues. Introduction of QMS, which also requires significant production of governance information from the central Risk and Governance team, is more real time and covers much more data and has replaced the infographic reports in 2022.

35. There are a series of Steering Groups that report into the Assurance Committee. Each of the current six Steering Groups below receive information and detailed reports from the sub committees reporting to them. Where it is appropriate, sub committees will have membership from each Directorate. This is another route information can be the brought through the framework to Assurance Committee i.e. in a Steering Group update and/ or submission of an annual report. The Steering Groups are as follows:

    a. Social Care Steering Group
    b. People & Culture Steering Group
    c. Clinical & Social Care Governance Steering group
    d. Safety & Quality Improvement Steering Group
    e. Involvement Steering

36. There are a series of external reports that are reported on:

    a. The Director for Mental Health & Learning Disability will also provide an update on all RQIA regulated Providers' Inspections. That will include MAH. The report includes an overview of the type of inspection, regulations, standard applied and progress made.

b. The Medical Director reports on open reviews within the RQIA Review programme, this includes thematic Reviews.

c. The Director of Children's Community Services reports on RQIA inspections of regulated services, such as day care facilities, nursing homes, supported living and domiciliary provision.

d. The Director of Adult Community, Older Peoples Services and Allied Health Professionals reports on RQIA inspections of regulated services within their remit.

e. Oversight Group updates – When the Belfast Trust requires a group to provide focused consideration of an external review and its recommendations, an Oversight Group may be constituted, e.g. the Independent Neurology Inquiry. The nominated chair will provide the update direct to Assurance Committee.

37. There are also a series of professional reports:

a. The Medical Director reports on:

   i. Quarterly GMC Dashboards, including data from training surveys across sights, including MAH;
   ii. Annual Revalidation and Appraisal.

b. The Executive Director for Nursing and User Experience & AHPs reports annually on the following:

   i. Supervision for Registered Nurses and midwives;
   ii. Revalidation for Registered Nurses and Midwives;
   iii. Allied Health Professions Assurance Report.

c. A Whistle Blowing update. A quarterly and annual report is presented, providing Assurance Committee with an overview of whistleblowing concerns raised centrally, their status and any learning.

38. In summary, there were no specific “regular risk and governance meetings” that pertained specifically to MAH at a strategic level within the Belfast Trust, however the Assurance Committee had strategic oversight of Trust-wide governance and risk-management arrangements. That Committee has been in place since the inception of the Belfast Trust. It is supported by a number of Steering Groups and Subcommittees feeding through to the overarching Assurance Committee, which supports the flow of information with regard to risk and assurances. The information is Trust-wide and can concern an individual service when identified circumstances require this, but cross-cutting information is also reported across multiple services.

i. How often meetings occurred

39. Assurance Committee has met quarterly since 2013. Prior to this, the committee met three times a year. The change occurred following recommendations from an Internal Audit report.

ii. Who attended meetings?

40. Between 2007 and July 2023 membership of Assurance Committee has been the Chair of the Trust Board and all Non-Executive Directors; the Chief Executive and the entire Executive team have been in attendance at the meetings. Since 2023, the current Chair of the Trust Board asked for this approach to be changed and nominated a Non- Executive Director to Chair the Assurance Committee, with membership of three Non-Executive Directors. The entire Executive Team continues to attend along with the Co-Director of Risk and Governance.

iii. Who decided the agenda for meetings?

41. The Medical Director and Executive Team, with agreement of the Chair of the Trust Board, agree the agenda for Assurance Committee. In my role as Co-Director of

Risk and Governance and Head of Office, I coordinated drafting of the agenda, presenting it to Executive Team and separately to the Chair of the Trust Board before finalising. Since my role was split in 2021, I have continued to draft the agenda on behalf of the committee.

iv. What regular reports were provided to meetings?

42. Emerging issues are included on the agenda as required. Since 2021 a request is made to Trust Headquarters by my Risk and Governance Team, to check what issues are to be included. Prior to this, in my joint role as Co-Director of Risk and Governance and Head of Office, I would have confirmed emerging issues to be included at Executive Team. The briefing with regard to an emerging issue is prepared by the relevant Director for the service involved and discussed with the Chief Executive.

43. The Board Assurance Framework risks document and the Corporate Risk Register extract are provided each quarter. This information is collated and finalised by the Risk and Governance team. The Directorate team for where the risk resides populates each risk, its description, controls, assurances, gaps and actions. The Corporate role is to seek the information and collate the update for inclusion in the document.

44. Quality Management System presentations are prepared by each Directorate team, and then presented by the Director.

45. A Risk and Governance Report is prepared by the Corporate Risk and Governance teams, based on information held centrally in relation to incidents, SAIs, complaints, claims and coroners' cases. As Co-Director of Risk and Governance, I review and approve the content before finalising the report. It has always been very high-level information, providing a helicopter view of governance activity throughout the organisation. It is not designed to look at the detail of specific cases. The report is presented by the Medical Director.

46. Each Steering Group update is presented by the Chair of the relevant Steering Group, the content is prepared by the team supporting the Steering Group Chair and approved by the Steering Group Chair.

47. As mentioned above, reports on external inspections will be prepared on behalf of the Directors where oversight for those inspections lie and is a mixture of service Directors and the Medical Director. Directorate structures have changed over time, but the Director who has responsibility for the area in question would report.

48. Any Oversight Group report would be prepared by the Director who chairs the relevant Oversight Group, or has led input on behalf of the Executive Team.

49. Professional Reports are prepared on behalf of each the Executive Director by their team. The report is approved and presented by the Executive Director in question.

50. Since 2022, quarterly whistleblowing reports have been prepared by the whistleblowing manager. Prior to this manager's appointment, as Head of Office, I would have prepared the report from the information held centrally. The report is approved by the Director of HR or Deputy Chief Executive.

v. How reports were prepared and by whom?

51. As above.

vi. Who reports were sent to?

52. Every effort is made to ensure all papers for the Assurance Committee are circulated to all who attend (both committee members, and those in attendance) seven days prior to the meeting taking place. When a paper is delayed, it will be circulated as soon as available. There have been circumstances when a paper is not available before the meeting, and is then tabled at the meeting. Following each Assurance Committee meeting, copies of the Assurance Committee papers are routinely shared with the sponsorship branch at the DoH.

Other Potential Sources of Oversight

53. In addition to the Assurance Committee, certain other meetings may have had some role in contributing to the overall governance of MAH, whether directly or indirectly, from a governance or risk-management perspective.

54. Sometime in 2015 or 2016 a Social Care Committee was established. I was not a member of that committee, nor did my team support it. That committee was supported through the Executive Director for Social Work. I cannot provide any information relating to that Committee's activities, although the Director for Social Work may be able to clarify what, if any, role the Committee played, directly or indirectly, in relation to MAH.

55. Following safeguarding concerns at MAH being raised in later 2017, a multi-agency meeting was convened. It was referred to as the Strategic Multi-Agency Group Meeting in response to Safeguarding Concerns at Muckamore Abbey. I recall that it met in October 2017, January 2018 and again in August 2018. Unfortunately, I have no memory of the actual meetings at this group and have recovered this limited information from my diary and email. Following the August 2018 meeting, the group may have evolved into another group, or, if it continued, then neither myself nor my service manager were required.

56. Having reviewed my calendar and emails, I believe I attended the first meeting but not the second or third. Risk and Governance appear to have been represented by a Service Manager with responsibility for SAIs up until the August 2018 meeting. The group was not administered by my team, and I am unable to provide any information about how agendas were agreed, what reports were considered and so on. The draft minutes, which are exhibited at Tab 4 of the exhibit bundle, show that the meeting was chaired by the Director of Adult Primary and Social Care, and that Directorate may be able to provide further information on the activities of this group.

Question 3

Please describe:

i. **How risks are escalated from practice units to the Trust Board.**

ii. **How incidents are escalated from practice units to the Trust Board.**

Please also explain who decided that such matters ought to be escalated? Was there guidance to identify when that ought to happen and what action ought to be taken?

How risks are escalated from practice units to the Trust Board

57. The principal way for a risk to be escalated from a practice unit (Care Delivery Unit), beyond the boundaries of the Directorate, is the Director responsible for the directorate in which the Care Delivery Unit sits bringing the issue to the attention of the Executive Team and Trust Board.

58. The Belfast Trust currently has 601 open risks across our entire range of services. These risks are at all levels, with 556 (93%) of them sitting operationally and 45 (7%) identified as corporate risks. It would not be feasible to bring all 601 risks to be the attention of Trust Broad, nor is it feasible that a small central team could have oversight of each of these risks.

59. The Trust has delegated responsibility and oversight of a service's risk, whether operational, corporate or strategic, to the lead Director with responsibility as overall lead for the services related to the risk. Directors are expected to ensure the significance of any risk is understood. It is expected they ensure those risks requiring the attention of Trust Board are identified, in a timely manner, and recorded either as a corporate risk and, if considered strategic with regard meeting Trust objectives, proposed for inclusion on the Board Assurance Framework risk document. Approval for inclusion of the risk on the BAF will be confirmed at the next available meeting of the Assurance Committee and the detail discussed with members for the first time at that committee.

60. Roles and Responsibilities are described in both the Integrated Governance & Assurance Framework, the Risk Management Strategy and a number of key policies, such as the Adverse Incident reporting policy. Directors are also accountable to the Chief Executive and are required through the current Trust Quality Management System (QMS), and their regular one-to-one meetings with the Chief Executive, to identify key risks associated with their services, along with controls and actions.

61. In practical terms, any risk identified at a practice unit (Care Delivery Unit) initially sits at an operational level. An overview of how risk is identified is provided at section 4.2 of the Risk Register Production and Management Guidance (TP 91/14), a copy of which can be found behind Tab 5 in the exhibit bundle:

> '*There are a number of ways this can occur operationally. Managers and staff at all levels must proactively identify hazards and potential risks to meeting objectives. These may relate to patient and client safety and wellbeing, quality of service, staff wellbeing, financial resources, targets / standards and reputation.*
> *Risk can be identified from a number of information sources and by using various tools and techniques.*
> *Information sources include adverse incidents, complaints, claims, risk assessments, staff absenteeism records, concerns raised, team meetings / workshops, internal and external audits/ inspections.*
> *Practical methods and tools for identifying risks include group workshops, individual interviews, observation and review of data / records. Risks may be identified and analysed by an individual, however a group or team approach is recommended in order to provide challenge and discussion leading to a well-defined and analysed risk'*

62. Once a risk is identified, it will be evaluated. The regional risk matrix tables adopted by Belfast Trust and used within our policies are those regionally agreed and used by all Trusts in Northern Ireland.

63. This evaluation stage will generally be completed by staff with management responsibility for the service concerned. To do this staff should use Appendix 1 from the above-referenced guidance, following the three steps described and applying the associated tables to analyse and evaluate the risk, as below:

- *Step 1*
  Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- *Step 2*
  Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- *Step 3*
  Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.
  The tables and matrix are used to score / grade both the current risk and the residual risk. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

64. Tables 4, 5 and 6 from Appendix 1 guide staff through expected timeframes for addressing the risk and at what level the risk should be escalated and monitored.

65. It is worth noting that since the 2009 introduction of Datixweb for managing risks, the documenting of the risk at operational level, its approval and escalation to a corporate level risk (with approval by the responsible Director) will be completed

electronically, however the principles of managing evaluation of risk has remained consistent throughout Belfast Trust. Staff identified as being responsible for adding and updating risks are invited to training and must attend prior to being given access to the system. This has been in place since 2009. The Directorate Governance manager will either propose these staff or approve their application to access the relevant electronic module.

66. Governance managers employed within each directorate have always had a key role in supporting their service teams and their Director in the creation and management of identified risks on an ongoing basis. This includes ensuring the responsible Director is made aware of any risk which meets the criteria for inclusion on the corporate risk register, ensuring this is discussed in a timely manner with the Director and those involved, and taking appropriate steps to ensure the risk is correctly identified as corporate, for inclusion on the corporate risk register.

67. The Directorate Governance manager will also ensure risks remaining "operational" are monitored and managed in line with the guidance referenced above, being re-evaluated if circumstances change.

68. Roles and responsibilities, including Director responsibility for their risks, is also contained within the Risk Register Production and Management guidance procedure (TP91/14). A copy is exhibited behind Tab 5 in the exhibit bundle. Section 3.0 says:

> *'Directors require assurance of appropriate management of all identified risks within their Directorate; however the role of 'Overall Lead' as described on the Datixweb risk form and in Section 4 below, can be delegated to Co- Directors, Committee chairs within the Assurance Framework or Service Managers depending on the evaluated risk level (see Appendix 1).*
> *Any risk identified as Extreme (red) must be escalated to the relevant Director via Directorate processes and an immediate investigation instigated with an action plan agreed to eliminate/ reduce/control the risk. The Director will remain identified as Overall Lead for all Extreme risks within their Directorate.'*

All Extreme risks should be considered against the Corporate Risk criteria outlined in Section 4.0.

Directors are responsible for confirming inclusion on the Corporate Risk Register via the Directorate Governance and Quality Service Manager'

69. Identification of a risk by service colleagues as a "Corporate Risk", using the above guidance, is the most likely method in the risk management process as to how a risk will be escalated from within a Directorate to Executive Team and the Assurance Committee of Trust Board. The specific criteria to be considered are also within the above-referenced guidance. Section 4.1 says as follows:

    1. *Has been evaluated as 'Almost certain' x 'Catastrophic'(25)*
    2. *Is evaluated as below 25 but:*
        - *The risk or concern has ramifications beyond the immediate area of clinical or managerial control;*
        - *The risk or concern cannot be satisfactorily managed within the immediate area of control;*
        - *The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.*

70. Following this guidance does not preclude any risk being escalated through the risk management process if, in the view of the relevant Director, circumstances require it, but, within the risk management process, those risks not identified as "corporate" may not to be raised beyond Directorate level arrangements.

71. There are a number of opportunities to escalate risk and/or double check risk has been considered effectively and identified correctly. To expand on this further some opportunities are as follows:

    a. Assurance Framework committee structure:
    This structure has a number of committees which will seek to be assured and/or escalate risk. The structure has changed over time and pathways for potential consideration of risk may have altered with movement of

sub committees between Steering Groups. Regardless of these changes, pathways and the ability for the committee structure to escalate risk has remained in place throughout.

b. Quarterly reporting to Assurance Committee:
   All strategic risks are provided to Assurance Committee each quarter, these may be identified by the processes previously described resulting in recording as a corporate risk. If the risk is believed (by the responsible Director and/or Executive Team and/or a Steering Group and/or Assurance Committee and/or Trust Board) to pose a significant risk to the organisation meeting its strategic objectives such as to require inclusion on the Board Assurance Framework (BAF) document, the risk will then be included on the BAF. This means that when Assurance Committee next meet, and from then on, the risk will appear on the BAF. The BAF is a living document, and it will reflect the up to date position for the risk at each quarterly Assurance Committee meeting. The Assurance Committee will consider in detail a number of the BAF risks at each meeting so that all the risks on the BAF document are worked through on rotation on an annual basis. When a new risk is added to the BAF it is discussed at the next available Assurance Committee meeting, and then it will take its place in the cycle of consideration until the Committee approves its de-escalation. Alongside this document, an extract of the Corporate Risk Register is routinely provided (an extract is used to strip out any duplication where a risk is recorded on both the Corporate Risk Register and BAF).

c. Quality Management System (QMS):
   The Belfast Trust introduced a Quality Management system (QMS) in 2021. Every Directorate reports on their data, on a rotational basis. This occurs twice yearly for Service Directorates and once per year for Corporate Directorates. Directors are required to consider and report on performance, including their key risks, and will have the opportunity to discuss this information with the Executive Director Group, describing their actions and seeking support as appropriate. This is an opportunity

to consider (with the benefit of key governance information) their service, its achievements and challenges. It supports the appropriate identification of risks, the controls in place, and if planned actions are progressing as expected. Following this, a summary of the presentation is also presented to Assurance Committee and specifically includes the key risks for the Committee's consideration.

d. Safety Huddle/Charles Vincent:
   On a daily basis (Monday to Friday) a series of meetings across all services, Belfast Trust-wide, take place. Information discussed can be quickly raised from service level to Executive team and is known as our Safety Huddle/Charles Vincent process. Introduced in 2020, this is an opportunity where staff can identify risk in real time to their senior managers. They, in turn, if not able to satisfactorily address, or, if appropriate to flag and provide assurance on actions, could escalate this information for consideration by Executive Team at 11am each day. If considered appropriate by Executive Team this information could be brought to the attention of the Chairman and Trust Board.

e. Directorate governance arrangements:
   Directorate governance arrangements have always been in place. These now include Live Governance meetings with agendas covering all key governance information indicating potential risk under consideration and those risks already identified. This is another potential conduit for escalation of risk. Risks will be considered here, including the controls in place and further actions required. This consideration could result in immediate escalation if appropriate and/or agreement of inclusion on the corporate risk register with management as described above. This is a meeting at Divisional level, the Collective Leadership Team with responsibility for a particular set of services will have an opportunity to consider all key governance information, seek to consider a risk and /or take immediate steps in response to an identified risk. This could result in escalation of risk to their Director and overarching Directorate

Governance meeting and onward to the Chief Executive, Executive Team and Trust Board if required.

f. Weekly Governance Teleconference:
   Each week a Governance Teleconference takes place. This was introduced in 2017 and is hosted by the Medical Director's Office. The report the meeting considers now includes any new Corporate risk approved over the previous 7 days. The meeting also supports discussion about all information contained within the report and there can be discussion regarding, for example, an Early Alert, SAI or high-risk complaint, including whether a risk has been identified and at what level. Actions agreed are now tracked and a copy of the report is then discussed the following day by Executive Team and shared with all Non-Executive Directors. This provides Trust Board with a range of governance information with potential associated risks and immediate actions taken and current status. The report is for the information of Non-Executive Directors, however if they have any queries they can contact the responsible Director to discuss further.

g. Emerging Issues:
   Trust Board and Assurance Committee have a standard agenda item at every meeting known as Emerging Issues. Risks could be escalated through this route by the Chief Executive and/or responsible Director. This would include provision of a briefing document and potentially a more detailed paper dependent on the timing and level of information available.

h. Early Alerts:
   The Early Alert process not only alerts the Department of Health and other external bodies on matters meeting a set of criteria and associated risk, it will also escalate risk within the organisation, including to members of the Trust Board. The responsible Director, if appropriate, will bring any matter raised as an Early Alert to the attention of the Chair who may share with all Non-Executive Directors in real time. In addition,

the weekly governance report is shared electronically each week with all Directors (Executive and Non-Executive). As described previously, all new Early Alerts from the previous seven days are included in this report.

i. Safety& Quality Visits (SQVs):
An annual schedule of visits by senior leaders commenced in 2014 and have, I believe since around 2018, included Non-Executive Directors. This is an opportunity for operational staff to discuss directly with members of the Trust Board their service achievements and challenges; risks could be discussed and actioned as a result. The Non-Executive Director provides feedback of their visit to Trust Board. Senior Service management are present during the visit and would be expected to respond and action any matters raised during the course of the visit.

j. Whistle blowing:
Staff are encouraged to raise concerns openly as part of day-to-day business, and managers throughout the organisation deal with many concerns immediately, wherever possible. This could identify a risk either directly or indirectly and may be raised within Directorate processes as appropriate. There are also occasions when a member of staff hasn't been able to approach the issue openly and staff can use the whistleblowing policy as appropriate. This was not an avenue widely used by staff, but arrangements have undergone considerable transformation with additional resource. Considerable effort has occurred to raise awareness of its importance in bringing matters of concern to the attention of the organisation. Whistleblowing concerns raised with the central team are recorded on a central register and Directorate management team are also encouraged to share concerns raised with them, even if able to satisfactorily address at that level. The Assurance Committee is updated quarterly on formal Whistleblowing concerns, facilitating escalation of risk with the committee if appropriate.

k. External Review, Inspection, Internal Audit or Trust Audit:
Findings from any of these sources could identify risks that management teams involved need to manage, either as an individual risk or in response to the findings in an action plan. If the risk was evaluated and identified as “Corporate”, then it would be added to the Corporate Risk Register and thus appear when that register is considered at the next Assurance Committee meeting. Further, the Assurance Committee could hear of information conveyed through quarterly assurance reporting or QMS reporting that results in the identification of a further corporate risk that is then added to the register.

l. Completion of a NICE Guidelines Baseline Assessment Tool (BAT):
Receipt of a new NICE guideline requires the services involved to complete the BAT. This process will potentially identify gaps and the Trust may not always be able to respond immediately, for example if funding is required and can’t be prioritised. This could result in development of a risk for inclusion on a risk register. Escalation is most likely to be through the Directorate processes described above.

