

Additional Documents for M10 Departmental witnesses

Description	Witness	Relevant section of statement	Page
Memo from Sean Holland to Grade 3s Chief Professionals Grade 5s Winterbourne View Reports	Charlotte McArdle	Page 77, paragraph 262. This document is Tab 2.	2
Assurance Framework for Professional Nursing and Midwifery Practice in Northern Ireland (Draft Version 4) - March 2019	Charlotte McArdle	Page 67, paragraph 225. The first sentence refers to 'a professional assurance framework' which was not attached.	27
MAH HSC Action Plan – April 22	Richard Pengelly	Page 6, Paragraph 21. The fourth sentence states 'I exhibit at Exhibit 14 the MDAG Action Plan from April 2022'. The attached document is not the April 2022 document.	52
Letter from Richard Pengelly to HSC Trust Chief Executives re Proposed HSC Senior Managers Forum	Richard Pengelly	Page 11, paragraph 39. The last sentence states the letter is at Exhibit 16, this is incorrect.	99

MEMO



Department of
**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

From: Sean Holland

Date: 22 April 2013

To: Grade 3s
Chief Professional Officers
Grade 5s

CC:

Introduction

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

In addition to the final report, and also in December 2012, a *DH Winterbourne View Review Concordat: Programme of Action* was published. This highlighted the signed commitment of 50 organisations/agencies to work together in the interests of change, and specified the respective responsibilities/actions of these organisations on how they were going to take forward action. The Government will publish a progress report on these actions in December 2013.

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

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

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

DH Action Plan

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

The DH Programme of Action includes:-

- a) *“By Spring 2013, the department will set out proposals to strengthen accountability of boards and directors and senior managers for the safety and quality of care which their organisations provide;*
- b) *By June 2013, all current placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible and no later than June 2014;*
- c) *By April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice;*
- d) *As a consequence, there will be a dramatic reduction in hospital placements for this group of patients;*
- e) *The Care Quality Commission will strengthen inspection and regulation of hospital and care homes for this group of people, including unannounced inspections involving people who use services and their families;*
- f) *A new NHS and local government-led joint improvement plan will be created to lead and support this transformation.”*

For Preliminary Action

In order to raise awareness across the DHSSPS on the content of these reports and to inform discussion on how the “corporate” DHSSPS might apprise Minister on how it might respond, if considered appropriate, the following are provided for your consideration and preliminary action:-

1. A brief summary paper on Winterbourne and its failings; **(TAB 1)**
2. MHDOP Directorate preliminary analysis of the 63 DH recommendations with gaps/issues highlighted in red type for the consideration of other relevant directorates/groups; **(TAB 2)**
3. The Concordat Actions (8 summary actions which complement the 63 actions above which all statutory, voluntary, professional, regulatory and independent sector organisations have signed up to **(TAB 3)**).

I should be most grateful for a preliminary response, by adding to the **TAB 2**, especially where red typeface has posed questions. Your response will inform a further discussion at Top Management Group on what might be DHSSPS next steps including any potential links with the Francis Inquiry report and the handling of the most recent Confidential Inquiry Report on Learning Disability.

I should be grateful for a response (by tracked changes), **by 30 April 2013**, to Christine McGuire, Integrated Projects Unit, Mental Health, Disability and Older People's Directorate.

A handwritten signature in cursive script, appearing to read "Sean Holland".

SEAN HOLLAND

Consideration of the Department of Health Transforming Care: A national response to the Winterbourne View Hospital Review

Background

1. The review was set up following a BBC Panorama programme in May 2011 exposing significant flaws in the treatment of Vulnerable Adults in the Winterbourne View private hospital. The follow up Serious Case Review found an additional catalogue of failings across the wider health care system.
2. The report focuses on the care provided for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging. These people are referred to as people with challenging behaviour throughout the report.

The Report findings

3. The report found:
 - that too many people do not receive good quality care,
 - that there is widespread poor service design,
 - there are failures of commissioning,
 - there is failure to transform services in line with established good practice, and
 - that there is failure to develop local services and expertise to provide a person-centred and multidisciplinary approach to care and support.
4. Throughout the report there is concern that:
 - too many people are placed in hospitals when there is no need
 - that people remain in hospitals for too long sometimes years
 - that people are placed away from friends and family,
 - people with challenging behaviour are not believed when they complain; and
 - that families are not consulted about the care of people with challenging behaviour.

Failings

5. As with many cases that have come to the public notice there appears to have been a number of warning signs at Winterbourne View that were not picked up or acted on by health or local authorities. These include;
 - high numbers of referrals to A&E,
 - the number of police call outs to the hospital,
 - the number of recorded restraints,
 - restriction on access for family and friends to certain parts of the hospital,
 - the number of complaints from family as well as those in the hospitals, and

- concerns raised by a whistleblower.

Conclusions

6. The report states hospitals are not homes and that the “priority for someone being admitted to hospital should be, from the start, their rehabilitation and referral home”. “In summary, the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment”.
7. The report states that where specialist support is needed for people with challenging behaviour the default position should be:
 - to put this support into the person’s home through specialist community teams and services, including crisis support and
 - to ensure the individual and her/his family is at the centre of all support.

This is in line with the DHSSPS current commitment in Transforming Your Care.