72. The Risk Register Production and Management guideline referred to above was introduced in 2014 to assist staff at all levels with understanding how to effectively manage and escalate risk. In developing this guidance there was consultation across the Belfast Trust with input from all Directorate Governance managers and its approval followed Belfast Trust process, with consideration by Policy Committee leading to its approval and ratification at Executive Team. At the time this new guidance was featured in “Safety Matters”, which is published widely across the Belfast Trust.

73. Directorate Governance Managers are the first point of contact with regard to supporting their colleagues in articulating their risks. The corporate Risk and Governance team monitors corporate risks quarterly, seeking to confirm with the Directorate Governance manager that there has been review and update to each risk. The Internal Audit plan also incorporates periodic consideration regarding management of risk registers, providing a level of assurance and making

recommendations for improvement. Services will be informed of any recommendations and are required to take action to address and provide evidence supporting implementation.

How incidents are escalated from practice units to the Trust Board

74. The Belfast Trust adverse incident policy and its procedures have been developed and maintained corporately, with input from, and in consultation with, Directorate Governance Managers and key stakeholders. These documents apply to all staff in the Belfast Trust, including our employees, students, agency workers, contractors and volunteers.

75. Directors and all levels of management within each Directorate are accountable to their respective line management and responsible for ensuring that the adverse incident policy and associated procedures are effectively implemented within their areas of responsibility. All levels of staff are expected to promote an open, honest and just reporting culture and ensure that appropriate reporting and review of incidents is carried out.

76. The escalation of an incident, and to what level in the organisation it will be escalated, will be dependent on how the service where the incident occurred respond and apply policy and procedure.

77. Corporately, the Risk and Governance team has led development of the Belfast Trust's adverse incident policy and its procedures. That has included developing and delivering mandatory adverse incident training for all staff. This training was historically provided face-to-face; however, with the availability of eLearning packages, whilst face-to-face sessions can still be facilitated, most training is now completed online.

78. Directors, their management teams and directorate-based Governance managers are responsible for ensuring the staff within the services access and complete this training, whether via face-to-face sessions or virtually on the eLearning platform.

79. Our policy, procedures and training are intended to support staff through the incident reporting and follow-up process. The Belfast Trust now has over 50,000 incidents reported annually. It is not feasible that all incidents will be reviewed to the same degree, or at the same level. There will be a limited number of incidents escalated to Trust Board, with most incident information managed at a local, service, divisional or directorate level. The Assurance Committee receives high level trend data on incidents each quarter.

80. Staff within Care Delivery Units, immediate line management, service, divisional and directorate management at all levels, are required to ensure the adverse incident policy and its procedures are applied. The application of a simple risk assessment process to incidents at the time of occurrence, if applied appropriately, enables a structured approach to how that incident is managed and by whom. This risk assessment process is available to all staff within the policy and procedures and is covered in our mandatory training. It is also covered in additional training delivered to those staff who approve incidents (Approver Training).

81. For an incident to be reported, a member of staff must first recognise an adverse incident has occurred. All Belfast Trust staff should, within their management structures, including local induction arrangements, be supported to fulfil their requirements described in the Adverse Incident policy, its associated procedures and training.

82. Corporately, it has always been our position to encourage reporting, and staff would not be discouraged in reporting any issue they felt to be an issue, even if, on review of the detail, it did not meet incident criteria.

83. We monitor the effective application of the Adverse Incident policy and its procedures through an annual external audit. This is carried out by Internal Audit, which is part of the Business Service Organisation and is external to the Belfast Trust. Internal Audit operate a 3-year cycle and will aim to scrutinise each Directorate over the 3-year period. These audits have been consistently "Satisfactory", with any recommendations taken forward to improve arrangements.

84. When an incident occurs, staff are expected, in real time, to assess the situation, dealing with any injuries/harm and making the situation safe. The staff involved will communicate with those involved, and inform the person in charge if not already aware. Any member of staff can report an incident. All those involved, whether directly or indirectly involved, a witness, or someone who has become aware, have a responsibility to ensure it is reported. This is the first opportunity at a local level to escalate information about the incident for consideration by the senior management teams for that service. It is possible escalation could then go beyond the Service, Division or Directorate and, if required, to Trust Board.

85. This process is now supported by the introduction of Safety Huddles. This provides a conduit for escalation of issues each day from the local area, through Service, Divisional teams to the Directorate huddle with the Director raising at the daily Executive Team Safety Huddle if appropriate to do so.

86. This does not detract from responsibility of each Director to discuss emerging issues with the Chief Executive, director colleagues and the Chair of Trust Board as appropriate, but it has improved the framework for potential timely escalation. Director responsibilities are articulated within the Risk Management strategy, the Incident policy, Early Alert circular and the Integrated Governance and Assurance framework etc.

87. As described above, it is not feasible for Trust Board to have sight of every incident, but an example of when this does occur is when an incident is considered to meet SAI criteria and/or requiring an Early Alert to Department of Health. Directorate staff will have considered the details via directorate arrangements and, if agreed at that level, will result in submission of a SAI report and/ or an Early Alert to the corporate Risk and Governance team for reporting externally.

88. A SAI submission should be made within 72 hours, and an Early Alert within 24 hours of when staff first became aware of the incident in question that they considered merited this response. There can sometimes be delays in reporting. Corporately we continue to encourage timely reporting and actively seek to confirm and understand how delays have occurred on the weekly governance call.

89. An Early Alert proforma submission is in fact stage two of the process. It is a brief summary of a telephone conversation that has already occurred between the appropriate Trust Director and the relevant Policy Lead at the Department of Health (DoH). An Early Alert is triggered if an event is identified by the service involved to have met any one of a number of criteria identified in the DoH Early Alert circular. Not every SAI requires an Early Alert, and not every Early Alert will also be a SAI; the criteria differ, and there can be Early Alerts which are incidents but not SAIs. The Early Alert circular also does not specify the Early Alert must be an incident.

90. A weekly Governance call was established by the Risk and Governance Department on behalf of the Medical Director in 2017. This call has evolved over time and proactively inquires/confirms whether a SAI or Early Alert also requires to be separately reported via another route, and considers all information in the report with regard its applicability for SAI and or Early Alert reporting.

91. Introduction of a weekly governance call and its weekly report created an additional opportunity to escalate key governance issues for Executive Team consideration and assurance as appropriate. The weekly governance report content has developed over time, but always included a summary of newly reported SAIs, Early Alerts that occurred over the previous week and provides the latest position on each. It also includes incidents not believed to meet the criteria for SAIs or Early Alerts, but which are recorded as being of catastrophic impact or extreme risk (such as events in the ED Department that inevitably occur with significant regularity). This allows a reconsideration of incidents in those categories, including as to whether they should be reported as a SAI or Early Alert.

92. To facilitate this call, the corporate Risk and Governance team extracts information held in Datix together with other centrally-held information from across the entire Belfast Trust. This information is collated and provided in a report to all Directorate Governance managers and relevant Directorate representatives each Wednesday, prior to the meeting held the following day at 1pm.

93. Governance managers have the opportunity to review and check the report content with their directorate Collective Leadership Team and Director, updating as appropriate, flagging any omissions or inaccuracies prior to the meeting. An updated version of the report is discussed on a Thursday lunchtime call, with a representative present from each Directorate. Immediately following the call, the report is updated once more with a note of immediate actions agreed and any new information not already provided. The meeting is chaired by a Deputy Medical Director, or myself, and (since summer 2023) our Clinical Directors aligned with the Corporate Risk and Governance team can chair the call. The final updated report is provided to the Executive Team before 5pm that afternoon for their consideration and discussion at the Executive Team Safety Huddle the next day (Friday). The report is subsequently shared with all Divisional Collective Leadership Teams, our Chair and Non-Executive Directors. Should Non-Executive Directors have any queries about the content of the report, then as agreed by Trust Board, they should contact the responsible Director or Head of Office.

94. Introduction of this mechanism has improved oversight and responsiveness to key governance issues, it reduces the risk of issues failing to be escalated into the correct external reporting process and supports senior leaders in oversight, risk management and decision making.

95. In a large complex organisation, it is not surprising this weekly report contains a significant volume of information. Currently we are trialling a summarised version for the Chair and Non-Executive Directors with focus on only new SAI and Early Alert information. The full report continues to be produced in its entirety for the consideration of the Executive and Collective Leadership Team's and action as appropriate each week.

96. The weekly report represents a low percentage of governance intelligence available, and the majority of incidents will not be brought to the attention of Trust Board in this way. The majority of incidents reported will be assessed and managed within the Directorate governance structures and will not require escalation to the Trust Board because they can be managed at Directorate level.

97. I believe there are currently fourteen Directorates and, of these, eight are responsible for delivering care directly to service users. Services provided differ from Directorate to Directorate and the Director for each service is accountable for ensuring they have developed appropriate governance structures to scrutinise and use their governance information, including incident information, in line with Trust policy. Directorate governance arrangements and structures can vary, however they are expected to accommodate the requirements of our Integrated Governance and Assurance Framework, Risk Management Strategy and a number of policies, including the Adverse Incident policy.

98. Incident information could also be escalated via committees within the Assurance Framework. By this I mean specialist groups, for example Medicines Optimisation will consider medication incidents and may have drawn to their attention an incident, or trend in incidents, which have not made the threshold for weekly consideration on the governance call, but the group could seek assurance, quality improvement work or escalation of a risk to its steering group and on to Assurance Committee. This may not be detailed information but may give an overview of immediate and intended actions, improvement plans and so on.

99. The Belfast Trust introduced Safety & Quality Visits (SQVs) in 2014. Each visit includes senior leaders, and Non-Executive Directors joined the schedule of visits in or around 2018. The meetings are constructed around a standard agenda which includes an opportunity to discuss incidents. The attending Non-Executive Director presents feedback to Trust Board following their attendance at these visits. Should an incident of concern be raised with the Non-Executive Director this could result in consideration by Trust Board. Changes to how these visits are conducted is currently under consideration.

100. The Assurance Committee receives quarterly Incident and SAI reports. These reports have followed a similar format since 2007 with an ongoing agile approach to improve information for the committee. It is high-level data and trend information concerning incidents and SAIs across the entire organisation, showing the main categories and reporting trends by Directorate/ Division over time. It does not provide detailed information on individual incidents. We continue to develop the

report with the intention of improving its content and usefulness for the Assurance Committee. Most recently, the Risk and Governance team are linking incident information to work with specialities and groups to demonstrate the potential impact that proactively using incident data can have to improve services.

101. In 2019 the Risk and Governance team developed a report known as an Infographic Report. This was an attempt to work closely with service colleagues in providing all their key governance information quarterly and encouraging their analysis and commentary on the information. This report was later stood down with the introduction of the Trust Quality Management System (QMS).

102. Assurance Committee now receives Quality Management System reports on rotation from each Director (approximately 3 presentations per quarter). This reporting will not usually result in direct escalation of individual incident details, but could, if the incident relates to a major risk for the service, result in high level discussion about incidents in relation to such a risk to services, our users and staff.

103. The Assurance Committee also receives a quarterly whistleblowing report, containing information in relation to the status of ongoing whistleblowing concerns. The Assurance Committee has the opportunity to interrogate the information provided and to discuss with the appropriate Director. Any whistleblowing concern that relates to fraud is reported quarterly to the Audit Committee.

104. With regard to safeguarding concerns, the system of referral and detailed management of such concerns, their investigation and reporting is not managed and overseen by the corporate Risk and Governance team, although there can be duplication across both the incident system and these processes. If a safeguarding concern meets the Adverse Incident definition, it is expected, in keeping with policy, that these will be reported on the incident system as well as going through the appropriate Adult Safeguarding processes. Directorate colleagues should have oversight and ensure this occurs.

105. If not already provided, the Executive Director for Social Work can provide an overview of Safeguarding referrals, reporting, and how this information is escalated

to Trust Board, including the role of the Social Care Committee. The Social Care Committee has been in place since 2016, reporting directly to Trust Board. Following review and development of the Integrated Governance and Assurance Framework in 2022 this Committee's reporting line was brought within the Assurance Framework, and now sits as a Steering Group, reporting to Assurance Committee. Escalation of safeguarding concerns also meeting the Adverse Incident definition should follow the same escalation pathway as described for any other incident and be escalated under arrangements for safeguarding referrals.

106. Investigation undertaken within the complaints process might highlight that an incident has occurred that was not recognised as such prior to the complaint. The complaint could then transfer into the SAI process, following discussion within Directorate Governance arrangements or following discussion on the weekly governance call. It could also be classified as a high-risk complaint with a summary listed for consideration and assurance at the Service User Experience Feedback Group (SUEFG). This group is jointly chaired by the Medical Director and a nominated Non-Executive Director, with a second Non- Executive Director also part of the group. Each Directorate is represented by a senior member of staff and can provide assurances, follow-up actions and share learning. An assurance update is developed and presented to Assurance Committee, again the detailed consideration is completed by SUEFG rather than at Assurance Committee.

107. The claims process might also identify that an incident has occurred that was not recognised as such at an earlier time. Due to the length of time it can take for claims to progress, the Risk and Governance team are working to ensure that lessons are learned during the ongoing claims process, through case conferences with legal advisors. In reporting on claims quarterly we have also introduced triangulation of individual claims with incidents, complaints and coroners Inquests.

108. Each Speciality has a Patient Safety Clinical Governance meeting (M&M) and identified lead clinician. These groups follow a standard agenda and could review a patient's case agreeing there are issues requiring reporting as an incident or even a SAI, potential escalating it into the various processes I have described above.

109. An external review, from the likes of a Royal College, RQIA, MHRA or other external body might identify an incident and cause escalation in the system.

110. With the launch of our Quality Improvement Strategy in 2017, the Medical Director at that time sought to underpin a 'ward to Board' approach of data analysis, capability to triangulate and escalate information. Incident data was part of a suite of information to be considered.

111. In summary any incident meeting the definition within the policy should be reported, but it does rely on those operational staff complying with policy. Management of the incident, its consequences, identification of associated risk, communication with those involved, learning and subsequent actions has always been the responsibility of the service involved and accountability for this is through the Director responsible for delivery of that service.

112. As referred to above, each Directorate has access to a Governance manager who is employed and has responsibility and accountability within the Directorate structures. These staff support their Director and Collective Leadership Teams from each Division within their Directorate to ensure application of the Trust Incident policy and procedures and will work to ensure incident information is extracted and reported from the Datix system for use and consideration at governance committees at Directorate level.

113. The Governance manager has been trained to extract create and retrieve reports from Datix for their own management teams and governance meetings. Should something become evident to them and/or their service management colleagues through to Director level, an incident or trend could be escalated through any number of routes described previously.

Question 4

Did the Risk and Governance Committee have any role in the Trust's response to inspections of MAH, including those carried out by RQIA? If so, please give details.

114. The overarching committee dealing with matters of clinical risk and governance is the Assurance Committee. The committee has been operational since 2007.

115. The agenda for this committee includes a range of governance issues from across the entire Belfast Trust. Whilst being accountable for seeking assurance regarding the governance arrangements and correct management of governance issues across the Belfast Trust, the Assurance Committee is strategic in its function and, unless escalated, it is not possible to include on the meeting agenda every inspection that takes place within the Belfast Trust. The Assurance Committee depends on the appropriate subcommittee receiving detailed assurance updates and escalating issues if appropriate, or a Director raising an issue via emerging issues.

116. Detail regarding inspections, their recommendations, Quality Improvement Plans (QIPs) and the response, are managed at Directorate level. Committees within the Assurance Framework will seek assurance that a response is appropriate with associated risks effectively managed, seek additional assurance and monitor actions if required.

117. It may be helpful to describe the arrangements within the Belfast Trust with regard to the oversight of RQIA Reviews & inspections.

118. The Medical Directors' Office has a role in ensuring that there are appropriate systems in place to manage the 3-yearly programme of RQIA thematic reviews, along with acute hospital unannounced inspections. These arrangements are managed in agreement with the individual services and Directorates who progress recommendations associated with their service.

119. A member of the central Risk and Governance team ensures that services facilitate each thematic review and respond appropriately, but the service inspected provides assurance on completion of actions contained within their Quality Improvement Plans (QIP) and that timeframes are monitored and responses are completed in a timely manner.

120. With regard to acute unannounced inspections, RQIA will inform Trust Headquarters, along with the Risk and Governance team, that an acute unannounced inspection is taking place on the morning of the inspection. Belfast Trust Headquarters will disseminate this information to those within the Directorate required to facilitate the inspection.

121. Following the inspection, the service will receive the RQIA report and QIP, initially for factual accuracy checking. The Risk and Governance team will monitor the service response to correspondence and completion of QIPs ensuring that these are returned within the timeframes stipulated by the RQIA inspection team.

122. Should it not be possible to comply with the RQIA response timeframes, the Directorate agree a revised response date with the inspection team or organisation. The central Risk and Governance team are included in this communication.

123. A sub- committee within the Assurance Framework committee structure, known as the External Reports Review Group (ERRG) monitors progress of the RQIA Thematic Reviews. The ERRG's Terms of Reference, which have changed over time, are included behind Tab 6 in the exhibit bundle. The ERRG has responsibility for monitoring the programme of inspections and progress of the QIPs related to recommendations arising from thematic reviews. Updates are provided by services to inform the six-monthly submission to the Department of Health on progress. This process continues until the Trust, Department of Health, RQIA etc. are assured that all actions have been achieved and implemented.

124. The Terms of Reference for the ERRG were revised in 2016 to include other external reviews as identified by Directors. This followed a recommendation from Internal Audit that highlighted other reviews could take place which may not feed into organisational assurance arrangements, and recognising that Directors may commission additional external reviews of their services, for example profession-specific College Reviews. The inclusion of these reviews in the monitoring arrangements of the ERRG is dependent on the Director identifying that an external review or inspection has taken place and that it is not already monitored in an alternative process.

125. The Medical Director chairs the ERRG with membership including a professional Executive and Service Director. Co-Directors and/or their Directors are required to attend and report on progress of any open reviews within their service.

126. The ERRG monitors and seeks assurance on progress and, where appropriate, escalates risk with regard to RQIA and external reviews included on its agenda. This process does not include regulatory inspections, unannounced hygiene inspections or Mental Health and Learning Disability reviews.

127. The remaining RQIA inspections for registered services, including those falling under the Mental Health and Learning Disability reviews and reports, are managed and monitored at Directorate level and escalation of any serious risk would be required from the responsible Director.

128. Directorates responsible for services being inspected by RQIA have specific individuals within their directorate (RQIA refers to them as “affiliates”), who, amongst other things, have responsibility for communicating directly with RQIA about the inspections.

129. The relevant Directorate will monitor, manage actions and escalate risk within their Directorate governance structures. This is a significant portion of the RQIA workload and the Medical Directors’ Office, with limited resource to support the thematic and Acute Hospitals unannounced inspection process, is not resourced to oversee the full remit of RQIA inspections across the organisation. To enable the corporate team to extend their responsibility to these additional services would require resource redistributed to the corporate Risk and Governance team.

130. RQIA has an escalation policy and serious concerns raised during a review or inspection may be notified to the Chief Executive who will be contacted directly by RQIA. A formal response will be required and if the Director for the relevant service has not already shared the issue/concern and planned remedial actions with the Chief Executive, they will take appropriate remedial action and provide assurance

within timeframes as identified by RQIA. This communication stream occurs between the CEO, the Director and RQIA.

131. The corporate Risk and Governance team will only be included in communications regarding thematic reviews or Acute Hospital Inspections. The role of the Risk and Governance team is not to progress these issues at service level. It is to ensure services and the managers are aware and develop appropriate and timely actions to deal with the issues raised.

132. There are several reports prepared quarterly for Assurance Committee regarding RQIA-related issues. These reports do not provide the minutiae of reviews and inspections and are provided for information and assurance purposes. The minutiae of reviews and inspections are discussed and noted at ERRG or within Directorate governance arrangements and only issues of concern will be escalated outside these arrangements. Information with regard to thematic reviews and unannounced Acute Hospital Inspections will be included within the ERRG assurance update to the Clinical and Social Care Governance Steering Group. If further escalation is required this will be included in the Assurance Update to Assurance Committee.

133. In addition, several reports are provided direct to Assurance Committee. The first internal report arising from the Thematic Review programme and Acute Hospital Inspections is prepared by the Risk and Governance team and presented by the Medical Director or nominated deputy to the Clinical & Social Care Governance Steering Group and Assurance Committee.

134. Service Directors for Mental Health and Intellectual Disability, Adult Community and Older Peoples Services and Children's Community Services all prepare high level reports on RQIA inspections occurring for regulated services within their remit. These reports are also included on the agenda of Assurance Committee.

135. I do not recall the Assurance Committee, The Learning from Experience Steering Group (LESG) or more recently the Clinical and Social Care Governance Steering Group (which replaced the LESG), or its subcommittee known as the External

Reports Review Group, having a role in managing response to individual RQIA inspections, including at MAH. The role at each level within the Assurance Framework is to seek assurance on actions against recommendations.

136. Responding to inspections at MAH would be managed at Directorate level, with the Director, or responsible Co-Director, providing assurance directly to RQIA. The RQIA also had its escalation procedure that I have referred to above. The relevant Director and the Governance manager with responsibility for the Directorate will be able to provide confirmation on the accountability and escalation arrangements within the service that included MAH.

Question 5

Do you recall the Risk and Governance Committee ever raising any concerns in relation to MAH with the Trust Board? If so, please give details.

137. Prior to July 2023 those who attended Assurance Committee included the full Trust Board, the Chief Executive and all Executive Directors and Operational Directors, and myself as Head of Office. Any issue raised through to Assurance Committee was effectively raised with the individuals comprising the Trust Board.

138. I have no recollection of the Assurance Committee having concerns about MAH raised with it, or itself raising concerns about MAH prior to the events of late 2017.

139. To try and help the MAH Inquiry, I arranged for all available minutes of Assurance Committee to be reviewed dating back to February 2012. I have been unable to identify any reference to Muckamore Abbey Hospital recorded prior to 14 November 2017.

140. From November 2017 on, Assurance Committee received regular updates from the Director for the service detailing any emerging issues and ongoing actions and assurances. These updates were in addition to routine updates also provided regularly to Trust Board. Assurance Committee and Trust Board have continued to be updated to the present day.

141. In addition, the Principal Risk Document, now known as the Board Assurance Framework (BAF) document had the risk '*SQ44 – On-going risk of harm to vulnerable patients in Muckamore Abbey Hospital (MAH) especially in regard to historical incidents*' added to the document in February 2019.

142. This document contains all principal/strategic risks relating to the Belfast Trust meeting its objectives. The lead Director for each risk arranges for the risk's description and associated information to be populated, providing this to the corporate Risk and Governance department for inclusion in the Principal Risk Document/BAF. The lead Director for SQ 44 presented the risk for consideration and approval by the committee, detailing controls and assurance in place, any gaps in control or assurance and remedial actions planned, timeframes for these and how assurance about the risk and controls is obtained. This risk has been considered as per the schedule for BAF risks since its addition.

143. In 2021, with introduction of the QMS schedule of summary presentations to the Assurance Committee agenda, the Director for Mental Health, Intellectual Disability and Psychological Services has presented on three occasions reporting on MAH. In addition, the Executive Director of Social work has also presented QMS information including MAH.

Question 6

Do you recall whether the Risk and Governance Committee had a role in the decision to install and operate CCTV in MAH? If so, please give details.

144. Risk and Governance meetings in relation to MAH would occur at Divisional and/or Directorate level and this is where I would expect installation and operation of a new development such as CCTV to be discussed in the first instance. I would not expect Assurance Committee to deal with an issue such as the installation of CCTV in an individual service unless the issue had wider risk or governance implications for other services within the Belfast Trust.

145. I do not recall being part of any meeting within the Assurance Framework where there was discussion about proposed installation and operation of CCTV in MAH,

or indeed any other service or Belfast Trust site, prior to the events unfolding in late 2017.

146. The Trust-wide meeting at which an issue such as this may have been discussed is the Capital Evaluations meeting (which is concerned with evaluating proposed capital expenditure). I am not a member of this meeting and do not know whether CCTV was discussed or not.

147. The associated policy for CCTV operation at Muckamore Abbey Hospital was a Directorate-specific policy and therefore the policy was developed, scrutinised and approved within the Directorate's own governance arrangements. This is normal practice. Once agreed within the boundaries of the Directorate it was included on the agenda for the Trust wide Standards and Guidelines Committee, jointly chaired by the Deputy Medical Director and Deputy Director for Nursing and User Experience at the time. Although members of my team support this committee and manage the Belfast Trust intranet policy site, I was not a member of this committee.

148. This process of policy approval is standard Trust procedure for approving Directorate specific policy. The policy was listed on the agenda for Standards and Guidelines Committee in March 2017. The record of the meeting does not reference any discussion and the policy was subsequently included in a list of policies and guidelines approved by Standards and Guidelines Committee for noting at Policy Committee when it next met on 7 June 2017. I was chair of this committee in my role as Head of Office but was not present at this meeting and the meeting was chaired by the Co-Director for Human Resources at the time. The meeting minute does not record any discussion regarding the CCTV guideline. This does not surprise me; it would be unusual for a policy or guideline already approved by Standards and Guidelines Committee to undergo further scrutiny. All policies agreed at that meeting are routinely included in a list of policies and guidelines for Executive Team final approval prior to sign off and uploading on the Belfast Trust intranet. This occurred for the CCTV policy on 28 June 2017. There is no indication in the meeting minute of any discussion at Executive Team.

149. If the relevant Director at that time felt a proposal for installation and operation of CCTV at MAH, or indeed any other matter, needed further discussion beyond the Directorate, they may have asked for it to be included on a weekly Executive Team agenda. I have no recollection of this being discussed at Executive Team.

Question 7

Do you wish to draw 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?

150. I hope in my responses above I have been able to bring further clarity to the governance arrangements in the Belfast Trust.

151. My role is a corporate function which concerns developing organisational policy and strategy with regard to governance and risk management, rather than application of those arrangements at Directorate level.

152. Setting direction for integrated governance and assurance is done with engagement and involvement of Directors, their Collective Leadership Teams and directorate governance managers. Following engagement on development or revision to the documents such as the Assurance Framework and Risk Management Strategy, the documents are brought before Executive Team and Assurance Committee for approval. Trust Board and Executive Team have sight of expectations described within the documents and opportunity to raise concerns or request further discussion and amendments as appropriate.

153. The integrated Governance and Assurance Framework aligns with the Corporate Management plan. The Risk and Governance team resides within the Medical Director's Office and, shortly after inception of Belfast Trust, there was a required drive to identify savings across all Directorates. A number of experienced Service Managers from the initial Risk and Governance team took the opportunity to avail of early retirement benefits. Those left behind extended their remit to accommodate the remit of the posts vacated with a loss of 50% of the senior

managers across the Risk and Governance department, not only reducing available resource but also expertise.

154. Allocation of funds for Directorate governance arrangements and governance administrative support has also been limited with Directorate Governance managers noting the extension of their roles and difficulty balancing priorities over time.

155. The size and scale of the Belfast Trust potentially contributed to various strands of governance information being split across various teams. Perhaps this has contributed to historic focus on information in isolation rather than collectively.

156. The corporate Risk and Governance teams and Directorate Governance colleagues work to improve this and have worked toward improved triangulation of information from 2016 onwards. This work led to the development of Infographic Reports and then to QMS arrangements. The corporate Risk and Governance team provide governance information each month to Planning and Performance, where information is drawn on by Directorates and their Divisions along with a range of other data about their service. This information is used to inform their QMS reporting. Facilitation of this still requires manual input, connectivity between Datix and other IT system is limited, and where it has been introduced it can be problematic.

157. Introduction of innovation through QI is supporting staff to think differently about information, improve how this is analysed, including triangulating information more effectively from 'ward to Board'. It has undoubtedly changed how we work.

158. Investment in Governance through IT and the staff at directorate and corporate level would support this, providing scope to further and maximise the capabilities of Datix. Any system is only as good as the information put into it, and capacity to provide sustained focus on this operationally and corporately could support ongoing work to improve our governance arrangements.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have 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: **Claire Cairns**

Dated: **24 June 2024**

Claire Cairns Organisational Module 9 Exhibit Bundle "CC1"		
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MAHI Muckamore Abbey Hospital Inquiry

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

13 March 2024

By Email Only
Ms Claire Cairns
Co-Director of Risk and Governance BHSCT

Dear Ms Cairns

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 are the Co-Director of Risk and Governance in Belfast Health and Social Care Trust (BHSCT).

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 are asked to give particular consideration to paragraphs 10-13 of the Terms of Reference.

Having regard to the Terms of Reference, the Panel requests that you address the following matters specifically in your statement:

1. Please describe your role and the responsibilities you held in respect of MAH

(including details of when you held such roles/ responsibilities).

2. What regular risk and governance meetings took place in relation to MAH? In answering this question please provide an explanation of:

   i. How often meetings occurred.
   ii. Who attended meetings?
   iii. Who decided the agenda for meetings?
   iv. What regular reports were provided to meetings?
   v. How reports were prepared and by whom?
   vi. Who reports were sent to?

3. Please describe:

   i. How risks are escalated from practice units to the Trust Board.
   ii. How incidents are escalated from practice units to the Trust Board.

   Please also explain who decided that such matters ought to be escalated? Was there guidance to identify when that ought to happen and what action ought to be taken?

4. Did the Risk and Governance Committee have any role in the Trust's response to inspections of MAH, including those carried out by RQIA? If so, please give details.

5. Do you recall the Risk and Governance Committee ever raising any concerns in relation to MAH with the Trust Board? If so, please give details.

6. Do you recall whether the Risk and Governance Committee had a role in the decision to install and operate CCTV in MAH? If so, please give details.

7. 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?

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.

The Inquiry is grateful for your previous contribution by giving oral evidence during the Evidence Modules which were heard from March to May 2023. 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 27 April 2024. Your statement should be uploaded to the Inquiry's document management platform BOX via the following link:

https://mahinquiry.box.com/s/j9ze9o32d8mteewv6lvv8hn2l4rmn9o5

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.

BOARD ASSURANCE FRAMEWORK

2015-2016

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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 Vision and Corporate Plan 2013/14 – 2015/16.

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, Social Services and Public Safety (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.

The Trust Vision & Corporate Plan 2013/4-2015/6 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 five strategic objectives. These are:

- 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 - Service Commitment: -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion
- Our People - Service Commitment: we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce
- Resources - Service Commitment: 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.

[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

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

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.

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.

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

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

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.

The 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

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. She/he will lead implementation for the revalidation of nurses and midwives, which is due to commence nationally in 2015-2016.

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 and 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.

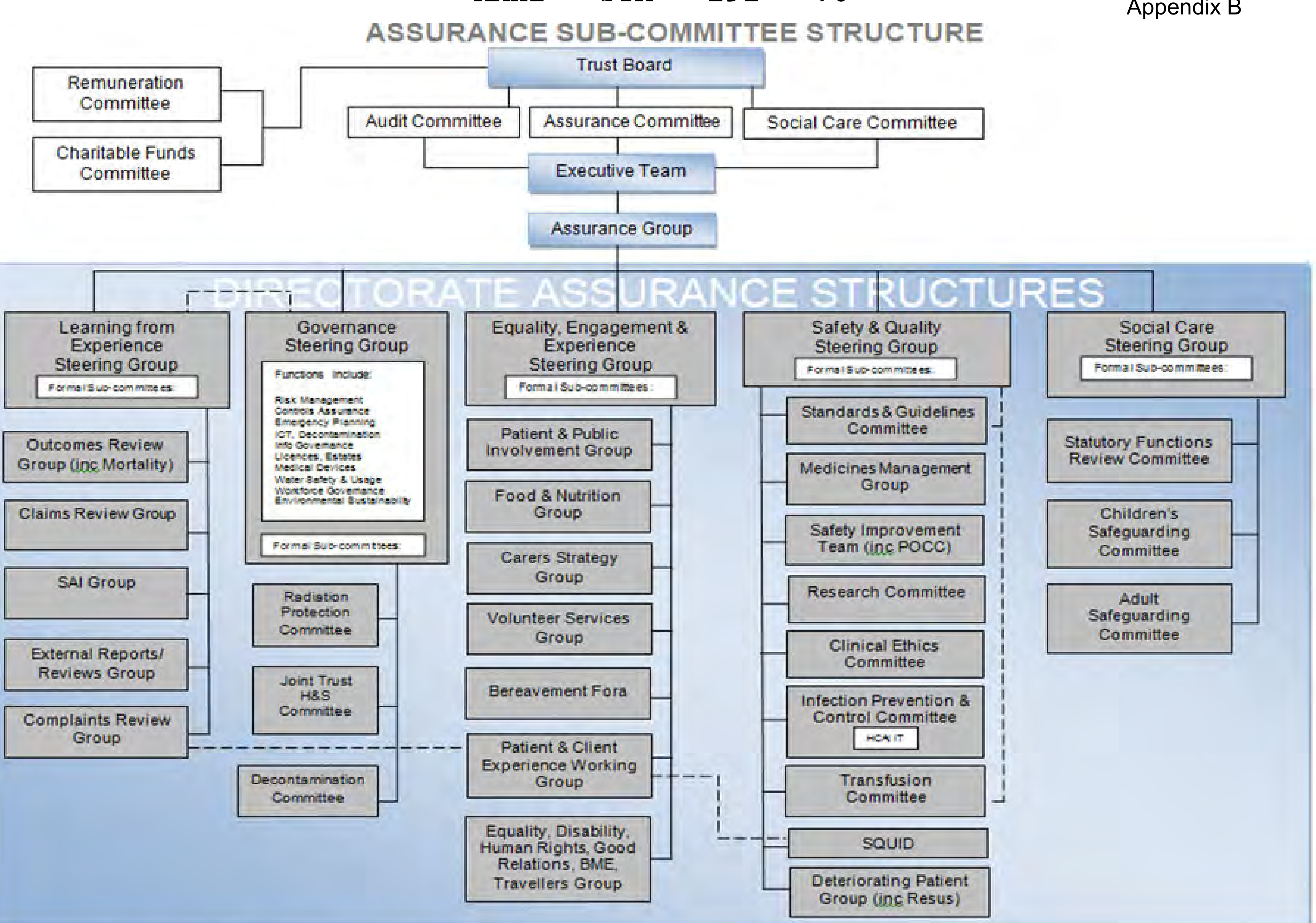
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the 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 Feb 2016 fv Approved

Integrated Governance and Assurance Framework

2022-2023

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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)

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.

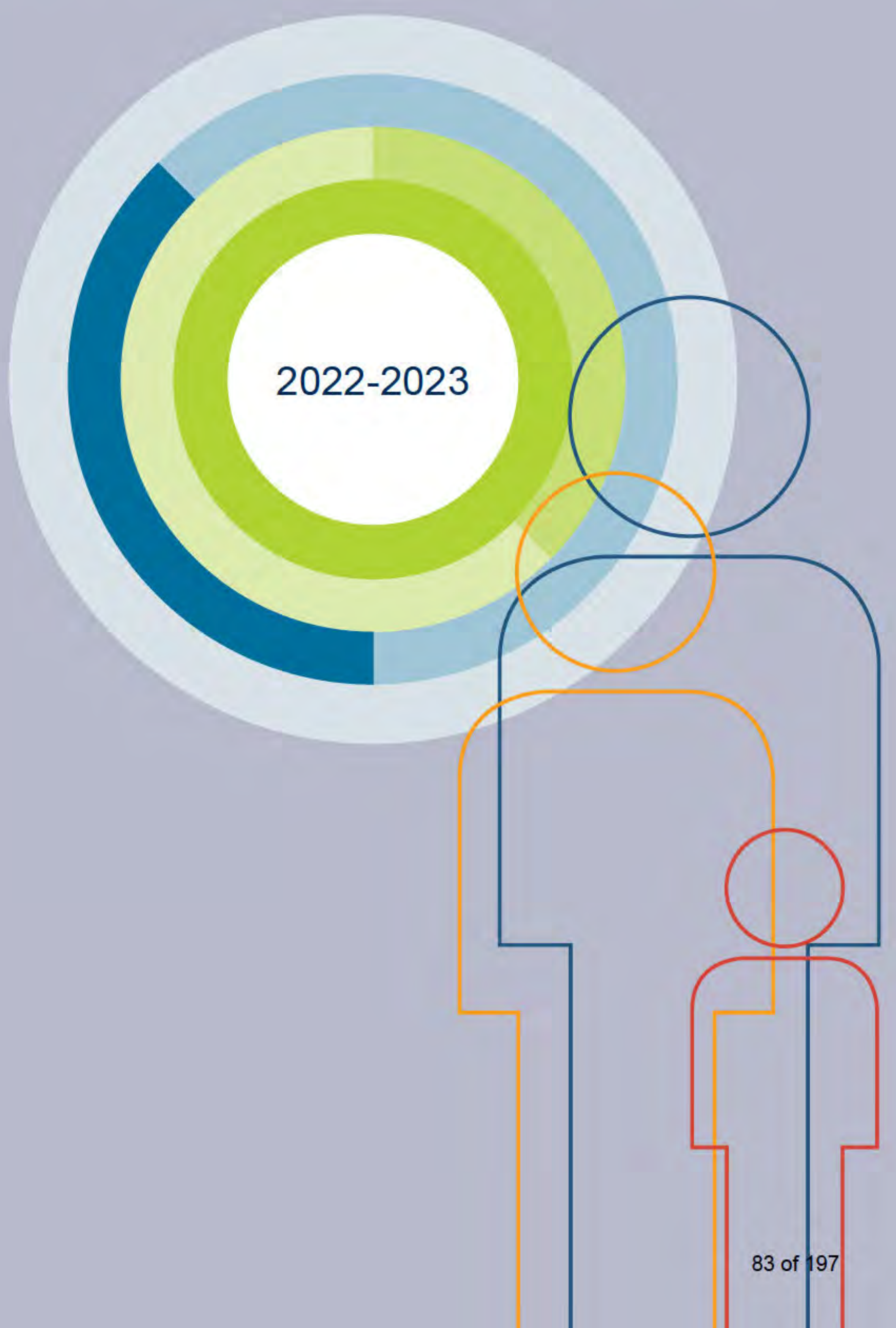
As a result of the COVID-19 pandemic, for 2020/21 the DoH advised that the Commissioning Plan Direction (CPD) and Commissioning Plan (CP) were rolled forward. A similar approach was adopted in relation to Trust Delivery Plans, which were formally replaced by three monthly Rebuild Plans, in line with 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

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

- 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.

MAHI - STM - 292 - 88

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.

3.2 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.