The Way forward

8. Services should be:
 - designed around people and with their involvement,
 - highly individualised and person centred across health and social care (including access to personal budgets and personal health budgets where appropriate);
 - people’s homes should be in the community, supported by local services;
 - people need holistic care throughout their life, starting in childhood;
 - when someone needs additional support it should be provided as locally as possible;
 - when someone needs to be in hospital for a short period, this should be in small inpatient settings as near to their home as possible.
9. People should only go into specialist hospital settings exceptionally and where there is good evidence that a hospital is the best setting to enable necessary assessment and treatment - not the only available placement. From the beginning, the reason for admission must be clearly stated and families should be involved in decision making.
10. When people with challenging behaviour have to be admitted to hospital service providers and the hospital should:
 - focused on the individual patient’s care plan,
 - make a real effort to maintain links with their family and the home community for example, maintaining the person’s tenancy of their home where relevant unless and until a more appropriate home in the community is found.
 - it is vital that families are involved in decision-making.

Action Plan Timetable

11. There are a total of **63 national actions** tabled in the report to be taken forward by the Department of Health and its partners. Many of the targets are already being addressed by DHSSPS under Transforming Your Care and the Bamford Review. Annex A lists the targets along with the comments on where they sit within the NI HSC system and the actions and targets currently taking forward similar views.

Concordat

12. The Concordat to the report also pledges to “safeguard people’s dignity and rights through a commitment to the development of personalised, local, high quality services alongside the closure of large-scale inpatient services and by ensuring that failures when they do occur are dealt with quickly and decisively through improved safeguarding arrangements”.
13. The Concordat has eight key actions each with a number of sub actions. There are also a number of actions for the DH and each of its partners (Annex B). Of the 32 DH actions in the concordat 26 are taken directly from the main review leaving an additional six to be considered. (Annex C).

**Department of Health Transforming Care:
A national response to the Winterbourne View Hospital Review
Action Plan**

<i>Key actions</i>				
Date		Action	Responsibility	Comments
1.	From June 2012	CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team.	RQIA/SQS	Would need to check with RQIA whether or not they use service users for inspections?
2.	From June 2012	CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place.	RQIA	Should be in place
3.	From June 2012	CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.	RQIA/SQS	Do RQIA check on the level of training of staff and numbers?
4.	From November 2012	The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the	DHSSPS	Interdepartmental Ministerial and Senior Officials Group in place Bamford Action Plan in place

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		head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.		MDT – Bamford taskforce in place at HSCB level
5.	From December 2012	The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions to protect individuals and their human rights and will report by Spring 2014.	DHSSPS/MHDOP	Mental Health The DOL was considered under the Bamford Action Plan completed in 2011, no actions have been taken forward into the 2012/15 Action Plan. (Interim Guidance revised in Oct 2012 – to be carried forward by Mental Capacity Bill)
6.	From December 2012	The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.	DHSSPS/RQIA/OSS/MHDOP	Is the Guidance on Restraint and Seclusion in Health and Personal Social Services produced in 2005 still relevant? Will be superseded by additional protections under the MC Bill.
7.	From December 2012	The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs.	DHSSPS/MHDOP	Advocacy commissioning guide developed in 2012 <i>Bamford Action 27 requires the implementation of the Regional Advocacy Policy Guide for Commissioners.</i> TYC Rec 70 <i>Advocacy and support for people with a learning disability, including</i>

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				<i>peer and independent advocacy</i>
8.	From December 2012	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.	As Above	As Above
9.	From December 2012	A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice,	PSNI	Will need to clarify with DoJ – possibly through a per sec letter to highlight Winterbourne
10.	From December 2012	The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;	NISCC/DHSSPS- OSS	OSS to clarify
11.	From December 2012	The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings.	MHDOP	Would need to keep abreast of this national development and consider for local endorsement
12.	From December 2012	The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.	MHDOP	Would need to keep abreast of this national development and consider for local endorsement

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13.	By end of December 2012	The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.	DHSSPS Board RQIA/MHDOP	<p>Note that Bamford Taskforce and Inter-ministerial Group are in place. But none include the regulator-RQIA</p> <p style="color: red;">We will need Ministerial endorsement in respect of Leadership arrangement – possibly through inter-ministerial group</p>
14.	By end December 2012	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh <i>Challenging Behaviour: A Unified Approach</i> to support clinicians in community learning disability teams to deliver actions that provide better integrated services.	<p style="color: red;">DHSSPS/CMO/ CNO Group</p> <p>HSC/DHSSPS MHDOP</p>	<p style="color: red;">This Professional Senate is a clinical Forum</p> <p style="color: red;">Would need to keep abreast of national developments and possibly endorse locally</p> <p>TYC Target 65 Support from integrated care partnerships to improve clinicians' awareness of the needs of individuals with a learning disability</p> <p>Bamford 2012/15 Action Plan</p> <p>action 53 - Development of UK wide framework for learning disability nurses</p>

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				action 47 - Improve services for children with challenging behaviours and their carers
15.	By January 2013	Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.	HRD/OSS/NISCC	Are these transferrable? Have we anything equivalent?
16.	By February 2013	Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour	HSS/OSS/NISCC	Are these transferrable? Have we anything equivalent?
17.	By March 2013	The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.	DHSSPS/MHDOP /HSCB	<p>No audit in place locally, but could be commissioned through GAIN by DHSSPS, especially in challenging behaviour (ie not MH or LD)</p> <p>However, the Community Integration Project lead by HSCB does know the figures for LD and MH for resettlement</p> <p>The figures for forensic MH are also known.</p> <p>Issue is EMI and slow stream rehabilitation - the actual number of patients and needs in hospital settings is not known(ie beds are</p>

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				<p>known but not patient numbers and disability But delayed discharge targets in place and resourced for 13/14.</p> <p>Bamford 2012/15 Action Plan action 51 Complete and maintain a map of learning disability services across Northern Ireland action 47 -- Improve services for children with challenging behaviours and their carers</p> <p>Service Mapping for MH and LD</p>
18.	By March 2013	<p>The NHS-CB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including:</p> <ul style="list-style-type: none"> □□ model service specifications; □□ new NHS contract schedules for specialist learning disability services; □□ models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and □□ a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress. 	<p>HSC Board</p> <p>LCGs</p>	<p>Dedicated commissioning group for MH/LD in HSCB. Commissioning specification in place</p> <p>DES in place for learning disability in GP practices</p> <p>LD service framework in place and MH</p> <p>No self- assessment framework</p> <p>TYC sections on LD and MH, and older people</p>
19.	By March 2013	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning	HSCB/SCD/MHDOP	Likely gap in commissioning/provision as

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		specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A		<p>challenging behaviour in children has many causes which would need both paediatric assessment, diagnosis and early intervention and possible social care input. ASD covered -pathway in place</p> <p>Possible inclusion ini paediatric Review?</p>
20.	By March 2013	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions.	CMO Group/ DHSSPS	Will need to keep abreast of national developments and possible consideration of local endorsement
21.	By March 2013	The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used.	As above	As above
22.	By 1 April 2013	The NHS CB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.	HSCB/HSC Trusts	Definite gap in commissioning and service provision locally – relates to inpatient care
23.	By 1 April 2013	The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.	As above	As above
24.	By 1 April 2013	The National Quality Board will set out how the new health system should operate to improve and maintain quality.	DHSSPS/MHDOP/HSC B	Home is the hub and personalisation – are core elements of TYC and commissioning plan

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25.	By 1 April 2013	The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards.	OSS/DHSSPS	Any views on existing measures
26.	From 1 April 2013	The NHS-CB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.	N/A	N/A
27.	From April 2013	The NHS-CB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours.	Board LCGs/ICPs	Work done on ASD pathway but not on the challenging behaviour DES in place for LD through general practice
28.	From April 2013	Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.	DHSSPS – HRD with Leadership Centre?	No specific education programme action locally – possibly linked to a Francis initiative on culture? More specifically: Bamford 2012/15 Action Plan actions 32 - Promote recovery orientated practice throughout all mental health services 53 - Development of UK wide framework for learning disability nurses

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				57 - Improve the experience of people with LD using acute general hospitals based on the GAIN Guidelines "Caring for people with a learning disability in general hospital settings"
29.	From April 2013	CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.	RQIA/SQS	Would need to be followed up to see how, if at all, inspection standards, methodology changes
30.	From April 2013	CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities.	RQIA	Systems already in place
31.	From April 2013	CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration.	RQIA	Systems already in place
32.	From April 2013	Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.	RQIA/SQS	No equivalent here
33.	From April 2013	The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHS-CB, ADASS and ADCS will promote and facilitate joint	Board/ DHSSPS	This rec relates to the integration of Health and social care budgets. Some crossover with TYC recommendation 15 <i>more integrated planning and delivery of support for older people,</i>

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				<p><i>with joined up services and budgets in the health and social care, and pilots to explore budgetary integration beyond health and social care</i></p> <p>Note that at present here, NI has no equivalent to Part 11 of Welfare Reform Act to allow for further integration of budgets beyond health and social care – pilots ongoing in England</p>
34.	From April 2013	The NHS-CB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities.	DHSSPS/HSC Board and Trusts	<p>TYC <i>ethos</i></p> <p>Also -cross governmental ASD strategy will be issued in 2013 by DHSSPS as per ASD legislation</p>
35.	From April 2013	Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide.	HSC Board and Trusts	Should be in place
36.	From April 2013	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.	DHSSPS/CAGU/HSC Board/Trusts	<p>Could governance arrangements be strengthened- Note that Controls Assurance do not apply to the regulated sector- but specific statutory obligations, departmental guidance, professional requirements could be written into their contracts</p> <p>Who is the assurance to be</p>

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				provided to Trusts, HSCB or should RQIA be responsible? Following GB lead could each organisation nominate one member of their Board with responsibility for quality who would be accountable to RQIA for quality of care. It needs to be made clear to these organisations' Boards that they need proper governance arrangements in place and that they need to take seriously their corporate responsibilities. In relation to our ALBs we our strengthening assurance on quality by having specific agenda items relating to quality at accountability meetings & will be reviewed by CAGU & SQSD in relation to Francis report and Winterbourne
37.	From April 2013	The Department of Health, the Health and Social Care Information Centre and the NHS- CB will develop measures and key performance indicators to support commissioners in monitoring their progress.	DHSSPS Board	Commissioning Plan Direction in place Bamford HSC Taskforce outcomes and BMG Outcomes paper attached to the 2012/15 Action plan
38.	From April 2013	The NHS-CB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.	DHSSPS/CMO Group PHA	?? Taken forward through public health framework

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39.	From April 2013	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINKs (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.	DHSSPS PCC	Section 75 of the NI Order and rural proofing of all Strategies and legislation Bamford HSC Taskforce New Bamford Sub -groups (to be set up) PPI Policy Guidance Anything else we should/might be doing?
40.	By Spring 2013	The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.	DHSSPS/CAGU/SQS/ CMO Group Board RQIA	Leadership and accountability enhancements - Possible overlap with Francis on Duty of Candour Unclear of impact on RQIA and associated legislation Need to determine how they can be held to account under current law. There has to be serious consequences for organisations that provide poor quality of care or where people experience neglect/abuse e.g. prosecutions, closure. Fit & proper person tests- can we legally use criteria eg involvement with a criticised organisation not to select people