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3. Objective/Priority Setting/Performance Management

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

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

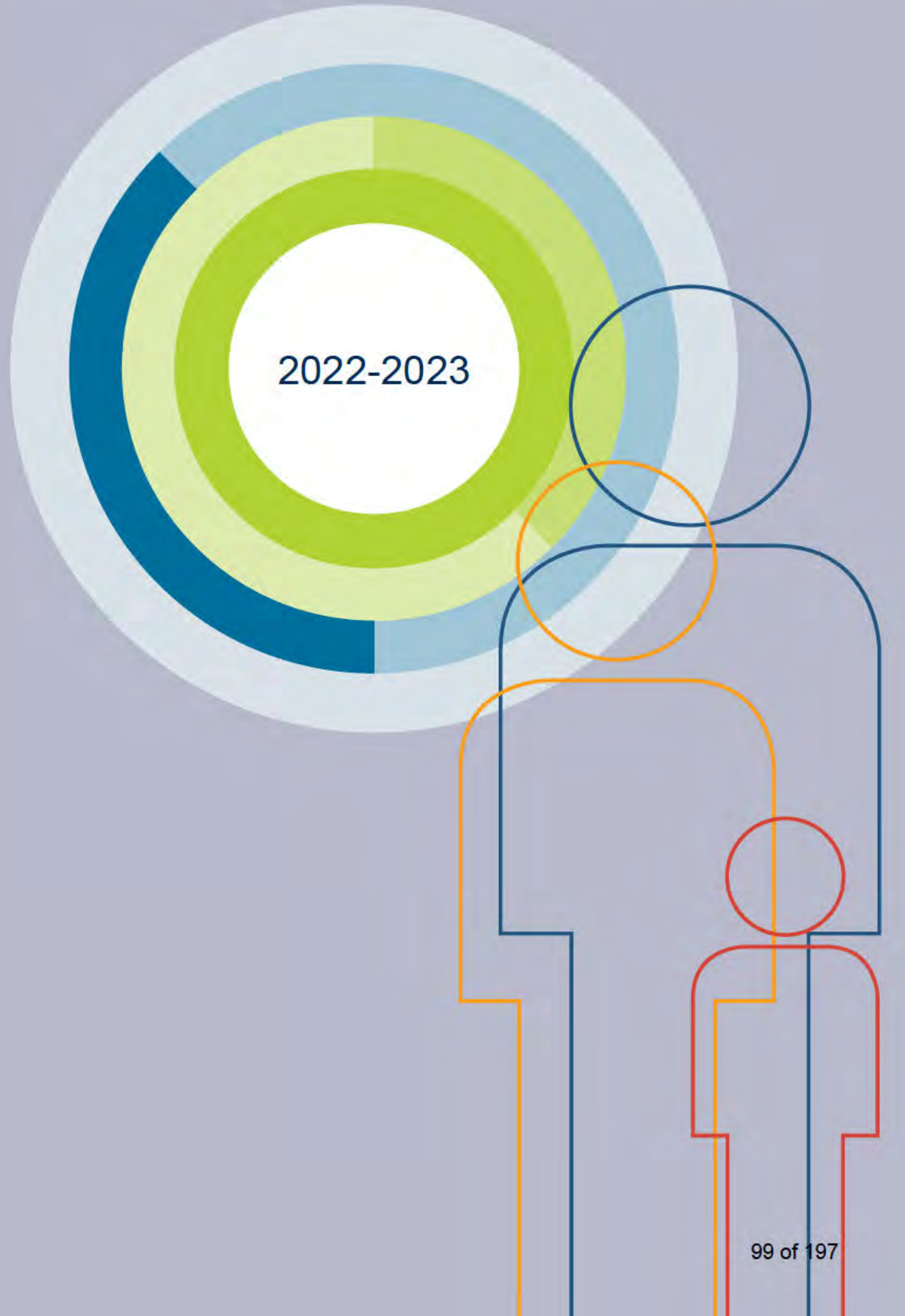
team member by working collaboratively with all colleagues in the HSC and the wider community

- 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

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.

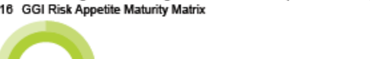
The Trust needs to know about risk appetite because:

- 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



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.

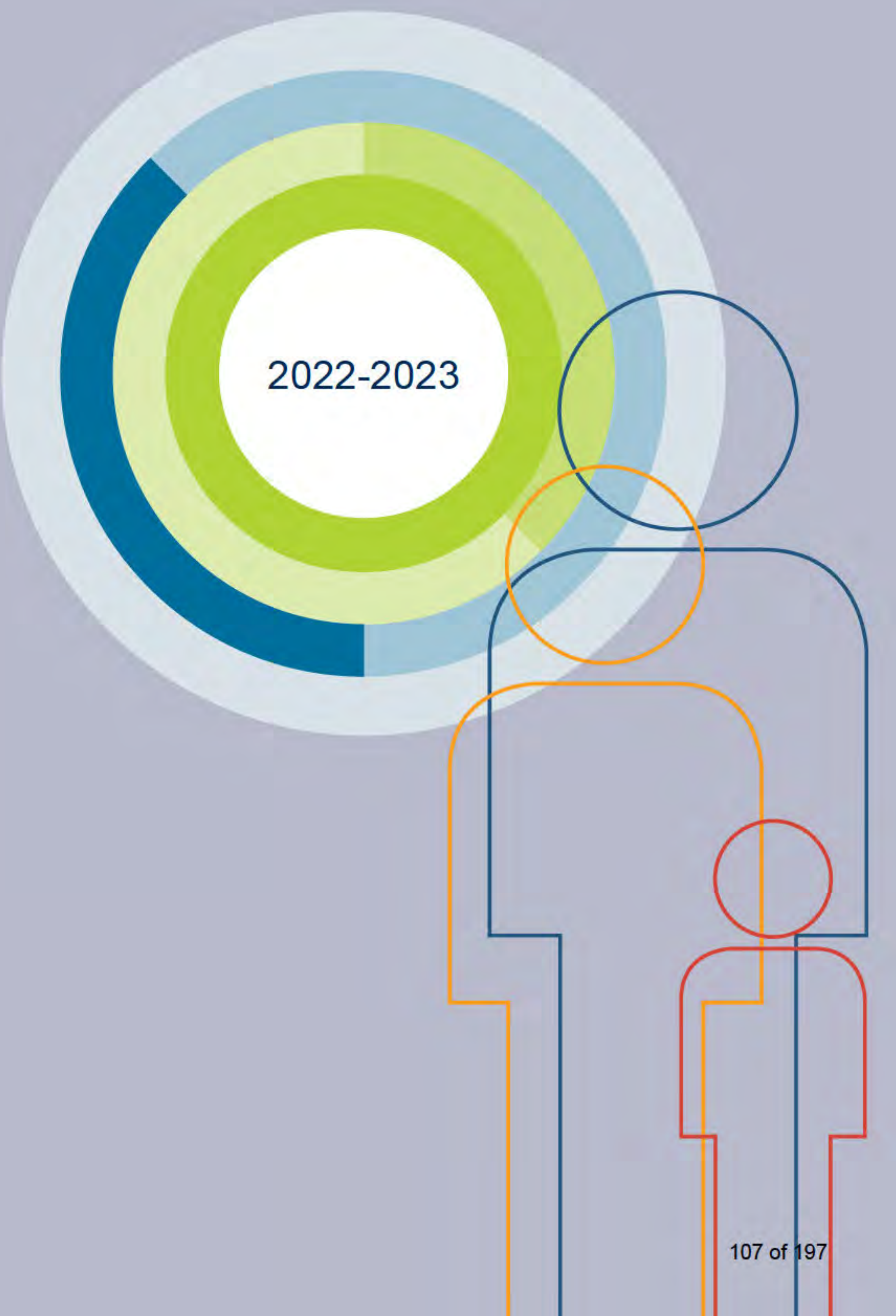
Directorate risk registers are comprised of a mixture of operational or corporate Risks. Corporate risks are those risks that meet the corporate risk criteria as detailed in the BHSCT Risk Management Strategy.[17] The corporate risk register is a collection of all corporate risks from directorate risk 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

6.1 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

- 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.

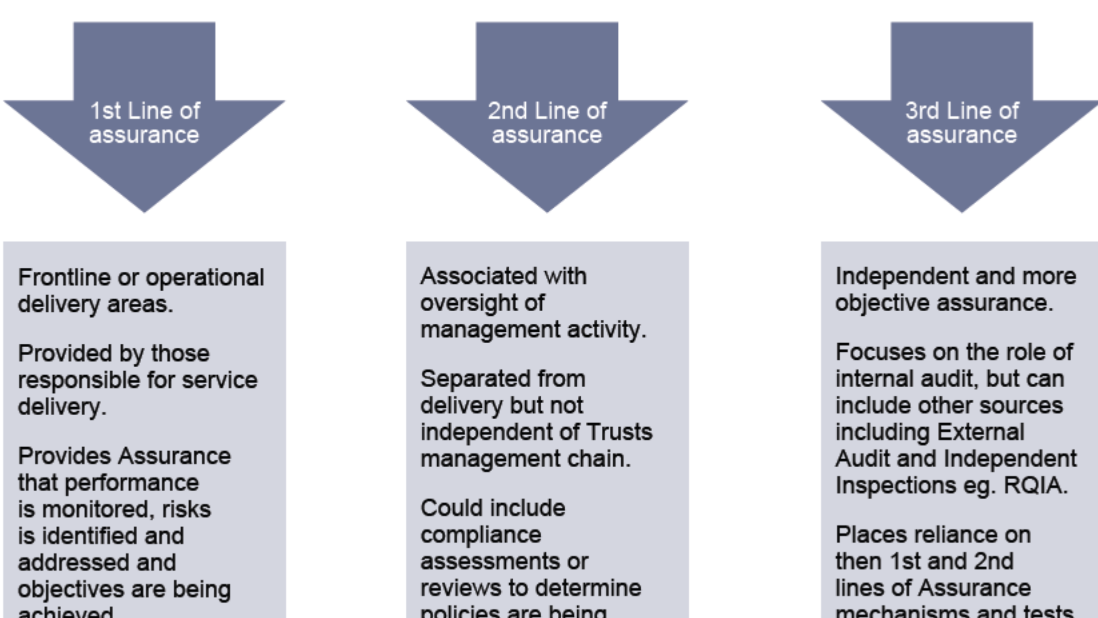
6.3 Three lines of assurance

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.

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

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

Examples

- 1:1 meetings
- Peer review of work
- Self Assessment returns eg. hand hygiene
- Incident review

Line 2

Examples

- Performance reports
- Financial reports
- HCAI reports
- Committee meetings
- Managerial reports
- KPI's

Line 3

Examples

- RQIA
- Internal/external audit
- Professional regulatory bodies eg. NISCC/Royal Colleges etc.

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.

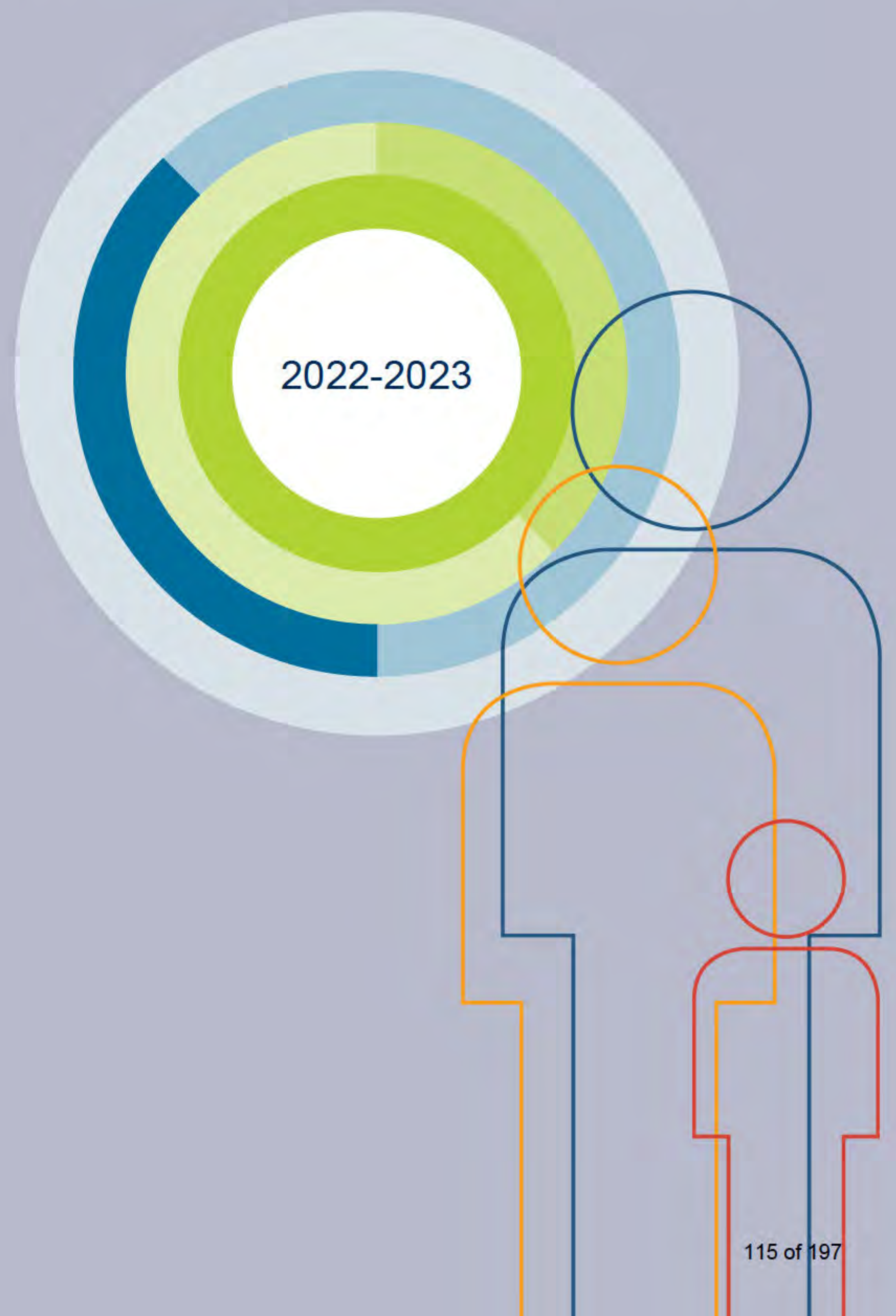
While internal auditors can be used by the Belfast Trust to provide advice and other consulting assistance, external audit do not typically providing such close support to the Trust. This is because external audit are not responsible to management or the Trust, their primary responsible lies with providing 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

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.

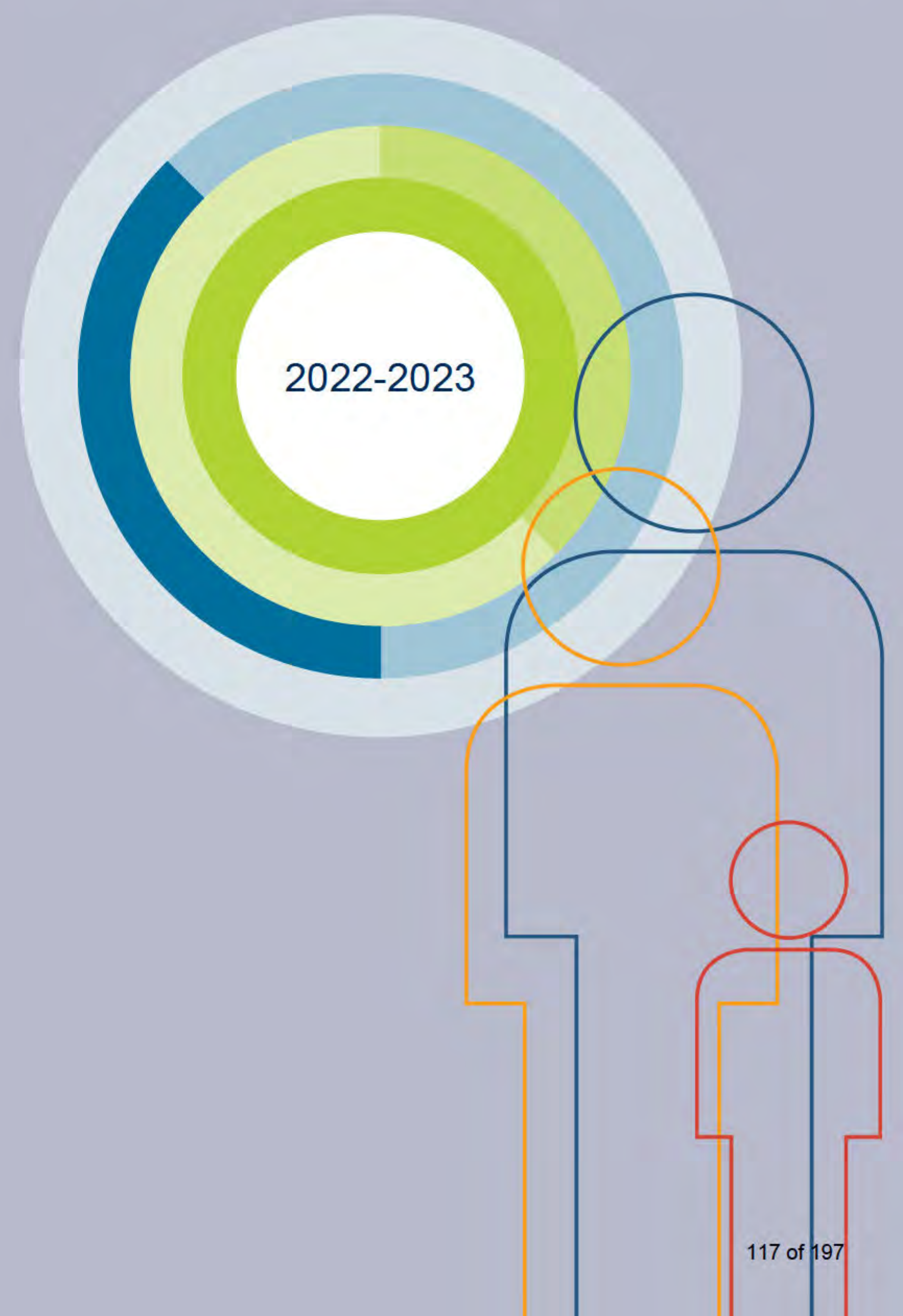
Quality Improvement is a key component of the Trust's overall system of quality management. In September 2020, the Trust developed a Quality Management System bringing together different approaches to performance management, quality improvement, assurance and accountability processes into a single integrated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

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

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:

- 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

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

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

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

BHSCT 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 our vision to provide the **Right Care**, at the **Right Time** in the **Right Place**

Our Vision

To deliver Safe, Effective & Compassionate Care through ***Right Care, Right Time, Right Place***

Our Priorities

- New Model of Care for Older People
- Urgent & Emergency Care
- Time-Critical Surgery
- Outpatient Modernisation
- Vulnerable Groups in our Population
- Seeking real-time feedback from staff & patients
- Regional Priorities incl. Orthopaedics
- Covid-19 Readiness

Quality Parameters and Key Measures

Quality Parameters	Key Measures
Safety	Safety - Divisional Top 3 Key Safety & Quality Indicators, SAIs, Complaints, Healthcare Associated Infections, Safeguarding, Priority 1 Outstanding Actions
Experience	Person Experience – Recommendations to friends & family, Regional Online User Feedback Service measures, compliments, service designed with input of service users Staff Experience - Staff survey measures, % recognising Trust as a good place to work, increased sense of engagement
Effectiveness	Outcomes - Population health outcomes, national benchmarking
Efficiency	Workforce – Sickness & absenteeism, compliance with SDR, compliance with stat/mand training, Consultant signed off job plans, number of apprentices, vacancy rate/retention, agency spend, new roles Resource Utilisation and Productivity Financial Management, utilisation of estate, comparative performance analysis
Timeliness	Access – IP/DC & OP Waiting Lists, length of time waiting for hospital and community care & treatment Capacity – theatre cancellations, ED waiting times, delayed discharges, length of stay, availability of appropriate social care services
Equity	Equality Impact Assessments, prioritisation of surgery and treatment according to clinical need, equitable community services by locality

Outcomes

- Better workforce engagement, increased staff morale, less waste and better productivity.
- Knowing our business and not being blind-sided to serious service failures.
- Improved patient, service users and carer outcomes and experience.
- Reduced risk of reputational damage.

UNDERPINNED BY: Culture | Leadership | Workforce | Involvement & Partnership Working | Resources

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

Past harm

Has patient care been safe in the past?

Reliability

Are our clinical systems and processes reliable?

Sensitivity to operations

Is care safe today?

Anticipation and preparedness

Will care be safe in the future?