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41.	From Spring 2013	CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.	RQIA/SQS	Are we doing enough?
42.	By 1 June 2013	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.	DHSSPS/MHDOP/ Board and Trusts	Major impact on HSC services to review inpatient care plans for all those with <u>challenging behaviour</u> . England are pressing ahead with this and not just for LD/ASD but all in "acute" hospitals with challenging behaviour e.g. stroke, dementia, ABI, etc.
43.	By Summer 2013	Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP)	Trusts/Vol/Independent sector/MHDOP	Should we do something similar? Bamford processes already in place
44.	By Summer 2013	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care.	DHSSPS	TYC Target 64 <i>Further development of the current enhanced health services on a NI basis.</i> In line with the Bamford ethos; would need to keep abreast of national initiatives
45.	By summer 2013	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of	DHSSPS/Pharmacy/SQS/ CMO Group	See QUB press release regarding the prescribing of medication to people in homes but of course,

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		medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.	Medicines Governance	<p>recommendation is much wider than this</p> <p>May require further work?</p>
46.	By June 2013	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood.	DHSSPS	<p>TYC</p> <p><i>Target 63</i></p> <p><i>Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)</i></p> <p>Transitions are covered in the Bamford Action Plan 2012/15 action 52 - Improve transitions planning for all children with statement of special educational needs</p>
47.	In 2013	The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.	DHSSPS /Family Policy unit DE	<p>Consider the role of Looked after Children</p> <p>Any more to be done?</p>
48.	In 2013	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.	DHSSPS DE	<p>Bamford Action Plan 2012/15 action 26 for DE - Take forward and implement Review of Special Educational Needs & Inclusion</p>

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49.	In 2013	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy.	DHSSPS	See Regional Advocacy Policy Guide for Commissioners. And the associated action plan
50.	In 2013	The Department for Education will revise the statutory guidance <i>Working together to safeguard Children</i> .	DE/DHSSPS/OSS/ Family Policy	Do we need to do anything??
51.	In 2013	The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines.	DHSSPS/Pharmacy/ CMO Group	Keep abreast of professional guidance See also action 45 Is there anything more that we should be doing on psychotropic medication?
52.	By December 2013	The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013.	DHSSPS	Bamofr Interministrerail
53.	By end 2013	The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.	DHSSPS/OSS/ MHDOP	Guidance on Restraint and Seclusion in Health and Personal Social Services. But should we be issuing guidance on positive behaviour support?
54.	By end 2013	There will be a progress report on actions to implement the recommendations in <i>Strengthening the Commitment</i> the report of the UK Modernising learning disability Nursing Review.	DHSSPS/NMAG/HRD	"The Strengthening the Commitment", the report of the UK Modernising Learning Disabilities Nursing Review is across all four UK

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				governments. Any report on the actions will require feed in from the DHSSPS
55.	By end 2013	CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance about compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the proposed changes to our registration process about models of care for learning disability services in 2013.	RQIA/SQS	Would need SQS input on what "quality and safety regulations" are
56.	From 2014	The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.	DE DHSSPS/MHDOP	This may be covered in NI by Special Educational Needs - Code of Practice Review of Special Educational Needs and Inclusion Every School a Good School – The Way Forward for Special Educational Needs and Inclusion Bamford Action Plan 2012/15 action 52 Improve transitions planning for all children with statement of special educational needs

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57.	By April 2014	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.	DHSSPS Board DSD Housing Executive	Different system here. Already integrated commissioning model in place on supporting people Bamford Action Plan 2012/15 action 14 and 15 Supported Housing Supported Housing currently has joint funding
58.	No later than 1 June 2014	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.	DHSSPS Board /MHDOP	TYC Target 62 <i>Close long stay institutions and complete resettlement by 2015. (Mental Health)</i> Target 71 <i>Commitment to closing long stay institutions and to completing the resettlement process by 2015. (Learning Disability)</i> Personalisation underpins TYC
59.	In 2014	The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review.	DHSSPS	New Code of Practice here will emerge from Mental Capacity Bill Need to keep abreast of developments

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60.	By December 2014	The Department of Health will publish a second annual report following up progress in delivering agreed actions.	DHSSPS	This Department will need to consider corporate response to the Winterbourne review, if any.
61.	From 2014/15	The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre.	DHSSPS	TYC target 69 <i>Development of information resources for people with a learning disability to support access to required services.</i> Would have to link to ICT Programme to implement
62.	By Summer 2015	NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.	DHSSPS endorsement process/SQS	Keep abreast of developments Nice guidance produced in March 2013 MH and LD Service frameworks in place
63.	By Summer 2016	NICE will publish quality standards and clinical guidelines on mental health and learning disability.	DHSSPS endorsement process/SQS	MH and LD Service frameworks in place

Concordat Programme of Actions

Key Actions

The key summary actions within the Concordat are:-

- 1. Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014.**
- 2. Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care. These plans should ensure that a new generation of inpatients does not take the place of people currently in hospital.**
- 3. There will be national leadership and support for local change. The Local Government Association and NHS-CB will establish a joint improvement programme to provide leadership and support to transform services locally.**
- 4. Planning will start from childhood.**
- 5. Improving the quality and safety of care.**
- 6. Accountability and corporate responsibility for the quality of care will be strengthened.**
- 7. Regulation and inspection of providers will be tightened.**
- 8. Progress in transforming care and redesigning services will be monitored and reported.**

See www.dh.gov.uk/health/2012/12/final-winterbourne/ for more detail underpinning the above and for respective roles and responsibilities.

Assurance Framework for Professional Nursing and Midwifery Practice in Northern Ireland

March 2019

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Background

Nurses and midwives in Northern Ireland perform their roles in a wide range of settings including hospital and community and in a wide range of teams both uni and multi-disciplinary, statutory and in partnership with the independent sectors. At the same time Trusts are large complex organisations which makes the process of professional assurance and accountability extremely challenging.

Professional governance frameworks should reflect the mechanisms by which the Executive Director of Nursing can provide assurances to their Chief Executive and Trust Board about the quality of nursing and midwifery care for those services both provided for and commissioned by that Trust.

When implemented, a robust assurance framework provides clarity about professional responsibility and evidence that structures and processes are in place to provide the right level of scrutiny and assurance across nursing and midwifery services.

Nursing and Midwifery Assurance in a Policy and Professional Context

Enabling the people of Northern Ireland to ‘live long healthy active lives’ is at the heart of Programme for Government and Delivering Together 2026 Vision. One of the core drivers within Delivering Together 2026 is the delivery of evidenced based, safe, effective and sustainable care services. This inevitably requires a systemic approach in order to ensure the contribution of the Nursing and Midwifery profession is maximised.

It is within this context the Minister established a Nursing and Midwifery Task Group. One of core purposes of this Task group in line with the quadruple aim, is to bring forward recommendations which ensures nurse and midwives are enabled to deliver the right care, in the right place, with right number of staff, doing right things at the right time, equipped with the right skills. This is entirely consistent with NMC code, the new NMC Proficiency Standards, and the four Chief Nursing Officer’s guidance on ‘Enabling Professionalism’.

A 'Nursing and Midwifery Professional Assurance Framework for Scotland' (X) was published in January 2014. In association with Scotland's Executive Directors of Nursing, the Chief Nursing officer outlined a high level framework identifying the need for professional assurance and who the framework is for. The four components of the framework are identified as follows:

1. Practitioners are equipped, supervised and supported according to regulatory requirements
2. There is dispersed leadership which focuses on outcomes and promotes a culture of multi-professional parity and respect
3. There is clear accountability for standards and professionalism at each level and upwards to the NHS Board
4. NHS Boards have a clear understanding about the quality of the nursing and midwifery service.

Primary and secondary drivers were developed with suggested indicators for achieving assurance on each of the components,

In 2016, the then CNO of England, Professor Jane Cummings, launched "Leading Change, Adding Value: A framework for nursing, midwifery and care staff" (X). Ten commitments are outlined in the framework, setting out the shared ambition and leadership potential for the nursing and midwifery contribution to achieving the best patient experience, the best health and well-being and the best use of finite resources into the future. Whilst not an 'assurance' framework, the document outlines the commitment required from Frontline Staff, Organisational Leaders, Educators and Trainers and System Influencers and Commissioners. A range of National and Local Quality Metrics and Measures are also helpfully referenced within the Impact Measurement Framework.

In Wales, the government produced 'Health and Care Standards' (X) framework in April 2015 to support the delivery of high quality services in the NHS. The framework embraces the principles of co-production and identifies seven themes, each with a number of standards, describing how a service provides high quality, safe and reliable care centred on the person. The framework does not apply specifically to nursing and midwifery and similar to England, it is not an 'assurance' framework. The standards however are all placed in the

helpful themes of Governance, Leadership and Accountability - all key components of Assurance.

The Department of Health in the Republic of Ireland launched its 'Framework for National Performance Indicators for Nursing and Midwifery' (X) in June 2017. The purpose of the Framework is to set out the policy context for the use of nursing and midwifery performance indicators, to demonstrate the relationship between inputs and outcomes/impact. It also provides guidance on performance indicators (including clarifying the relationship between Structure, Process and Outcome). It also aims to ensure that there is a standardised approach to the development, prioritisation, endorsement, implementation, and monitoring of nursing and midwifery KPI's. Work is ongoing with stakeholders to develop and agree the minimum data set for the nursing and midwifery workforce.

The Health and Social Care (Reform) Act (Northern Ireland) 2009 provides the legislative framework within which the health and social care structures operates. The Health and Social Care Assurance Framework (2011) describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

This document sets out the high level functions of the various health and social care bodies, providing the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

Accountability for the exercise of proper control of financial, corporate and clinical and social care governance in the HSC system rests with the Department and the Minister. Assurance to the Department and the Minister about the safety and quality of services is provided from a number of different sources. Each health and social body has clearly defined roles and responsibilities in this regard.

The existing Assurance System for Nursing related to HSC Trusts and the Public Health Agency dates back to 2011 and is attached in **Appendix 1**. This provides an assurance

system for nursing from Health and Social Care (HSC) Trusts through the Public Health Agency (PHA) to the Department of Health Social Services and Public Safety (DHSSPS). The framework builds on the direction and description of roles and responsibilities detailed in the DHSSPS Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009.

This document divides the assurance system into the following sections:

- Entry into employment as a registered nurse
- Maintenance of registration
- Quality of Nursing Practice
- Managing performance

The requirements for HSC Trusts within these four areas are further broken down within the document. The document concludes by describing the reporting process, escalation of issues and importance of Professional Communication. The current system is an essential part of HSC Trusts overall Governance and assurance arrangements.

Whilst nursing and midwifery still enjoys high levels of public confidence, over the last number of years there has been a significant number of practice and system challenges, which if left unaddressed will further erode public confidence and compromise patient safety, nursing and midwifery practice. It is therefore crucial a new quality assurance framework for nursing and midwifery care is developed to safeguard the public and provide assurance.

The word assurance can mean different things to different people. It is therefore important that nurses and midwives at all levels in developing, implementing and monitoring an assurance framework are clear in what it means for them and their organisation.

In this context, assurance is defined as follows:

Assurance	
Provides	Confidence/Evidence/Certainty
To	Nurse leaders/Directors/Nonexecutive Directors/CEO/CNO

That	What needs to be happening is actually happening in practice
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Adapted from “A board assurance toolkit for the health sector – Do we really know what we think we know” NHS Providers Baker Tilly

The ultimate purpose of developing a regional assurance framework is to support the nursing and midwifery systems leadership assure the public and the profession of the standards of nursing and midwifery practice in services provided by or commissioned by the HSC system. It is also to help ensure healthcare organisations have effective processes and structures in place to identify, monitor and address current and future risk relating to the standards of professional nursing and midwifery practice.