Integration and learning

Are we responding and improving?

Safety measurement and monitoring

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

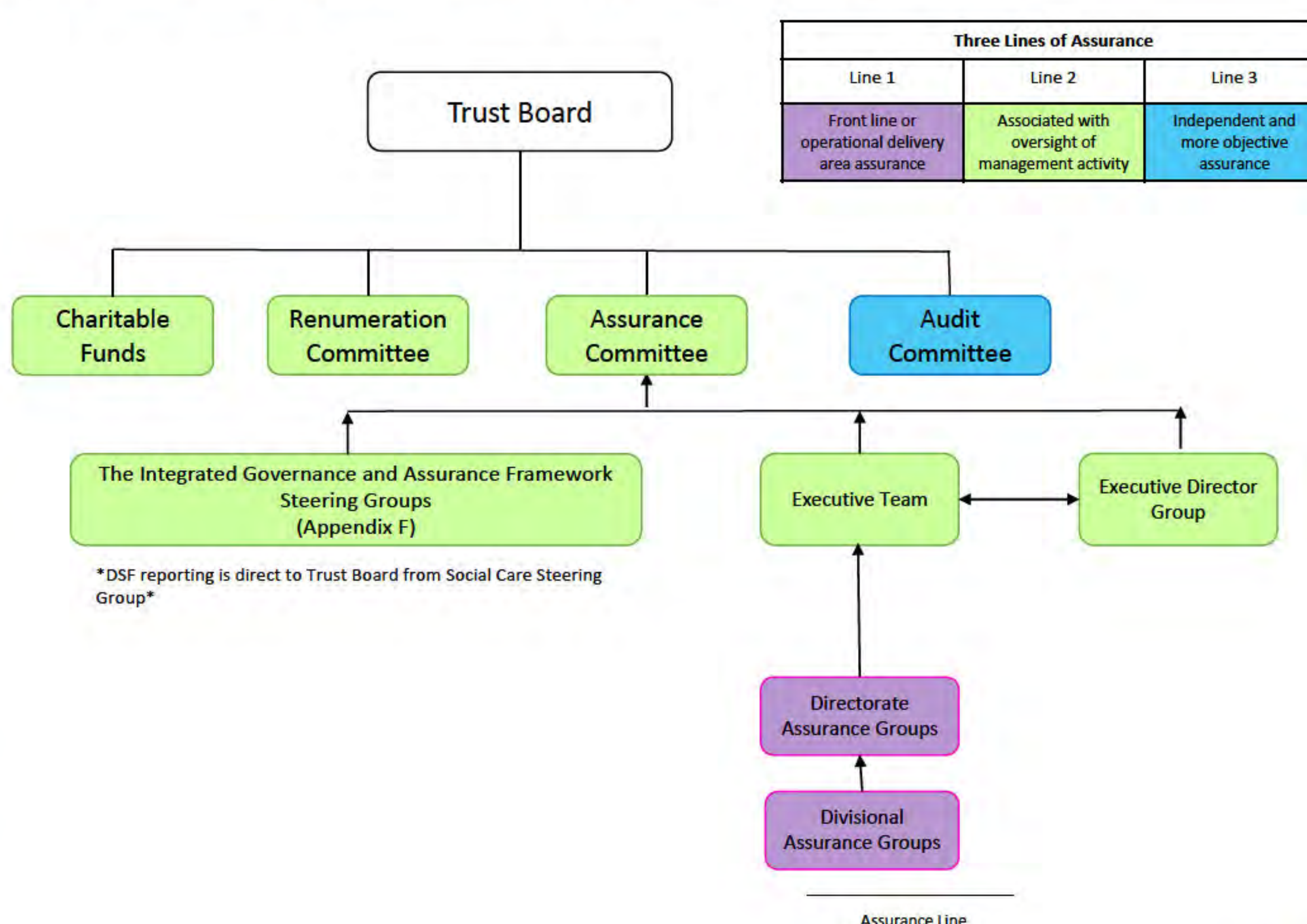
Reliability prompts
- Specify the level of reliability you would expect in areas of standardised practice
- Use local and national audits and initiatives to monitor reliability
- Understand what contributes to poor reliability

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



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

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

BELFAST HEALTH & SOCIAL CARE TRUST

Strategic Multi-Agency Group Meeting in response to Safeguarding Concerns at Muckamore Abbey

STRICTLY PRIVATE AND CONFIDENTIAL

Held on Monday 30th October 2017
at 2.30pm in Meeting Room 1, A Floor, BCH

DRAFT

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Present:

Mrs Marie Heaney	Director Adult, Social & Primary Care (Chairperson)
Miss Brenda Creaney	Director of Nursing and User Experience
Ms Claire Cairns	Co-director Corporate Risk and Governance
Ms Yvonne McKnight	Trust Adult Safeguarding Specialist
Mrs Esther Rafferty	Divisional Nurse of Learning Disability
Mrs Mairead Mitchell	Head of Learning Disability
Mr Robert Henry	Service Manager, Corporate Risk and Governance
Mr Patrick Convery	Regulation and Quality Improvement Authority
Ms Valerie McConnell	Health and Social Care Board
Ms Jacqui McIlroy	Department of Health, Social Services and Public Safety
Mr Rodney Morton	Department of Health, Social Services and Public Safety
Inspector Angela McKernin	Police Service Northern Ireland
Miss Shauna White	Personal Assistant (Minute Taking)

Item No		*Action*
1	**Introductions** Marie welcomed everyone to the meeting and thanked them for attending at such short notice. Introductions took place.	
2	**Purpose of meeting** • Mrs Heaney advised that the meeting was being held in response to serious safeguarding concerns identified in Muckamore Hospital. Mrs Heaney highlighted that the meeting was in line with procedural requirements in relation to the Memorandum of Understanding 2013 and Adult Safeguarding 2016. The functions of the Adult Safeguarding Strategic Management Group were distributed. • Mrs Heaney informed that a safeguarding incident was reported in August 2017 and that further safeguarding concerns had since emerged as well as additional detail due to the availability of CCTV images. Mrs Heaney noted that since becoming aware	

	of these incidents liaison with RQIA, HSCB, PSNI and DHSSPS has taken place and will be ongoing. • Mrs Heaney highlighted that the purpose of this meeting is to ensure effective multi-agency strategic management of these incidents and to ensure clarity in relation to roles and responsibilities. She identified herself as the lead director but emphasised that she is working jointly with Miss Creaney as the Director of Nursing on these issues. Miss Creaney added that her role would be to support Mrs Heaney in this work and to take a lead role in relation to nursing issues. • Roles and responsibilities were clarified as follows: Trust – Investigation Improvement Accountability DHSSPS – Strategic oversight and ministerial assurance PSNI – assessment of criminal threshold and liaison with PPS RQIA – compliance with regulatory standards HSCB – Commissioning responsibilities and professional standards Mrs Heaney advised that there would be a number of processes involved in the management of this complex investigation. She identified these as follows: - Serious Adverse Incident, Level 3 investigation with an expert independent panel of experts, appointments underway - Adult Safeguarding investigation under Regional Adult Safeguarding Procedures (Sept 2016) - Police investigation under Regional Joint Protocol procedures (Sept 2016) - Disciplinary investigation and, where appropriate, professional investigations - Multi-agency Strategic Management Group. Mrs Heaney stressed the primary of patient safety and the importance of working closely with patients and families in the months ahead.	
3	**Delayed Discharge** Discussion took place regarding delayed discharges in relation to Muckamore. Mrs Heaney highlighted that approximately 70% of patients living in the hospital should be living in the community. While this was acknowledged it was agreed that this meeting should focus on the serious safeguarding concerns identified and how these will be addressed. However the level of delayed discharges and the impacts will form part of improvement plans. Mr Convery reminded the meeting that RQIA are currently completing their report on community services which will be relevant to this discussion.	

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4	**Nature of Incidents, details** In summary, Mrs Mitchell provided the following information in relation to the nature of these incidents: - 2 incidents of physical assault - A small number incidents which suggest the inappropriate use of physical restraint and seclusion - Neglectful practices specifically the lack of meal supervision with vulnerable patients - An apparent lack of meaningful engagement with patients - Concerns regarding nursing practices, for example sleeping on duty - Staff apparently observing some of these practices which were not subsequently reported. All of these are currently subject to further analysis by the PSNI and multi-discipline staff. To date the incidents have occurred mainly out of hours and the actual incidents are confined to the members of staff already suspended. However the investigative processes are still at an early stage and this is an evolving picture. • It was noted that the first incident related to a report by a Staff Nurse that a Healthcare Support Worker had punched a patient in the stomach on 12 August 2017. The incident of 12 August 2017 was not reported until 21 August 2017; when reported it was immediately referred to Adult Safeguarding and the PSNI. The staff member involved was placed on precautionary suspension. At this stage the PSNI informed the Trust that a single agency approach was being followed for this incident. • At the time of the incident the CCTV monitoring system that had been installed was not due to become a live system until 11 September 2017. • On the 29 August 2017 the Trust became aware that CCTV was being tested and may be available. Advice was sought from Department of Legal Services (DLS) to establish whether the Trust could view the test footage CCTV as part of the investigation into the allegation. • On 6 September 2017 DLS confirmed that CCTV could be viewed and the CCTV installation company were contacted to arrange for senior staff to view. • The viewing centred on the date of the incident (12 August 2017) and at this viewing were identified and involved the staff member already on precautionary suspension and another Healthcare Support Worker. Mrs Mitchell and Mrs Rafferty advised that other safeguarding concerns were identified along	

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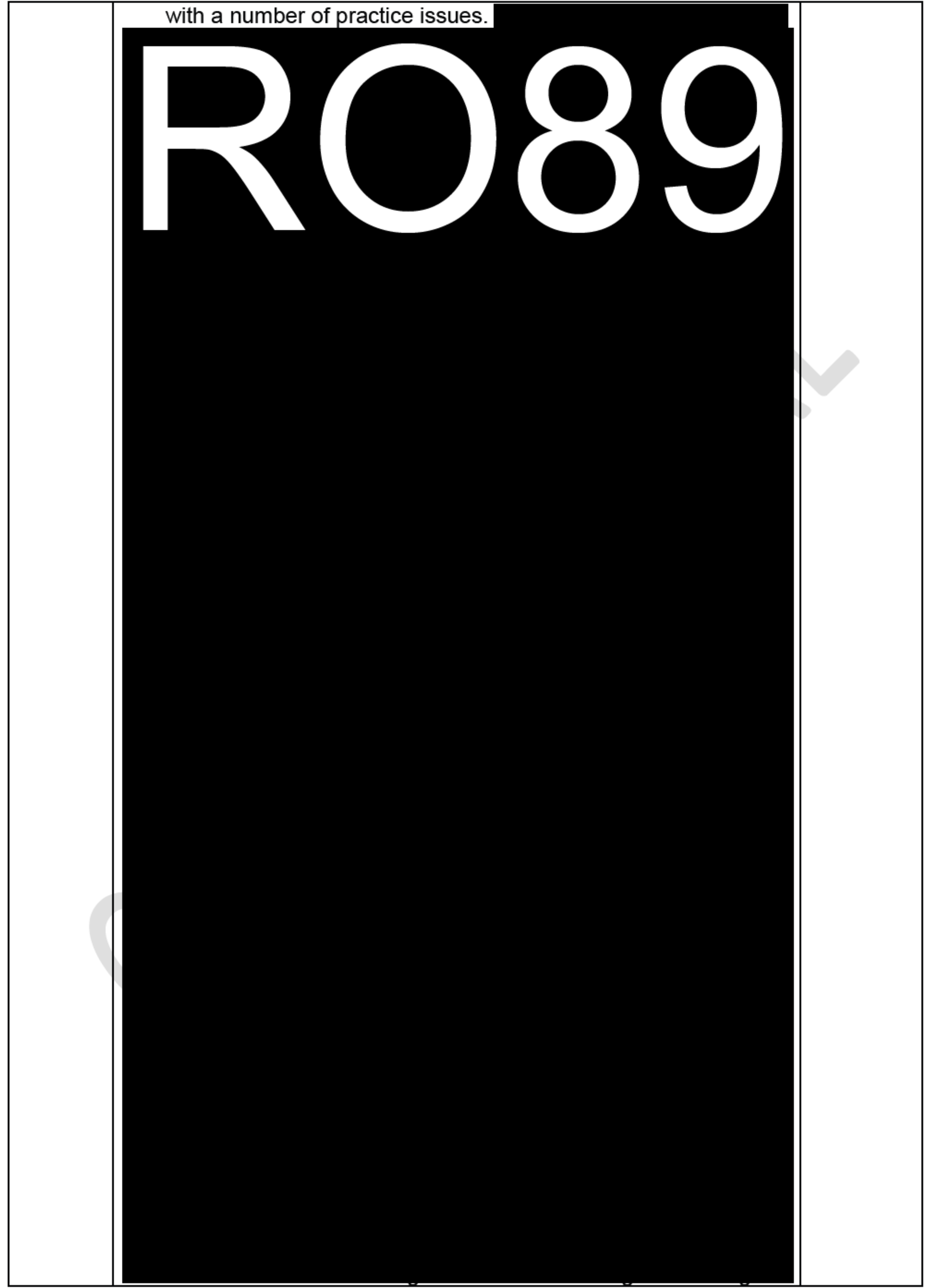
with a number of practice issues.



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Mrs Mitchell informed that CCTV was installed in March 2017 and it became apparent that the CCTV had been active from March 2017 but staff were not aware of this. Hospital security team informed that there was over 200,000 recorded hours. Information was provided regarding the arrangements in place to view the CCTV and it was highlighted that viewing would involve joint viewing by a senior member of hospital staff and a Trust professional independent of the hospital. Mrs Mitchell advised that currently the Trust are planning to view a 25% sample of the CCTV focusing on different shift patterns both day and night. She explained that this was resource intensive but acknowledged the importance of this work and stated that this is in progress.

Agreed Action: Records need to be secured in order to retain footage.

Mrs Rafferty highlighted that on 26 October 2017 at a viewing of CCTV further incidents of concern were noted, some of which related to poor practice and some which were reported to Police. It was noted that staff involved in incidents are the same staff who are currently on precautionary suspension. The staff had already been reported to Police and Police were updated in relation to the new concerns.

Mr Morton queried if the other nurses who had observed the incidents but did not report, were still in post. It was highlighted that two nurses have been redeployed to Six Mile ward and are being closely monitored and supervised by the charge nurse. Miss Creaney advised that there was not enough grounds to suspend these staff and discussion took take place in relation to this.

It was confirmed at this point in time the Trust have suspended two health care workers and two nurses and two nurses are currently redeployed to Six Mile Ward. Questions were asked whether there had been any previous concerns in relation to the staff identified. The Trust confirmed that there were previous issues in relation to one healthcare worker where a case went to court but the worker was found not guilty and that there had also been a further adult safeguarding allegation in 2015 but that the witness withdrew their statement. The Trust acknowledged its intention to carry out a comprehensive analysis of the history of the staff named. There will also be a review of all previous safeguarding concerns, complaints, adverse incidents and serious adverse incidents.

It was noted that healthcare workers are not required to be registered with any professional body and that this is a significant

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	gap. Miss Creaney advised that professional alerts have been submitted for the two nurses on precautionary suspension.	
5	**Police Involvement** Inspector McKernin informed that each case referred to the Police will be looked at individually and consultation with PPS will take place. The importance of joint working with Police under Joint Protocol procedures was acknowledged, along with the need for tight timescales in terms of follow up. Inspector McKernin advised that the Police would need to have a more thorough understanding of patients' care plans and what is acceptable and unacceptable practice. She further advised that it would be difficult to commit to a timescale at this early stage in the investigative process. It was noted that she has one Officer currently dealing with two incidents and Ms McKnight formally asked Inspector McKernin to address and dedicate an Officer to the Muckamore investigation. **Agreed Action: Inspector McKernin agreed that she would review the situation and workload with a view to allocating investigations to a dedicated officer**	
6	**RQIA** Mr Convery stated that there were no recent safeguarding concerns identified in previous RQIA inspections and he suggested that RQIA would suspend investigations until after the New Year given that they did not want to add any further disruption to the ward. Mrs Heaney acknowledged that this was helpful in the circumstances.	
7	**Nursing and Medical Students** With regard to nursing and medical students, Miss Creaney queried whether it was appropriate for them to be on the ward at this time. A brief discussion took place concerning professional obligations to these staff but it was also highlighted that students can provide a richness of information and a fresh perspective. Miss Creaney advised that she is meeting with Mrs Mitchell and Mrs Rafferty the following day to review the situation on the wards and that further discussions will take place in relation to this issue at that time.	
8	**Working with Patients and their Families** • Discussion took place in relation to information shared with families and work with patients and families. It was noted that safeguarding will have a key role in relation to working with patients and families and that Ms Rhoda McBride, Services Manager for Learning Disability will be leading on this but is not here today. • Mrs Mitchell confirmed that the focus to date has been in relation to patients and families where incidents have been identified. Mrs Amanda Burgess, Assistant Service Manager has been in contact with the families and they have been informed of the	

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	incidents and will be kept updated. Mrs Mitchell advised that one patient involved in an incident was a Northern Trust patient and she reported that the Northern Trust were advised of this. **Agreed action: Northern Trust will be invited to future meetings.** • Mr Morton highlighted the importance of engaging with patients and their families to ensure that they are given a voice to share their experience of the care provided on the ward. Mrs Heaney acknowledged the importance of this work and noted that working with patients and families would be a key priority. Lengthy discussion followed regarding how to maximise engagement with patients and families. Mrs Mitchell provided details on current independent advocacy services available in the hospital. Mr Morton suggested that further consideration could be given in relation to how this could be developed. **Agreed Action: Further consideration to be given to how the Trust can work with patients and families.**	
9	**Communication Strategy** There was also an acknowledgement that one of the families had spoken to their MP and that if the assembly were in session concerns in relation to Muckamore may well have been tabled. The need to be prepared for media attention was also agreed. **Agreed Action: Media statements to be prepared by each organisation. Liaison between organisations to take place to agree key messages.**	
10	**Protection Plan** Mrs Heaney emphasised that the Trust will take the steps necessary to ensure patient safety. A comprehensive Director Level Governance and Improvement Structure and plans are currently being developed which will be shared at the next meeting. It was highlighted that in addition to staff being placed on precautionary suspension, there has been an increased level of scrutiny and monitoring on the wards. Miss Creaney noted that as per DHSSPS requirements, 24-hour monitoring was provided over the weekend. She stressed that this was not sustainable in the long term and that the patients on the wards, most of whom have autism, are presenting as unsettled and anxious in response to changes and increased monitoring. Miss Creaney formally thanked Mrs Rafferty and her team for working over the weekend at extremely short notice. The need for contingency plan was also discussed.	

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	Agreed Action: Miss Creaney will review current arrangements in place with Mrs Mitchell and Mrs Rafferty at meeting planned for Tuesday 31 October 2017.	
11	**SAI** Ms Cairns noted the need for an Independent SAI Panel and asked was there any further information available at this stage who the panel members would be. Miss Creaney put forward a suggestion in relation to a professional nursing representative from Queen's University. Difficulties in identifying panel members were acknowledged. Mrs Heaney was clear that the panel must constitute independent representatives. Ms Cairns asked that Mr Henry be informed of any updates.	
	Marie thanked everyone for their attendance and agreed minutes would be circulated by email. Attendees were asked to provide their email address to facilitate this. Next meeting TBC for December 2017.	

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BELFAST HEALTH & SOCIAL CARE TRUST

Strategic Multi-Agency Group Meeting in response to Safeguarding Concerns at Muckamore Abbey

STRICTLY PRIVATE AND CONFIDENTIAL

Monday th anuary 201
2.00pm in Boardroom A Floor, Trust HQ, BCH

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Present:

Mrs Marie Heaney	Director Adult, Social & Primary Care (Chairperson)
Mrs Carol Black	Personal Assistant
Miss Brenda Creaney	Director of Nursing and User Experience
Ms Claire Cairns	Co-director Corporate Risk and Governance
Ms Yvonne McKnight	Trust Adult Safeguarding Specialist
Mrs Esther Rafferty	Divisional Nurse of Learning Disability
Mrs Mairead Mitchell	Head of Learning Disability
Mr Robert Henry	Service Manager, Corporate Risk and Governance
Mr Patrick Convery	Regulation and Quality Improvement Authority
Ms Valerie McConnell	Health and Social Care Board
Ms Jacqui McIlroy	Department of Health, Social Services and Public Safety
Mr Rodney Morton	Department of Health, Social Services and Public Safety
D Inspector Scott Thompson	Police Service of Northern Ireland
Ms Pauline Cummings	Learning Disability Head of Service, Northern HSC Trust
Ms Briege Quinn	AD Nursing, Public Health Agency

Item No		*Action*
1	Introductions Marie welcomed everyone to the meeting and wished everyone a Happy New year Everyone introduced themselves Other colleagues joined the meeting at 2.12pm from the Board and the Department	
2	Review of previous meetings Mairead went through the highlights of the previous meeting were gone through to see if any changes needed to be made. Meeting held due to a number of safeguarding incidences. This will help with good information sharing. Northern Trust where not at the last meeting. Talked about communication strategy Happy with accuracy of the notes. Now signed off	

3	Matters arising Scott, advised re joint protocol P316 and P119 No investigation started By PSNI. However, the Northern Board have started by Northern Trust. They are fully aware of this • CRU • P399 case – Update will be provided • Child case – need more information about this • P109 – received update from RQIA.There are capacity issues with this girl. • P96 - a number of separates incidences under same serial no. • One of suspects, interview arranged for Friday, The punch was viewed on cctv and it was seen as a push back with the back of hand • Pulled by arm and pushed into garden • H117, interview Friday • H398, asked to volunteer himself for an interview, He has asked to speak to legal representative. However, he will be arrested if he does not present himself. • H189, gave information re techniques and training • Push on chest use of restraint board. Spoke to investigating officer today, all covered under 1 serial no. • P55 incident involving H54, H117 and H398 • All being interviewed regarding all issues at the same time. • P60, alleged to have been hit in the face, IO will seek to H927, possible witness. At present no evidence available at this time as no CCTV. • If IP declines, investigation we will still interview the person. • P5 - H54 interviewed on the 20 12 17. Police advised about ill treatment, Solicitor did not want to deal with all matters on the same day. • Suspect denied ill treatment. Awaiting more witness details. • If necessary people will be interviewed again if necessary MH how many will PPS take forward to prosecution Should all be progressed, under each of serial numbers where several incidences are under one serial number Approximately should be progressed to prosecution Timescales – number of factors, illnesses, Christmas period. Investigation officer was off ill. Changing faces, in Belfast PPU New people trying to get up to speed as well Things are progressing. Officers have other cases as well too Rhoda- complete overview of progress, breadth and depth of the Safe Guarding Investigation.	

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	Yvonne McKnight Issue with meeting with PPS, common assault and ill treatment Common assault is statute barred at 6 months so pressure there to progress things. If it has potential to become statute barred we can extend the time limits protects the potential for prosecution Most of them will not be common assault as the victims may lack to mental capacity to understand. If common assault we will protect those as well Scott left the meeting at 2.30pm Came into post on August, background in mental health Meets with the team every two weeks 2 categories Members of staff causing harm Members of staff that failed to report the incidence 12 15 2 10 17 6 incidences relating to one member of staff. All verbally reported and then written down in asp form One incident happened in patients bedroom, no cctv and therefore it won't be taken forward One man made 6 whistleblowing incidence Physical assault in the swimming pool Handled roughly a child in the back of a mini bus Took cigarettes, of a patient, no timeframe or name of patient Sexual behaviour 3 of them are screened out as we cannot find who the patient is Extensive research done to try to identify the patient concerned Whistle blower reported one of the incidences at the time to his line manager and the line manager told him not to report it. Whistle blower also advised his colleague and she did not do anything about it. Band 2 and Band 3 subject to precautionary suspension And Social Media, The use of this and historical patients named. Facebook postings stating that patients not being taken care off. Interviews have taken place but patient identified so it will be screened out. Patient on patient issues 14 single agency screened out 12 that are current includes whistle-blower 2 historical abuse, previously investigated but being reviewed again Social Media incidences Rodney – asked what does screened out means closed	

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	Have been investigated and screened out due to a number of factors, evidence, and mental capacity. Good reasoning for those cases that have been screened out. This is an important point and because of the nature of things at Muckamore everything is being looked at where there is an allegation and put those accused on restrictive duties until witnesses etc. were interviewed. Face book posts- Belfast Live- comments based on media coverage , 109 posts Were trawled through.so no ex or current staff who were involved in this. All posts were printed off. Comments such as This has been going on for years .Historical cases (30 or 40 years old) A patient name was mentioned. So we are investigating to see if we need if the person needs support. Should we contact those who have posted comments via private message Question is, is this appropriate Action: Bronagh advised that we could private message the people. Needs brought to oversight committee was discussion on whether to take this forward Six mile – No CCTV footage in the bedrooms Practice issue with what we did see. Still gathering evidence, PSNI will speak to the alleged suspect We will do our own investigation Are previous allegations being looked at as well We will review Adult Safeguarding files, 2 that allegedly caused harm, have previously had allegations made about them Mairead has asked why some of the staff weren't summarily dismissed. One of the incidences was 15 years ago. This is an outstanding piece of work. Review of decisions made by previous panels. Failure to maintain records of disciplinary cases. North and west community Trust were in charge back in 1997. SAI being conducted RHODA Protective Measures Amanda Burgess, link with the families No of staff suspended, (6) no. of staff under restrictive service Getting enhanced supervision 2 of staff NMC reported 1 member of staff with NISK Professional body No are not registered with any professional body Plan to install CCTV in wards, swimming pool and Day Care All CCTV has been preserved, Retrospective viewing of 15 min per shift, 3 shifts a day is happening Besides 12 and 15th dates, no further adult safeguarding issues 25% sample has been viewed to date 540 hours' worth of footage.	

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This will take approximately a year to view all the information
Approached Mencap
Owen Barr has suggested someone outside the Trust to view this footage. Frances cairn

Patrick asked about time scales, and being able to take things forward with PPS.
Marie advised that 1 year is a long time and needs to be accelerated.
Need timescales tightened and those who are reviewing the footage. What is the year timeline based on
Different people have different perspectives on the same footage. Need consistency need to be factual Need the right people and what instructions we give them. We need to make sure the people involved in looking at the footage is aware of the set up in Muckamore.

Need to ensure we are comprehensive so when or if this arises again that we are clear that things were done thoroughly.

CCTV has been very helpful in screening out incidences, it helps patients, staff and visitors.
Patterns, after 5pm. Always have a manager on the shift
CCTV is motion censored.
Bernie Murdoch, recently retired, have asked her to come back for some bespoke training

Rhoda has done training with ward staff
Policies are being reviewed and updated
Internal and external monitoring being done
Increased in positive behaviour support, prior to Christmas
Managed through phycology.
Policy agreed, training started, PHA gave funding
PICU
Reflective practices, taking teams out but all staff are now more amenable to this across the site. This will happen monthly for each team MDT team and domestic services as well. Domestic team very good at reporting incidences
Including domestics and estate services in safeguarding and MAPA
Keeping yourself safe programme will be rolled out at end of January February.
Carers advocate, Mencap and Bryson House
A lot relatives do not want advocacy. Your voice counts Our staff invite carers in and have some very positive feedback
6 suspended (2 in the swimming pool)
4 in PICU 1 in Six Mile are on restrictive practice
Whistle-blower is back to work tomorrow after sick leave and annual leave. Will come back on a phased return.

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	1. Agreed a template with colleagues in Northern Trust and South Eastern Trust to discuss with relatives of patients who have been through PICU and Six Mile 2. Actual patients. 3. Screen broad spectrum of staff in PICU and Six Mile HR will be updated on the investigations Disciplinary team will be agreed once terms of reference have been agreed Michael McBride will need to be involved as he is the MAPA lead to bring to bear his expertise Timescales, ideally 6 – months. Some things will be done more quickly than others, Hopefully bulk of it will be done in these timescales. Previous disconnect with the police, good opportunity to work in tandem will ensure consistency, across the piece. Does the board feel that they have been given enough information and feel informed Will attend if there is new information but don't feel the need to attend every meeting. Directors group want assurance that things are being coordinated, and challenged where appropriate. Expertise will come via Frances Curren and Owen Barr to ensure we are on track with what we are doing. It is largely a Nursing environment, should be inbuilt into their work ethic to safe guard. We want reassurance that nursing practices are in line with the code of conduct Muckamore feels more like social care rather than a hospital because of the delayed discharge Staff should need to be registered, this is across Northern Ireland. Two of those involved in this were two key members of staff and they were not obliged to be registered. Governance around this needs to be discussed. Breige – C and O, requested Mary Hinds re code of conduct, send out template e learning disability nursing practice Draft report available tomorrow, will be discussed with directors of nursing on Friday this week, agreed and will then be shared Muckamore – People should receive safe competent care. If this is not being delivered there is a need to look at Nursing Listening groups set up (30) Staff engagement Workplace issues	

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	MM has a plan arising from this. Can see a change in morale Have weekly meetings with ward managers not just about this but things moving forward. Working on this with Paula O'Kelly. Hoping to see a big change in next 6 months SAI Marie Heaney has a call this week with Margaret Flynn Margaret Flynn is on the panel Nursing Michaela Brown Dr Roy consultant physiatrist Bryce McMurray Southern Trust 6 month timescale starting in early February Patrick RQIA Contact from patients mother, able to give her a copy of recent report Dec 2016. She was very positive, issues mainly around PICU exclusion We had a whistle-blower ourselves in October, allegations about staffing levels, getting breaks long shifts 20 12 17 report written up. a lot of the issues were historical Report highlights that. Will be available next week There is a high level of skill and knowledge needed to manage the patients at Muckamore. We need highly skilled staff to work in this environment. All nursing staff should be registered. MM will be working with colleagues in central nursing, We will be asking, what is it we need regarding the staff in Muckamore Each Ward is different. Frances Curran Owen Barr will be working with Mairead Mitchell to take this forward. We need to look at the complexities on the wards and what skill mix is needed. We have very stressed staff, There are money issues that need to be talked about at another time Not enough nurses being trained We cannot discharge patients as the support networks are not there. Open University, keen to expand this, The board would be keen to expand this. 4 year plan to boost the numbers. On the job training is key AOB No other business Next Meeting, every two months early March Discuss who will attend so there is no duplication as board are being updated every two weeks. Meeting over at 3.50pm	

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BELFAST HEALTH & SOCIAL CARE TRUST

Strategic Multi-Agency Group Meeting in response to Safeguarding Concerns at Muckamore Abbey

STRICTLY PRIVATE AND CONFIDENTIAL

Monday 6th August 2018 at 12MD
Meeting Room 1, A Floor, Trust Headquarters, BCH

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Apologies:

Ms Claire Cairns	Co-director, Corporate Risk and Governance
Mrs Mairead Mitchell	Head of Learning Disability
Mr Robert Henry	Service Manager, Corporate Risk and Governance
D/Inspector Niall Collins	Police Service of Northern Ireland
Mr Rodney Morton	Department of Health, Social Services and Public Safety
Ms Marie Roulston	Department of Health, Social Services and Public Safety

Present:

Mrs Marie Heaney	Director Adult, Social & Primary Care (Chairperson)
Miss Brenda Creaney	Director of Nursing and User Experience
Ms Yvonne McKnight	Trust Adult Safeguarding Specialist
Ms Rhoda McBride	Divisional Social Worker, Learning Disability
Mrs Esther Rafferty	Divisional Nurse, Learning Disability
Ms Sarah Meekin	Lead Clinical Psychologist, Learning Disability
Mr Colin Milliken	Chair of Division, Learning Disability
Ms Brona Shaw	Nurse Manager, Governance and Patient Experience
Ms Jackie McIlroy	Department of Health, DHSSPS
Ms Joyce McKee	Health and Social Care Board
Chief Insp Jill Duffie	Regional Police Adult Safeguarding Lead, PSNI
Insp Paula Gilmore	CRU, PSNI
Ms Pauline Cummings	Learning Disability Head of Service, Northern HSC Trust
Mr Randal McHugh	Trust Adult Safeguarding Specialist Northern HSC Trust
Ms Briege Quinn	Nursing, Public Health Agency
Ms Mary Francis McManus	Nursing Office, DHSSPS
Mr Patrick Convery	Regulation and Quality Improvement Authority
Mr Alan Guthrie	Regulation and Quality Improvement Authority

In Attendance:

Miss Shauna White	Minute Taking

Item	
1	**Apologies** Apologies received and noted above.

2	**Introductions** Mrs Heaney welcomed everyone to the meeting. Introductions took place with each person present outlining their role. Mrs Heaney informed that the purpose of the meeting is under the memorandum of understanding, which provides updates from Adult Safeguarding, PSNI and other agencies and any issues that need resolved. In terms of the initial safeguarding investigation, Mrs Heaney advised that there were a number of incidents identified on CCTV relating to PICU, an incident in October 2017 in Six Mile and a series of incidents associated with the swimming pool. She noted that investigations were in process and stated that today's meeting was in relation to providing updates and highlighting additional incidents of concern and areas of work. From April 2018 historical viewing of CCTV has been ongoing. This viewing has resulted in a significant number of additional incidents being identified. As a consequence additional staff were placed on precautionary suspension and a further 10 staff are to be interviewed in relation to concerns regarding failure to report. Ms Creaney advised that the External Assurance Team (Professor Owen Barr, Frances Cannon, NIPEC and Yvonne McKnight) had been commissioned to provide a report to the Directors. She confirmed that the report has been completed and there are a number of actions to be taken forward by the Collective Leadership team and the Senior Nursing team. Ms Creaney stated that since September 2017 there have been a number of processes put in place in order to provide assurance to Trust Board and other commissioned services. Ms Creaney provided an update in relation to staffing in Muckamore and advised that this is still an area of concern. She stated that significant work had taken place to recruit more Healthcare Support Workers (HSW) and Registered Nurses. A number of HSW have taken up post. The majority of Nurses appointed are pre-registration and will not be in a position to take up post until October 2018. The Collective Leadership team have put in place arrangements to meet with staff to discuss concerns. Ms Creaney also advised that Open University attended Muckamore week commencing 30th July 2018 and carried out a risk assessment for student placements. Ms Creaney advised that she is awaiting their report.
3	**Minutes of previous meeting** The minutes of the previous meeting reviewed and agreed.
4	**Matters Arising** No items discussed under matters arising.

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5	**Update from Adult Safeguarding** Ms McBride provided an update in relation to the adult safeguarding investigation. She noted that the initial SAI was in relation to a number of incidents in PICU in August 2017, an incident in Six Mile Ward and a number of allegations associated with the swimming pool. She advised that Police investigated a number of these incidents and Police have now concluded their investigations in relation to all of the initial incidents. There are currently files with the Public Prosecution Service (PPS) in relation to two staff regarding six incidents. Ms McBride highlighted that the Trust adult safeguarding investigation had been put on hold in relation to any incidents subject to a Police investigation, as there were concerns that this may jeopardise the criminal investigation. Any incidents not being investigated by the Police were being progressed by adult safeguarding. The incidents associated with the swimming pool had been screened out by Police and therefore the Adult Safeguarding and Disciplinary investigations were able to proceed. Rhoda advised that the Adult Safeguarding and Disciplinary investigations in relation to the swimming pool incidents has concluded and a report has been provided to Mairead Mitchell, Head of Learning Disability. With regard to the historical viewing of CCTV from March 2017 onwards, Rhoda explained that the independent team viewing the CCTV have been identifying any issues which they have concerns or queries in relation to and these issues are then reviewed by the Adult Safeguarding team. Completion of historical viewing of CCTV by the independent team of viewers is anticipated by late August / early September 2018. Ms McBride reported that 49 incidents have been flagged by the CCTV viewing team and the adult safeguarding team are currently in the process of reviewing these incidents. She advised that a number of incidents have been referred to PSNI. As part of the ongoing historical CCTV viewing, a further five members of staff have been suspended on the basis that it is alleged they were involved in inappropriate physical contact; four of these are nurses and one a non-registrant. One further registrant remains on sick leave and a decision to place on precautionary suspension will be actioned if she reports for duty. In addition the charge nurse was placed on precautionary suspension. A further 10 staff are being interviewed to seek clarification in relation to appearing to have witnessed incidents and failed to act, report or escalate the concern. Ms McBride advised the Trust continue to have a number of mechanisms in place as part of an assurance framework. She stressed that protective measures are in place in response to incidents of concern identified. Yvonne advised that as part of the assurance process, any CCTV incidents of concern are being considered under adult safeguarding. Application of the adult protection threshold was discussed and Joyce McKee advised that she would have no difficulties with the Trust moving to a position of applying the higher threshold.

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	Screening Interviews Ms McBride advised that, with the help of SEHSCT and NHSCT, interviews with families of patients who had been in Six Mile and PICU from March 2017 until January 2018 had been conducted. In total 27 interviews had taken place; 30% of concerns were in relation to historical events; no current adult protection concerns were raised. One family raised concerns regarding dignity and respect and some concerns were noted including attitude of staff. Overall, the feedback received was considered positive. Patients in PICU and Six Mile wards were interviewed as part of a screening process. 42 responses were received. Again, in the main the feedback was positive and any issues identified were followed up. Screening interviews with staff were also planned. A questionnaire was developed to facilitate these interviews. Ms McBride advised that the Trade Union had intervened and objected to these planned interviews and therefore adult safeguarding were not able to proceed. It was noted that the Director on-site meetings had provided staff with an opportunity to raise concerns and some staff who had attended raised issues regarding the ongoing safeguarding processes and staffing levels. Ms McBride informed that following media interest last year, Brendan Ingram helped go through posts on Facebook and identify if any concerns related to current or past patients. Historical investigations were reviewed and are now closed.
6	**Update from PSNI** C/Insp Duffie acknowledged the Trust might have received different messages from the Police in terms of advice regarding proceeding with the adult safeguarding investigation. She clearly stated that there is no requirement for the Trust to delay its investigation and this could proceed if the Trust considered this necessary. Mrs Heaney and Ms Creaney highlighted the importance of progressing the management and adult safeguarding investigations and welcomed the Police's clearly stated position that the Trust could proceed. C/Insp Duffie highlighted that Trust investigators should ensure that staff are advised that any concerns of a criminal nature will be shared with the Police. Trust staff welcomed this position and noted that they had put the adult safeguarding and disciplinary investigations on hold because of the Police investigations. Ms Creaney highlighted the role of professional bodies and advised that a number of referrals have been made to the NMC. She advised that NMC plan to hold initial hearings on Friday. Again, C/Insp Duffie advised that if these need to happen then they should proceed. C/Insp Duffie informed that there are expert MAPA trained staff within PSNI who are reviewing the CCTV and this will help inform the Police decision in relation to which incidents will progress to a Police investigation. Police will screen information received from the Trust, along with CCTV footage and determine whether incidents will be progressed to a full investigation. C/Insp Duffie advised that some of the incidents may not meet a criminal threshold

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and will therefore be matters for the Trust in terms of adult safeguarding and/or disciplinary.

Insp Gilmore advised that PSNI have set up a dedicated team of four Officers (D/C Chris Williams, D/C Charlene Allen, D/S Keith Mills and D/I Niall Collins) to oversee any CCTV footage to be viewed. She further advised that Joanna Lowry is the nominated PSNI Officer within CRU who will respond to any AJP forms being submitted by the Trust in relation to Muckamore. Insp Niall Collins will take the lead role in relation to the Police investigations being conducted.