It is also important that nurses and midwives are clear about where assurance comes from.

How effective are current systems?

The existing legislative framework for HSC organisations including as the Health and Social Care (Reform) Act (Northern Ireland) 2009 and The 'Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003' apply a statutory duty of quality on the HSC Board and Trusts. This means that each organisation, large or small, has a legal responsibility to ensure that the care it provides must meet a required standard. Furthermore, the HSC Assurance Framework requires organisations to formally report levels of assurance on a range of quality, safety and financial measures.

Current professional nursing and midwifery assurance methods are sophisticated and have been evolving over time. There is a wealth of data and information being captured by all organisations. As more qualitative and improvement metrics are being used, organisations are noticing certain risks earlier and identifying what areas require greater levels of assurance. There remains a significant focus on performance data and there is a lack of standardisation or consistency across organisations. Some of the limitations with the current information being reported on and the frameworks in use are listed below:

- There is a lot of data captured but not enough analysis or contextual interpretation
- Primarily acute (hospital) focused

- Lack of inadequate context and analysis of the factors that contribute to the results/findings e.g. balancing measures and special cause/common cause variation
- Choosing inadequate or inappropriate measures e.g. percentages and averages
- Choosing inadequate and inappropriate visualisation e.g. tables and charts
- Highlighting important data ineffectively or inappropriately
- Limited use of qualitative data to inform decision making

Therefore, it is clear that current systems fall short of answering the question - Is what needs to be happening, actually happening in practice?

The outcome from this work will be to provide a standardised framework that organisations can use to support their approach to assuring a high standard of nursing and midwifery practice.

Development of a Draft Framework

A programme board and project team were constituted and commenced work on the framework in late September 2018 (**Appendix X**).

The Programme Board agreed at the outset that a model of Assurance for Professional Nursing and Midwifery Practice should to be grounded in the NMC Code for Professional Standards of Practice and Behaviour. Support for delivering professional nursing practice and maintaining the standards within the code has been further described in the 2017 joint CNO publication 'Enabling Professionalism'. The four pillars underpinning the professional standards with the Code (Prioritising People, Practicing Effectively, Preserving Safety and Promoting Professionalism and Trust) have provided a guiding structure for the frameworks development.

Enabling Professionalism (EP) states that professional nursing practice is achieved through the following:

1. Consistent outcomes of Care
2. Effective care that enables people to have the best health status and quality of life they can achieve

3. Care settings that enable nurses and midwives to flourish
4. People describing good experiences of care and services
5. Individualised care and services, evidenced through support for personal choices in decision making about planned care or services
6. Better use of resources
7. Improved outcomes for populations

It was in this context that the project team held a number of workshops to map the main issues, including the components of enabling professionalism against other key strategic and policy drivers i.e. Delivering Together and the Quadruple Aim (**APPENDIX X**). The group also attempted to draft some components of an assurance framework using the above seven EP criteria against quality measures using process, outcome and structure framework. However, whilst proving to be a helpful mapping exercise to show the linkages with the strategic and policy direction, it was felt that these exercises did not fit with the overall aim of the work.

Furthermore, the team attempted to use the four pillars of the code (Prioritising People, Practicing Effectively, Preserving Safety and Promoting Professionalism and Trust) as primary drivers to develop the structure for the framework. However, once again this proved to be too restrictive and would not deliver a robust assurance framework.

The project team went back and further teased out the aim of this work. Using a Quality Improvement methodology across a number of workshops, the project team were able to articulate the key overarching components of what a professional nursing midwifery assurance framework should focus on. In taking this approach, the project team developed five areas as primary drivers for nursing and midwifery assurance - **accountability, leadership, person-centeredness, practice environments and workforce.**

Ultimate Aim

To develop a regional nursing and midwifery assurance framework on the standards of nursing practice and behaviour, including prioritising people, practising effectively,

preserving safety, promoting professionalism and trust, from every care and service setting to the Executive Director of Nursing to the Trust Board and through to CNO.

Primary Drivers identified within the framework

1. We need to ensure that there are explicit and effective lines of nursing and midwifery **accountability** from every registrant in every care and service setting to the EDON, Trust Board and through to CNO
2. We need to ensure there is collective professional **leadership** across every care and service setting
3. We need to ensure **person-centeredness** is prioritised and embedded across every care and service setting
4. We need to ensure that **practice environments** are conducive to promoting positive health and well-being in every care and service setting
5. We need to ensure that the nursing and midwifery **workforce** is sufficiently supported and equipped for practice across every care and service setting

Within each of the five above components, a small number of primary drivers or essential requirements have been identified. In turn, these lead on to the identification of secondary drivers or enablers to achieving the requirements. A list of potential indicators has also been identified within each of the components to support the assurance process.

The five components are not listed in priority order and there is some overlap within the requirements and indicators. This is not to create duplication, instead it can help provide a means for triangulation of evidence across the indicators once potential metrics and measures have been agreed.

Each of the secondary drivers (or enablers), have been mapped against the NMC Code four pillars Prioritise People (PP), Preserve Safety (PS), Practice Effectively (PE) and Promote Professionalism and Trust (PP&T).

If and when the framework is regionally agreed, it is proposed that the next steps will be to test the components across a range of settings in order to develop a range of consistent metrics and measures - using outcome, process and structure measures (Donabedian 2005).