C/Insp Duffie advised that to date 72 reports have been brought to Police attention and that 19 of these were closed at the point of referral, as they did not meet a criminal threshold. She advised that a number of others had been screened out following initial information gathering and there are a number of others yet to be looked at. Belfast Trust Adult Safeguarding have reported the majority of incidents to the Police to be screened/triaged. C/Insp Duffie considered this reasonable given the level of concerns in relation to Muckamore. Police recognise the importance of their role in determining whether cases meet a criminal threshold and/or whether cases proceed to a full Police investigation. Potential offences in relation to common assault are statute barred and therefore historical incidents identified via CCTV will not be able to go forward for consideration under this offence. It was noted that a number of incidents, which may in the first instance be perceived as not meeting a criminal threshold, could potentially meet Article 121 of the Mental Health Order if they relate to a pattern of incidents in relation to the same staff member. Discussion took place regarding Article 121 of the Mental Health Order. A meeting with the Public Prosecution Service is due to take place on 8 August 2018.

Action: *Mrs Heaney and Ms Creaney advised they will be attending the meeting planned with PPS.*

The viewing of CCTV was discussed during the meeting. Mrs Heaney highlighted the importance of having clear protocols in place regarding viewing of CCTV and clearly defined Terms of Reference.

Action: *Ms McBride to ask Mrs Mitchell to forward details of the current Protocols and arrangements in place for viewing of historical CCTV.*

Insp Gilmore advised that the PSNI have received Freedom of Information requests in relation to Muckamore. The importance of good inter agency communication strategy was noted.

Mrs Heaney thanked C/Insp Duffie and Insp Gilmore for their update.

7 Update re Serious Adverse Incident Review

Mrs Heaney advised that the SAI draft report with appendices had been submitted with a request from the Chair that the Trust review the report in terms of a factual accuracy check. Mrs Heaney informed she was unable to comment further at this stage and that once the report has been signed off by Trust Board it will be sent to the HSCB Designated Risk Officer (DRO).

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Ms Cummings enquired whether the report would be shared with NHSCT. It was advised that the final report will be shared once approved by the HSCB DRO. Ms McKee (DRO) asked if the report could be submitted as soon as possible and preferably in advance of the HSCB Steering Group meeting at end of August 2018. In terms of process, it was agreed that following factual accuracy checks, the draft report would be shared with Trust Board and then forwarded to Ms McKee and Ms Quinn. It would be reviewed by DRO and then be submitted to HSCB Steering Group for final approval.

Mr Convery requested a copy of the draft SAI report. Ms McKnight stated she had thought RQIA had already been provided with an opportunity for comment in relation to the Inspection briefing paper. Mr Convery stated they had only limited access and requested a copy of the full draft report.

Action: *Mrs Heaney to share SAI report with RQIA colleagues.*

Discussion took place in relation to a communication strategy and coordinated approach to the sharing of the SAI report. The importance of working with the Trust and other media departments was acknowledged. Ms Meekin highlighted the need for this process to be handled sensitively and in a coordinated way.

Ms Cummings queried whether there would be a further SAI given the additional concerns. Mrs Heaney advised it is Belfast Trust's view that this will not be required as plans for the historical viewing were part of the original SAI. She emphasised that there are a number of processes in place for managing these additional concerns.

Ms McManus queried if there has been additional supports put in place for staff. Ms Meekin advised that staff morale is extremely low at present and she confirmed that meetings with staff have taken place and that a counselling service for staff has been set up. She also acknowledged the anger and trust issues for families and Mrs Heaney stressed the importance of putting patients and families at the centre of decision making in terms of looking to future arrangements.

Mrs Heaney advised that she has had some discussion with the other Trusts in relation to service provision going forward as there is a need to consider provision of care for Learning Disability at a regional level. A potential workshop to look at the findings of the SAI and the provision of future care for those with learning disability was discussed. Ms McKee indicated that HSCB would wish to engage with Ms Flynn in terms of future strategic planning and the roll out of key messages from the SAI Report. Mrs Heaney indicated that she would be meeting with Ms Flynn, as the Belfast Trust need to consider carefully the report findings and if any immediate steps need to be taken.

8	**AOB** Ms McIlroy queried if Belfast Trust will continue to provide monthly updates to DHSSPS as these updates have been very useful. Mrs Heaney confirmed that this would continue to happen. Mr Convery highlighted that the minutes attached to the diary invite were not password protected and even though they were marked confidential, they could be accessible to other staff who can view diary. Mrs Heaney reminded Miss White of the importance of this and agreed this would be rectified for sending further information.

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Reference No: TP 91/14

Title:	**Risk Register Production and Management Guidance**			
Author(s)	Claire R Cairns, Co-Director Risk and Governance, Tel: 028 95 040114 claire.cairns@belfasttrust.hscni.net Gillian Moore, Administration and Datix Manager, Corporate Governance, Tel: 028 95 048757 gillianm.moore@belfasttrust.hscni.net			
Ownership:	Dr Chris Hagan, Interim Medical Director			
Approval by:	Trust Policy Committee Executive Team Meeting		**Approval date:**	06 February 2020 12 February 2020
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Version No.	3	**Supercedes**	V2 – August 2016 – May 2019	
Key words:	Risk management			
Links to other policies	BHSCT Risk Management Strategy (2019) TP 58/08 BHSCT Adverse Incident Reporting and Management Policy (2018) TP 08/08 BHSCT General Health and Safety Policy (2018) TP 50/08 BHSCT Board Assurance Framework BHSCT Risk Assessment Guidance			

Date	**Version**	**Author**	**Comments**
June 2014	1.0		Final version issued
June 2016	1.1	C McMullan G Moore	Corporate Governance review
August 2019	2		Final version issued
May 2019	2.1	G Moore	Corporate Governance Review

1.0 INTRODUCTION / PURPOSE OF GUIDANCE

1.1 Background

This document is intended to support the Trust Risk Management Strategy, providing operational guidance on the production and management of risk registers at all levels in the organisation.

1.2 Purpose

It is vital that staff with management responsibilities at all levels in the organisation have clear guidance on how to produce and maintain a risk register ensuring that identified risks are effectively monitored to provide assurance regarding their management, thus supporting the Trust to do its reasonable best to protect service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings.

This guidance document supports the Risk Management Strategy, and links with the Adverse Incident Policy and Procedures, the Board Assurance Framework and the General Health and Safety Policy and Risk Assessment Guidance.

1.3 Objectives

- Support staff in understanding the various sources for risk identification
- Provide clarification on how to apply the risk evaluation system to identified risks
- Provide clarification in relation to appropriate monitoring and review of risk registers at all levels of the organisation.
- Provide clarification for the management of escalation, de-escalation and acceptance of risk
- Assist staff in allocating risks to appropriate corporate objectives

2.0 SCOPE OF THE GUIDANCE

This guidance applies to all staff with management responsibilities for delivery of a service or services at all levels of the organisation.

3.0 ROLES/RESPONSIBILITIES

All clinicians, managers and co-directors must ensure that all activities within their area of responsibility are assessed for risk and that any identified risk is eliminated or controlled. Where this is not possible they must ensure that the director is advised. It is a requirement that each directorate produces and maintains risk registers and action plans, to address identified risks. The 'Datixweb for Risks' system is used to maintain risk registers. Areas not yet using Datixweb should contact Corporate Governance for access to the system and arrange appropriate training.

Managers must ensure the implementation and monitoring of local risk action plans.

Managers are also responsible for ensuring that staff are adequately informed and trained in order to undertake their duties effectively and safely. Managers must ensure that the procedures for adverse incident reporting are adhered to.

Chief Executive

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 Chief Executive:

- will ensure that responsibilities for the management and co-ordination of risk are clear and that the structure for risk management outlined in this document is implemented; and

- has delegated responsibility for the strategic development and operation of clinical and social care governance and risk management arrangements to the Medical Director. However, in order to discharge the responsibilities of Accounting Officer the Chief Executive will ensure that risk management features regularly on the Trust's operational and Trust Board agendas and will discuss issues and progress with the Medical Director.

Directors

Directors require assurance of appropriate management of all identified risks within their Directorate; however the role of **'Overall Lead'** as described on the Datixweb risk form and in Section 4 below, can be delegated to Co-Directors, Committee chairs within the Assurance Framework or Service Managers depending on the evaluated risk level (see Appendix 1).
Any risk identified as Extreme (red) must be escalated to the relevant Director via Directorate processes and an immediate investigation instigated with an action plan agreed to eliminate/ reduce/control the risk. The Director will remain identified as Overall Lead for all Extreme risks within their Directorate.

All Extreme risks should be considered against the Corporate Risk criteria outlined in Section 4.0. Directors are responsible for confirming inclusion on the Corporate Risk Register via the Directorate Governance and Quality Service Manager

Committee Chairs within the Assurance Framework

On occasion risks can be identified via the committee structure within the Board Assurance framework. It may be appropriate that the chair of a key committee will be identified as Overall Lead. In such instances they will ensure an appropriate risk lead is identified and an investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Collective Leadership Team

Senior collective leadership teams are collectively accountable to the Director across all aspects of the corporate objectives in their Division.

Co-Directors

Co-Directors may be identified as **Overall Lead** for risks evaluated as High (amber) or below. As Overall Lead they will ensure a Risk Lead is identified and an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing and regular monitoring of the risk until such times as it is closed. Co-Directors may also be identified as the **Risk Lead** as described on the Datixweb risk form and in Section 4 below.

Depending on the nature of the risk and the criteria as described in section 4.0 the Co-Director may consider a risk evaluated as High (amber) requires inclusion on the corporate risk register. Inclusion must be approved by the Director.

Service Managers

Service Managers may be identified as Overall Lead for risks evaluated as Medium (yellow) or below. As Overall Lead they will ensure a Risk Lead is identified to ensure an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk. They will oversee ongoing monitoring and management of the risk until such times as it is closed.

Service Managers - Governance and Quality

Within their own areas, and collectively, these managers must ensure that the systems necessary for effective risk management are implemented and maintained at all levels of the Belfast HSC Trust. They are responsible for liaising with Directorate staff in relation to population and maintenance of risk registers using the Datix risk management system and work closely with their Director to ensure appropriate approval of risks for inclusion on the corporate risk register. They will also act as a resource for expert advice.

4.0 KEY GUIDANCE PRINCIPLES

DEFINITIONS

4.1 Corporate Risk

A corporate risk can be of any grade but is only included on the corporate risk register once approved as meeting specific criteria by a Director as follows:

1. Has been evaluated as 'Almost certain' x 'Catastrophic'(25)

Is evaluated as below 25 but:

2. The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
3. The risk or concern cannot be satisfactorily managed within the immediate area of control;
4. The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

Although described as 'corporate', ownership of the risk still lies with the appropriate Director.

Corporate risks will be monitored four times a year at Board level by the Assurance Committee. These may form part of the Assurance Framework Principal Risks and Control document.

Operational Risk

An operational risk will be below 25 (Catastrophic x Almost Certain) but can be of any grade including extreme (red), but has been deemed by the Director as being appropriately managed at operational level and therefore not required for inclusion on the corporate register.

These risks may be managed at Ward / Facility / Specialty / Service Area or Directorate level.

Operational risks evaluated as Extreme (red) or High (amber) must be closely monitored and reviewed no less than four times a year at Directorate level.

Overall Lead

Director / Co-Director / Manager with overall responsibility for the area within which the risk has been identified. They must ensure that an appropriate risk lead is identified.

Risk Lead

Manager with lead responsibility for the risk. They must ensure that an appropriate investigation is instigated with an action plan agreed to eliminate/ reduce/control the risk, and must oversee ongoing monitoring and management of the risk until such times as it is closed. This may be the same person as the overall lead.

Residual Risk

The level of risk that is likely to remain once all proposed actions have been implemented.

Risk Register
A risk management tool which acts as a central repository for all risks identified by the Directorate / Service Area / Specialty / Ward / Facility.

Risk Appetite
Some risks are unavoidable and it is not always within the organisation ability to manage to a tolerable level such as risk arising from extreme weather. In these circumstances the organisation will ensure appropriate contingency plans are established to minimise any potential impact of a risk maturing.

Risk appetite is expressed by a series of boundaries appropriately authorised by management giving clear guidance on the limits of risk and at what level in the organisation these can be managed (see Appendix 1 for detail).

Risk Tolerance/ Acceptance
The willingness to live with a risk, but with the confidence that it is being properly controlled. The risk must still be reviewed at least annually with the aim of reducing further risk.

It is often hard to judge the level of risk that can be tolerated. This is because the risk is balanced against the benefit and whether there is a better alternative to accepting the risk. It is reasonable to accept a level of risk if the risk from all the other alternatives, including doing nothing, is even greater. A risk is not acceptable if there is a reasonable alternative that offers the same benefit but avoids the risk. Acceptable risk may become unacceptable over time or because circumstances change.

4.2 Identifying a Risk

Managers and staff at all levels must proactively identify hazards and potential risks to meeting objectives. These may relate to patient and client safety and wellbeing, quality of service, staff wellbeing, financial resources, targets / standards and reputation.

Risk can be identified from a number of information sources and by using various tools and techniques.

Information sources include adverse incidents, complaints, claims, risk assessments, staff absenteeism records, concerns raised, team meetings / workshops, internal and external audits/ inspections.

Practical methods and tools for identifying risks include group workshops, individual interviews, observation and review of data / records. Risks may be identified and analysed by an individual, however a group or team approach is recommended in order to provide challenge and discussion leading to a well-defined and analysed risk.

4.3 Risk Description

The risk description should be clear and concise, whilst still providing enough detail for it to be clearly understood. Each risk issue should be kept separate. If the risk is not clearly defined, appropriate controls, current grading and actions may not be forthcoming.

If a problem has materialised such as not achieving standards or having enough resource to deliver a service, this has now happened (real and current), as the management team are already managing a live situation. This is not to say there is no risk associated with the situation, but it is important to identify and describe the risk accurately, i.e. non-compliance with a standard is not a risk, rather the impact of the non-compliance is a risk, and this impact is what must be described. In other words, the risk description should state both **cause** and **effect**.

4.4 Linking a Risk to a Corporate Theme / Objective

The organisation has identified five key themes as follows:

- Safety, Quality and Experience
- Service Delivery
- People and Culture
- Strategy and Partnerships
- Resources

There are a number of corporate objectives associated with each of these themes (see Appendix 2). These should be considered for each risk in terms of the impact of the risk on the themes and associated objectives. One or more themes should then be applied to the risk.

4.5 Allocating overall lead and risk lead – different roles

The risk grade will determine how the overall lead and risk lead are allocated (see Section 3.0 Role/Responsibilities and section 4.0 Definitions). Overall lead and risk lead can be the same person.

4.6 Identifying Current Controls

Controls are existing processes, policies, devices, practices or other actions which act to minimise risk.

Some controls are stronger than others. For example, physical measures and additional staffing are stronger controls than procedures and training. When identifying current controls, their strengths and weaknesses should also be considered and taken into account when scoring / grading the risk.

4.7 Analysing and evaluating the risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix at Appendix 1

The tables and matrix are used to score / grade both the current risk and the residual risk.

The risk should be scored / graded taking into account all the controls already in place.

4.8 Proposed actions

Proposed actions are those actions which will be implemented to eliminate, reduce or control the risk. Some actions, like controls, are stronger than others and this should be considered when identifying actions. They should be explicit, timebound and deliverable. Avoid actions such as 'remind staff', 'promote awareness' but if they have to be used, explain how this will be done.
All proposed actions should have an expected date of completion recorded against them.

See tables 4, 5 and 6 in Appendix 1 for who is responsible for remedial action and the associated timescales.

4.9 Use of action plans

Generally, use of the risk register module on Datixweb will allow monitoring and review of actions adequately. However certain complex risks may benefit from separate action plans. Review and update of action plans should take place alongside review of the risks themselves and can be attached to the risk on Datixweb.

4.10 Ensuring appropriate and regular review and update

All risks require ongoing monitoring and review to ensure effective management. This also applies if the risk is accepted, as such risks may become unacceptable over time or because circumstances change. It is therefore essential that all open risks are regularly reviewed.

Extreme (red) risks must be reviewed at least four times a year, high (amber) risks twice to four times a year, while medium (yellow), low (green) or accepted risks may be reviewed less frequently. See table 5 in Appendix 1 for guidance. The review date of risks should be checked regularly to ensure that dates have not passed.

Corporate risks will also be reviewed four times a year by the Risk Register Review Group.

Review of risks should include careful consideration of whether proposed actions have been implemented. If so, and where applicable, these actions should be considered current controls and transferred accordingly. The risk grading should then be reassessed.

4.11 When a risk needs upgraded or escalated to a Corporate Risk

The circumstances surrounding a risk may change, requiring it to be amended and re-scored. In accordance with Directorate processes, the Director / Co-Director / Quality and Governance Manager must be notified if a previously medium (yellow) or low (green) risk is amended to become high (amber) or extreme (red).

If circumstances surrounding the risk change so that any of the following criteria are met, the Director must be notified and approval sought for inclusion on the Corporate Risk Register:

1. Has been evaluated as ‘Almost certain’ x ‘Catastrophic’(25)

Is evaluated as below 25 but:

2. The risk or concern has ramifications beyond the immediate area of clinical or managerial control;
3. The risk or concern cannot be satisfactorily managed within the immediate area of control because of a lack of resource or authority;
4. The risk requires escalation to another HSC body due to its significance or the need for commissioner involvement.

4.12 When a risk can be downgraded or de-escalated

Where actions have been implemented and controls improved, it is expected that risks will be amended and re-scored to a lower grade.

Where these actions and controls have resulted in a corporate risk no longer meeting the criteria outlined in section 4.10, the Director may approve de-escalation of a risk from corporate to operational. This should be managed via Directorate processes and noted on the risk record on Datixweb and also at the Risk Register Review Group.

4.13 Closing a risk

A risk should only be closed when all proposed actions have been implemented to good effect and the risk no longer exists. The date should be entered in the ‘Closed date’ field against the risk and a progress note recorded which outlines the reasons for closure. Closed risks should be excluded from risk register reports.

4.14 Accepting a risk

Where a risk has been accepted (i.e. it has been agreed to live with the risk as long as it is properly controlled) the risk should still be added to the risk register and reviewed as required, at least annually.

The exception to this may be where medium (yellow) or low (green) risks have been identified as the result of a general risk assessment. Having appropriate risk assessments which are reviewed in line with policy will be sufficient to manage these risks at departmental level.

These risks need only be added to the risk register if:

- there are further actions required to adequately control the risk and which need to be closely monitored to ensure timely progress, or
- the risk meets the criteria for inclusion on the Corporate Risk Register

4.15 Removing a Risk

Risks can only be removed from Datixweb by a system administrator. Staff should contact the Corporate Governance department if they require a risk to be removed. Corporate Governance will change the status of the risk to 'Rejected'. This retains the risk on the system however it is only viewable by Corporate Governance.

4.16 Training/Advice

Each Directorate has a Governance and Quality Manager, or equivalent, and a partnered Health and Safety Manager who are available as sources of expert advice.
Other related training courses include, for example, general risk assessment and adverse incident reporting. Datixweb for Risks training is also provided by the Corporate Governance Dept and must be completed by any member of staff registered as a full user.

4.17 Helpful reading

See Section 7.0

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Responsibility of Service Directorates

6.0 MONITORING

The effectiveness of this procedure will be monitored by liaison between Corporate Governance and Directorate Governance and Quality Senior

Managers. It will be formally reviewed every 5 years or in the event of changes in guidance.

7.0 EVIDENCE BASE / REFERENCES

- A Risk Matrix for Risk Managers Jan 2008 – National Patient Safety Agency
- BSI IS0 31000: 2018
- Making it Happen – A Guide for Risk Managers on How to Populate a Risk Register, Risk Register Working Group
- WHSCT Risk Management Strategy and Procedure for the Production of Risk Registers
- Escalation of risk within and between Health and Social Care Organisations, Nov 2011, DHSSPS
- BRAAT (Belfast Risk Audit and Assessment Tool)

8.0 CONSULTATION PROCESS

Circulated to Directorate Governance and Quality Senior Managers for consultation.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Analysing and Evaluating the Risk
Appendix 2 – Corporate Themes and Objectives

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The

guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_______________________________ Date: 12 February 2020

Chris Hagan
Interim Medical Director

_______________________________ Date: 12 February 2020

____

Cathy Jack
Chief Executive

Appendix 1

Analysing and Evaluating the Risk

Risks are analysed and evaluated using the consequence and likelihood tables and the risk matrix, Tables 1-3 of this appendix:

- **Step 1**
Using table 1, choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in the same row to assess the most probable potential consequence. If the risk could impact upon more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

- **Step 2**
Using table 2, determine the likelihood of the risk occurring. The frequency is the most appropriate column to use in most circumstances however the time framed descriptions of frequency or the probability columns can be used instead if considered more appropriate.