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1. There must be explicit and effective lines of nursing and midwifery accountability from every registrant in every care and service setting to the EDON and through to CNO

We need to ensure..	This requires..	Indicators
<p>1. Robust process mechanisms are in place for assurance on the standards of professional Nursing and Midwifery practice from all care and service settings to the EDON and CNO</p> <p>2. There are clearly defined professional nursing and midwifery accountability structures from every care and service setting through to EDON</p>	<ul style="list-style-type: none"> • Retrospective and real-time nursing and midwifery specific quality and experience data is collected and reviewed at all levels, from care setting to Board level (PS) • Nursing and midwifery professional leaders are involved in all relevant decisions impacting on Nursing and Midwifery practice and workforce using a shared-governance approach (PE) • Explicit processes for the dissemination, escalation and action on professional nursing and midwifery practice and workforce issues across all care and service settings (PS) • Information relating to the five components of the Regional Nursing and Midwifery Assurance Framework will be reported to the (Trust) Board in a clear, structured and timely manner (PE) • A defined structure for nursing and midwifery professional accountability outlining roles and responsibilities from EDON to all RN/RM (PP) 	<p><i>Every care and service setting has either a regionally agreed and/or bespoke data set of measuring safety, quality and experience</i></p> <p><i>Nurses and midwives are represented on all decision making fora where nursing and midwifery practice and workforce issues are discussed e.g. service reconfiguration, HR policies, service developments</i></p> <p><i>Application of the agreed reporting schedule for professional assurance framework through the Trust Governance structures to the Board</i></p> <p><i>Organisational chart demonstrating professional accountability from all care and service settings through to EDON and Trust Board</i></p> <p><i>Contemporaneous risk reporting including risk registers, action plans and escalation reports</i></p> <p><i>Annual self-assessment of the effectiveness of professional governance structures</i></p>

Examples of quality and experience metrics and measures:

Organisational internal governance arrangements, structures and processes

2, There must be collective professional leadership across every care and service setting that maximises the unique contribution of Nursing and Midwifery to safe and effective care.

We need to ensure..	This requires..	Indicators
<p>1 Nurses and midwives occupy roles of leadership and influence across every care and service setting</p> <p>2 Leadership is focused on improving patient outcomes</p> <p>3 Continuous development of Nursing and Midwifery leadership capacity across every care and service setting</p>	<ul style="list-style-type: none"> • An organisational structure that enables nursing and midwifery leaders to engage in shared governance and decision making, recognising the need for collective leadership, parity and respect (PE) • A defined decision making process that underpins the selection of the most appropriate profession to provide aspects of specific care based on assessed need and person-centred outcomes (PE) • Systems and processes are in place that support and enhance the development of Nursing and Midwifery leaders across all care and service settings (PP&T) • Continuing Leadership development should be promoted and supported within and across all care and service areas (PE) • A framework to support leadership development opportunities within, across and between organisations (PE) 	<p><i>Regional and Organisational Leadership Strategy in place</i></p> <p><i>Nursing and midwifery leadership structure with clarity of roles and responsibilities</i></p> <p><i>Clear decision making processes within the (draft) multi-professional governance framework for delegation.</i></p> <p><i>All nurses and midwives have access to formal supervision and support mechanisms</i></p> <p><i>Coaching, supervision and mentoring embedded across the organisation</i></p> <p><i>Continuous investment in leadership development</i></p> <p><i>Leadership development opportunities within, across and between organisations</i></p>

Examples of regional and local context including quality and experience metrics and measures:

- Patient outcome data*
- Regional Collective Leadership Strategy*
- Staff survey data*
- Staff engagement and experience data*

3, Person-centred practice must be prioritised and embedded across every care and service setting

We need to ensure..	This requires..	Indicators
<p>1. Nurses and midwives must ensure shared decision making with people receiving care and services</p> <p>2. Nurses and midwives treat people with kindness, respect and compassion across all care and service settings</p> <p>3. Structure and processes are in place to generate, share, disseminate and promote evidence informed practice in all care and service settings</p>	<ul style="list-style-type: none"> • Nurses and midwives to work with the values and beliefs of people to partner in decision about their care (PP) • Nurses and midwives possess the knowledge, skills and behaviours to engage effectively in co-production across all care and service settings (PP) • Nurses and midwives practice sympathetic presence and authentically engage with people (PP) • Nurses and those in receipt of care, experience compassionate and caring cultures (PP) • Nurses incorporating up-to-date evidence in daily practice (PE) • Participation in the generation of new evidence and working innovatively (PE) 	<p><i>Patients report good experiences of care and evidence of involvement in decisions about their care in real time user feedback</i></p> <p><i>Documentation of care is evidenced</i></p> <p><i>Nursing and midwifery staff receive training in co-production principles</i></p> <p><i>Evidence of participant and non-participant observations of care and relationships</i></p> <p><i>Patient experience standards</i></p> <p><i>Staff experience</i></p> <p><i>Existence of healthful culture demonstrated through workplace culture analysis</i></p> <p><i>Clinical academic posts</i></p> <p><i>Research posts</i></p> <p><i>Partnerships with High Education Institutions</i></p>

Examples of national and local context, including quality and experience metrics and measures:

Regional Nursing KPI's

10,000 More Voices

Person-Centred Practice Framework (McCormack and McCance 2017)

4, Practice environments must be conducive to promoting positive health and well-being in every care and service setting