- **Step 3**
Calculate the risk rating by multiplying the consequence and likelihood scores (scale of 1 to 25) and plot the scores on the risk matrix (table 3) to determine the risk grade – low, medium, high or extreme.

  Please note that the risk matrix (table 3) is replicated on Datixweb. Users simply click once in the matrix to enter the risk grade

The tables and matrix are used to score / grade both the current risk and the residual risk.

Table 1

BHSCT Impact Table

DOMAIN	SEVERITY / CONSEQUENCE LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspec ion – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ na ional standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Cri ical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecu ion – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisa ion - absorbed with significant formal intervention wi h other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Table 2

Risk Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

BHSCT RISK MATRIX

Table 3

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	Medium	Medium	High	Extreme	Extreme
Likely (4)	Low	Medium	Medium	High	Extreme
Possible (3)	Low	Low	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

Table 4

Risk Colour	Remedial Action	Decision to Accept Risk	Risk Register Level
Green	Ward/Dept Manager	Ward/Dept Manager	Operational
Yellow	Local Manager	Service Manager/Co Director	Operational
Amber	Service Manager	Director	Operational / corporate if meets specific criteria
Red	Director	Assurance Group	Operational / corporate if meets specific criteria

Table 5

Risk Level	Timescale for Action	Timescale for Review
Red- Extreme	Action immediately	Review within 3 months
Amber – High	Action within 1 month	Review within 3- 6 months
Yellow – Medium	Action within 3 months	Review within 9 months
Green – Low	Action within 12 months/accept risk	Review controls within 12 months

Table 6

- **Issues falling in Red boxes are prioritised as EXTREME RISK. They must be referred to the Directorate Director and an immediate investigation instigated and an action plan agreed to eliminate/reduce/control risk. Corporate Governance must be informed of all extreme risks. The risk will be added to the Directorate/Service Area/ Specialty Risk Register and considered for inclusion on the Corporate risk register by the relevant Director.**
- **Issues falling in AMBER boxes are prioritised as HIGH RISK. Senior management i.e., Directorate Director and Co-Director must be involved in determining the level of investigation required and the subsequent action plan to eliminate/reduce/control risk. Control mechanisms must be regularly reviewed. The risk will be recorded on the Directorate/Service Area/Specialty risk register and if meeting one or more of the specified criteria also the corporate risk register for monitoring by the Assurance Group.**
- **Issues falling in YELLOW boxes are prioritised as MEDIUM RISK. Management action must be specified at departmental/local level. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**
- **Issues in GREEN boxes represent LOW RISK and it is likely that nothing further can be done to eliminate/reduce/control risk further. If any action is possible to eliminate the risk of recurrence then this should be implemented. A low risk of recurrence may remain and this is deemed acceptable. These risks will be added to Directorate / Service Area/ Specialty risk registers for monitoring and review unless already monitored via the general risk assessment process.**

Appendix2

Objectives Summary for Belfast Trust Corporate Management Plan 2018-21

Our vision is to be one of the safest, most effective and compassionate health and social care organisations

Corporate Themes	Safety, Quality & Experience	Service Delivery	People & Culture	Strategy & Partnerships	Resources	Expected Outcomes
What this means	Work with service users and carers to continuously improve Safety, Quality and Experience for those who access and deliver our services.	Drive improved performance against agreed goals and outcomes in partnership with our service users and carers, staff and partners in the community and voluntary sectors.	Support a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams.	Innovate and develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors.	Work together to make the best use of available resources and reduce variation in care for the benefit of those we serve.	
Corporate Objectives	1. We will seek, listen and respond to service user and carer experience, including real-time feedback in order to inform and develop our services. 2. We will make our services safer and achieve agreed improvements across our safety improvement measures. 3. With our partners, we will encourage our population to play an active role in their own health and wellbeing. 4. We will support people with chronic and long term conditions to live at home, supported by carers, families and their communities. 5. We will optimise the opportunities for young adult care leavers through education, training and employment. 6. We will further develop safeguarding services in partnership with service users, parents, carers, communities and other agencies to enhance safety and welfare of vulnerable adults and children. 7. We will improve community support to enable more timely discharge for older people and those with chronic conditions. 8. We will deliver agreed improvements for our unscheduled care patients and develop services to avoid unnecessary admission. 9. We will deliver agreed elective care improvement each year, including acute, mental health and cancer services. 10. We will increase staff engagement in order to improve the delivery of safe, effective and compassionate care. 11. We will work with partners to innovate and to develop strategies to transform health and social care in partnership with our service users and carers, staff and partners in the community and voluntary sectors. 12. We will build a sustainable workforce, deploy our resources in an effective and efficient manner, invest in infrastructure which is fit for service delivery and achieve financial balance.						Improved service user and carer experience Improved service safety & quality Improved access to community & social care services Improved access to unscheduled care Improved access to elective care Improved staff engagement Improved use of resources

respect & dignity · openness & trust · leading edge · learning & development · accountability

ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	**External Reports / Reviews Group**
PURPOSE	• To review external reports (including social care) following inspection by statutory and professional bodies e.g. RQIA and NIMDTA. • To monitor the implementation of actions for the Trust as outlined in the reports. • To review the outcomes of all RQIA Thematic Reviews and report on progress against action plans. • To review the outcomes of all NIMDTA reviews. • To quality assure responses to the HSCB, PHA and other agencies. • To facilitate the integration of all External Reports and RQIA Thematic Review recommendations into management planning and performance management within the Trust.
MEMBERSHIP	**Chair:** Medical Director **Co-Director/Senior Manager from the following Directorate Services:** Unscheduled and Acute Care Surgery and Specialist Services Specialist Hospitals and Women's Health Children's Community Services Adult Social and Primary Care Services Nursing and User Experience Medical Director's Group Performance, Planning & Informatics Human Resources Head of Pharmacy Services Allied Health Professionals *Representation from Directorate specialist affiliates in line with on-going reviews will be invited to attend meetings as and when required. **Support** Mrs Mary Carey, Senior Manager, Risk and Governance

DUTIES	• To ensure that all recommendations and actions from External Reports and Thematic Reviews are being taken forward by the Trust in adherence to agreed timeframes. • To identify areas of risk and address these in support of Directorates. Members are responsible for bringing forward other reports that have cross cutting issues across the Directorates. • To address any issues arising which relate to implementation of recommendations and completion of action plans. • To provide regular assurance reports to the Learning from Experience Steering Group.
EXCLUSIONS	The remit of the group does not include the review of SAIs, Licences, HTA or other external reports which are being addressed through other streams of the Assurance Framework.
AUTHORITY	The committee operates under the authority of the Medical Director.
MEETINGS	• **Quorum –** A quorum is the minimum number of members of a committee necessary to conduct business and especially to make binding decisions. A quorum will be defined as a majority of the committee i.e. half the membership plus one member. Documents for approval will be circulated electronically in advance of the meeting. In the event that a member cannot attend, they can advise of their comments/issues by communication with the author or committee administration in advance of the meeting. • **Frequency of Meetings -** The Committee will meet quarterly. • **Papers** - Minutes will be circulated to committee members within 10 days after the meetings and will detail action points and responsibilities.
REPORTING	The External Reports / Reviews Group is directly accountable to the Learning from Experience Steering Group for its performance in exercising the functions set out in these terms of reference. The External Reports / Reviews Group, through its Chair and members will work closely with Directorates to ensure that the Trust meets its responsibilities in complying with the recommendations outlined in External Reports and RQIA Thematic Reviews. In doing so, the External Reports / Reviews Group shall facilitate the integration of all External Report and RQIA Thematic Review recommendations into management planning and performance management within the Trust.

	The External Reports / Reviews Group Chair shall: • Report formally, regularly and on a timely basis to the Learning from Experience Steering Group on the group's activities. • Bring to the Learning from Experience Steering Group's specific attention any significant matter under consideration from the External Reports Review Group.
CONFLICT/ DECLARATION OF INTEREST	Under the responsibilities will come a requirement for committee members, co-opted members and members of working groups to declare personal or commercial interests that may conflict with the impartial working of the committee when making decisions.
REVIEW	**October 2015**

TERMS OF REFERENCE

NAME	External Reports Review Group
PURPOSE	*Our Current Trust Vision* *'To be one of the safest, most effective and compassionate health and social care organisations'* Working together Excellence Openness & Honesty Compassion • To review external reports following Thematic reviews by RQIA • To review other external bodies as requested by the Directors where cross Trust issues have been identified as part of the outcomes of the inspection. • To monitor the implementation of actions for the Trust as outlined in the above reports. • To oversee the timely completion of action plans, taking into consideration delays and how to support them • To facilitate the integration of all RQIA Thematic Review recommendations into management planning and performance management within the Trust.
DUTIES	• To ensure that all recommendations and actions from External Reports and Thematic Reviews are being taken forward by the Trust in adherence to agreed timeframes. • To identify areas of risk and address these in support of Directorates. Members are responsible for bringing forward other reports that have cross cutting issues across the Directorates. • To address any issues arising which relate to implementation of recommendations and completion of action plans. • To provide regular assurance reports to the Learning from Experience Steering Group.
AUTHORITY	The committee operates under the authority of the Medical Director.
REPORTING	The External Reports Review Group is directly accountable to the Learning from Experience Steering Group for its performance in exercising the functions set out in these terms of reference.

	The External Reports Review Group, through its Chair and members will work closely with Directorates to ensure that the Trust meets its responsibilities in complying with the recommendations outlined in External Reports and RQIA Thematic Reviews. In doing so, the External Reports Review Group shall facilitate the integration of all External Report and RQIA Thematic Review recommendations into management planning and performance management within the Trust. The External Reports Review Group Chair shall: • Report formally, regularly and on a timely basis to the Learning from Experience Steering Group on the group's activities. • Bring to the Learning from Experience Steering Group's specific attention any significant matter under consideration from the External Reports Review Group.
LEAD RESPONSIBILITY	Dr Cathy Jack
MEMBERSHIP	**Chair:** Medical Director **Co-Director/ Senior Manager from the following Directorate Services:** Medical Director (chair) Director of Medical Education Nominated Professional Director Nominated Service Director Co-Director Risk and Governance Co-Director Performance Management Senior Manager Corporate Risk and Standards Senior Manager Emergency Planning & RQIA *Co-Directors from Directorates will be asked to report on progress against all RQIA action plans for their directorate. **Support** Admin – EP/RQIA
MEETINGS	• **Quorum –** A quorum is the minimum number of members of a committee necessary to conduct business and especially to make binding decisions. A quorum will be defined as all committee members being present. Directors are responsible for ensuring that Co-Directors responsible for overseeing completion of Directorate action plans attends the meeting at their scheduled time. • In the event that the Co-Director cannot attend, they should nominate a representative to attend in their place and advise them of their comments/issues in advance of the meeting. • **Frequency of Meetings -** The Committee will bi-annually (March

	and September) • **Papers -** Minutes will be circulated to committee members 10 days before the meetings and will detail action points and responsibilities.
CONFLICT/ DECLARATION OF INTEREST	Under the responsibilities will come a requirement for committee members, co-opted members and members of working groups to declare personal or commercial interests that may conflict with the impartial working of committee when making decisions.
EXCLUSIONS	• The remit of the group does not include the review of SAI's, Licences, HTA, NIMDTA or other external reports which are being addressed through other streams of the Assurance Framework.
REVIEW	September 2020
OUTPUT	Reports into Assurance Group as per Assurance Framework quarterly. This group provides an update on progress of Thematic Reviews and reporting timelines to Department of Health

TERMS OF REFERENCE

NAME	**External Reports Review Group (ERRG)**
PURPOSE	Our Current Trust Vision *"To be one of the safest, most effective and compassionate health and social care organisations'* Working together Excellence Openness & Honesty Compassion As a group within the Integrated Governance and Assurance Framework (the Framework), the purpose of the External Reports and Review Group (ERRG) is to provide assurance to the Clinical and Social Care Governance Steering group around RQIA **Acute Hospital** Thematic Review process's and to integrate Directorate Specific recommendations into Management Planning and Performance within Belfast Trust. This group has been constituted by the Clinical and Social Care Governance Steering group and it is expected that the EERG ensure and promotes: - Working to continuously improve safety, quality and experience - Supporting a culture of safe, effective and compassionate care through a network of skilled and engaged people and teams - Working with partners, where appropriate, to innovate and to develop strategies to transform health and social care - Improving performance against agreed goals and target outcomes in partnership with RQIA and other external agencies when required. - Making best use of available resources and reducing variation in care for the benefit of those we serve The following **Acute Hospitals** within Belfast Trust are subject to RQIA Thematic Review process are: Royal Victoria Hospital Royal Belfast Hospital for Sick Children Musgrave Park Hospital Mater Hospital Belfast City Hospital

DUTIES	The EERG, when providing advice to the Clinical and Social Care Governance Steering group, will ensure the effectiveness by: • Ensuring that it meets the responsibilities as outlined in its Terms of Reference. • Supporting the identification, review, and escalation of risks associated with the work of ERRG. • Providing quarterly assurance updates to the Clinical and Social Care Governance Steering group, escalating key issues and risks that require further consideration to allow scrutiny of ongoing Trust assurance arrangements. • Reviewing any audit activities related to the individual functions of the services reporting into EERG. • Identifying assurance sources to be utilised by each service, using lines 1, 2 and 3 assurance, as per the Integrated Governance and Assurance Framework. • Overseeing service work streams, considering external/commissioned reports, findings and recommendations, and seeking assurance as appropriate. • Monitoring and holding to account through the submission of the quarterly assurance update and formal reports, ensuring that a central repository is maintained.
AUTHORITY	ERRG is authorised by the Clinical and Social Care Governance Steering Group to investigate or have investigated any activity within its Terms of Reference. In doing so, ERRG shall have the right to inspect records or documents of the Trust relevant to the group's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any: • Employee (and all employees are directed to co-operate with any reasonable request made by the group or its members in the process of gather evidence to support the self-assessment process) • Other Committees or groups established within the Assurance Framework to assist in the delivery of its functions.
REPORTING	The External Reports Review Group is directly accountable to the Clinical and Social Care Governance Steering Group for its performance in exercising the functions set out in these terms of reference. The ERRG, through its Chair and members will work closely with Directorates to ensure that the Trust meets its responsibilities in complying with the recommendations outlined in External Reports and RQIA Thematic Reviews.

<table>
<tr><td></td><td>The Chair of the ERRG shall:
Report formally, regularly and on a timely basis to the Clinical and Social Care Governance Steering Group. This includes verbal updates on activity, the submission of minutes and written reports.
Bring to the Clinical and Social Care Governance Steering Group's specific attention any significant matter in relation to the Organisational Assurance process.
Ensure appropriate escalation arrangements are in place to alert the Executive Team or Chairs of other relevant Committees, of any urgent/critical matters that may compromise patient/client care and affect the operation and/or reputation of the Trust.
The Risk and Governance team shall seek and oversee the submission of an assurance update from lead assessors in advance of the Committee Meeting. This assurance update should identify:
Key issues and concerns, and actions taken to address them.
Risks that require escalation: are they being managed effectively, on a risk register or linked to the Board Assurance Framework risk document?
Efficacy of controls and assurance in relation to issues/risks/concerns
Items that require escalation to Clinical and Social Care Governance Steering Group
Provide assurances around service improvements relating to the activities of each service.</td></tr>
<tr><td>LEAD RESPONSIBILITY</td><td>Medical Director</td></tr>
</table>

<table>
<tr><td rowspan="5">MEMBERSHIP</td><td>Chair:</td><td>Medical Director</td></tr>
<tr><td>Deputy Chair:</td><td>Deputy Chief Executive
Deputy Medical Director for Risk & Governance</td></tr>
<tr><td>Membership:</td><td>Director Nursing/User Experience
Deputy Medical Director for Medical Education
Deputy Medical Director for Risk & Governance
Co-Director Risk and Governance
Director or Unscheduled Care
Director of Child Health and NISTAR & Imaging, Medical Physics and Outpatients Director Acute Services
Director of Trauma, Orthopaedics, Rehab Services, Maternity, Dental, ENT, Obstetrics and Sexual Health
Director of Performance, Planning and Informatics
Exec Director Social Work
Director of Children's Community Services
Director of Adult Community, Older Peoples and Allied Health Professionals
Director of Mental Health and Intellectual Disability
RQIA Liaison Officer, Risk & Governance</td></tr>
<tr><td>In attendance:</td><td>Co-Directors/Senior Managers will be required to attend meetings to present and provide an update on Directorate Reviews.

Member appointments:
Other members (Trust staff or agencies external to the organisation) may be invited to attend as required.

Co-Directors/Senior Manager from Directorates duties are as follows:

• Address risks/issues identified by RQIA Thematic Review Reports by Directorate
• Produce an Action Plan with Priorities and Recommendations
• Advise on deadlines for Completion and RAG Tracking
• Prepare Reviews and provide status updates</td></tr>
<tr><td>Support:</td><td>The management, administrative and secretarial support required to support the ERRG Group will be provided by the S&G/RQIA Facilitator within the Risk & Governance Department</td></tr>
</table>

<table>
<tr>
<td>MEETINGS</td>
<td>
Quorum
The quorum for the meeting will be no less than 60% of the membership.

Directors are responsible for ensuring that Co-Directors responsible for overseeing completion of Directorate action plans attend the meeting as per scheduled time on Agenda.

In the event of a quorum not being achieved at a meeting, an additional meeting will be scheduled to meet its delegated responsibilities.

Frequency of Meetings

The ERRG Group will meet on a Bi-Annual basis (March and September)

Meeting Arrangements
The Chair of the ERRG, in discussion with the Secretary shall determine the time and places of meetings.

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Secretarial Support
Formal minutes of this committee will be taken. Minutes will include the following:

The names of all present at the meeting; a register of attendance will be maintained to support the ongoing monitoring of attendance)
A record of the decisions made and any dissent
Details of how the group was assured and the evidence on which this was based
Risks discussed and a record of decisions regarding management/ escalation
Details on any issues to be escalated to include details of relevant member/ committee
Declarations of interest of members and participants.
An action log.
Draft minutes will be issued at latest two working weeks following each meeting. If necessary, this may include a Chair’s summary that will include any matters requiring escalation.

Papers
Agenda and papers will be disseminated to Steering Group members five working days before the date of the meeting.
These will include committee update reports. Additional papers may also include, but are not restricted to:
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	• Review of risks/new risks • Correspondence and reports received from external bodies • Associated Action Plans. • RQIA communication re new thematic reviews/inspections. **Extraordinary Meetings** The Steering Group will hold extraordinary meetings as required **Withdrawal of individuals in attendance** - From time to time, depending on what is for discussion this may need to happen. If so, a brief outline of this should be included and this will be documented in the minutes
CONFLICT / DECLARATION OF INTEREST	The Chair shall seek and record any declaration or conflict of interest from members prior to every meeting
REVIEW	• Terms of Reference must be reviewed on at least an annual basis • Membership to be reviewed on at least an annual basis • Updated Terms of reference and updated membership of committees to be submitted to the steering group for approval on an annual basis • Assurance that an annual review of the Terms of Reference of all committees that report directly into this group have been completed. ***A copy of all updated Terms of Reference for the Groups listed within the Integrated Governance and Assurance Framework must be sent to Risk and Governance after approval on an annual basis***
OUTPUT	Chair of the ERRG, on behalf of the committee will provide a regular assurance update to the Clinical and Social Care Governance Steering Group as per Assurance Framework schedule. Risk and Governance, on behalf of the Chair of the committee, shall oversee the retention of the following: • *Terms of Reference (annually)* • *Agendas (after each meeting)* • *Minutes (on approval)* • *Tracker of submissions by lead assessors.*