We need to ensure..	This requires..	Indicators
<p>1 Nursing and midwifery staff are supported to escalate 2q1all concerns about public safety, care and service provision, and professional practice</p> <p>2 Nurses and midwives learn lessons from incidents, reviews and events to support quality improvement</p> <p>3 Systems and processes are in place that enable appropriate support and feedback to nursing and midwifery staff on resource issues impacting on the care environment</p>	<ul style="list-style-type: none"> • Robust processes and policies exist to support nurses and midwives to raise and escalate concerns about public safety, care and service provision, and professional practice (PS) • The implementation of a robust delegation framework for nursing and midwifery tasks and duties across all care and service settings (PE) • Robust organisational arrangements to review and reflect on the outcomes of care and service provision (PE) • Robust organisational arrangements to agree lessons for practice improvement, including bidirectional cascade processes to/from care and service settings (PE) • Policies that promote and support critical thinking in practice and decision making (PE) • Organisational risk assessment that supports and accepts nursing and midwifery professional judgement as a basis for action (PE) 	<p><i>Application and compliance with relevant policies, with regular reporting schedule to the EDON on:</i></p> <ul style="list-style-type: none"> • <i>Patient experience</i> • <i>RQIA inspections/reviews</i> • <i>Serious adverse incidents</i> • <i>Complaints relating to professional nursing and midwifery practice</i> • <i>Professional concerns about patient safety</i> <p><i>Senior nurse/midwife involved in all investigations of serious adverse incident reporting, investigation and dissemination across all care settings</i></p> <p><i>Senior nurse/midwife included in internal Trust accountability and governance processes</i></p> <p><i>Staff and patient feedback mechanisms in place</i></p>

Examples of national and local context, including quality and experience metrics and measures:

Health and Well-Being – Delivering Together
 ‘Your right to raise concern – Whistleblowing policy’

5, The Nursing and midwifery workforce must be supported and equipped for practice across every care and service setting

We need to ensure..	This requires..	Indicators
<p>1 All care settings have a robust workforce plan, that utilises evidence, is informed by available professional standards, and complies with policy and/or other requirements</p> <p>2 All nursing and midwifery staff have the right skills and competencies to practise effectively and are supported to work to the upper limits of their scope of practice</p>	<ul style="list-style-type: none"> • Staffing levels across all care settings meet all policy and/or other requirements (PP&T) • Nursing and midwifery workforce plans exist across all service areas (PS) • Robust practices and policies that support the retention and development of nurses and midwives (PP&T) • All nursing and midwifery staff are recruited in line with professional guidance and standards (PS) • Every practising registered nurse and midwife meets their professional regulatory requirements (PP&T) • All nursing and midwifery staff are supported to undertake mandatory training requirements (PE) • Ongoing CPD post registration (PE) 	<p><i>Evidence informed local workforce plans with clear accountability exist</i></p> <p><i>Staffing and skill mix reviews clearly documented and regularly reviewed</i></p> <p><i>Nursing and Midwifery workforce data (e.g. vacancies, sickness absence, bank, agency and overtime usage, retention and recruitment) from all care and service settings agreed locally - recorded and reported regularly to EDON.</i></p> <p><i>Reporting and scrutiny of Dependency/Occupancy/Skill mix/nurse to patient ratio/caseload information.</i></p> <p><i>Capability, disciplinary and grievance information specific to nursing and midwifery</i></p> <p><i>Professional supervision standards met</i></p> <p><i>Records on referrals to NMC, outcomes and trends</i></p> <p><i>All 'fitness to practice' requirements being met</i></p> <p><i>Pre and post registration audit requirements met</i></p> <p><i>Training and development records maintained and up to date</i></p>

Examples of national and local quality and experience metrics and measures:

Nursing and Midwifery Task Force
NMC regulatory requirements

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Responsibilities associated with professional nursing roles

XXXXXXXXXX To be added XXXXXXXX

Executive Director of Nursing

Assistant/Deputy Director of Nursing

Lead Nurse/Midwife

Charge Nurse/Sister Ward/Department

Registered Nurse/Midwife

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Appendix 1.

Assurance System for Nursing related to HSC Trusts and Public Health Agency

Introduction

1. This document provides an assurance system for nursing from Health and Social Care (HSC) Trusts through the Public Health Agency (PHA) to the Department of Health Social Services and Public Safety (DHSSPS). The framework builds on the direction and description of roles and responsibilities detailed in the DHSSPS Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009.
2. The Framework Document describes the roles and responsibilities of each part of the HSC system. Section six describes the mechanisms by which the system is held to account for the exercise of proper control of financial corporate and clinical and social care governance in the HSC. While ultimate accountability rests with the Department and Minister this section describes the various lines of accountability and how they are exercised at different levels. The Framework document augments the current processes and does not detract from the fundamental accountability between HSC Trusts and the Department.
3. The key principles are described as:
 - The Department has ultimate accountability for the effective functioning of the HSC across four dimensions, corporate control, safety and quality, finance and operational performance and service improvement;
 - The Department will provide clear guidance across each of the four dimensions, specifying outputs and outcomes that are appropriate, affordable and achievable. This guidance will be developed with the involvement of HSC bodies, consistent with their roles and responsibilities;

- Each HSC body is locally accountable for its organisational performance across the four dimensions and for ensuring that appropriate assurance arrangements are in place. The obligation rests wholly with the body's board of directors. It is the responsibility of boards to manage local performance and to manage emerging issues in the first instance;
- The standard assurance arrangements and associated information streams within individual HSC organisation will, as far as possible, be used to meet the assurance requirements of the HSCB and PHA, and those of the Department, subject to such additional independent verification as may be deemed necessary;
- The Department, and in turn the HSCB and PHA (where they have a performance and assurance role in relation to one or more of the other bodies), will maintain a relationship with other HSC bodies based on openness and the sharing of information, adopting an informal, supportive approach to clarify and resolve issues as they arise, and thereby minimising the need for formal intervention.

Safety and Quality Dimension

4. The Framework Document describes specified elements of safety and quality in particular the arrangements for ensuring that the HSC services are, safe, effective and personalised. The role of each the health and social care body is described and their relationship one to the other.
5. In paragraph 6.14 one of the specific roles of the PHA is described, ***'The PHA is responsible for monitoring and reporting to the Department on Trust compliance with accepted standards for medical, nursing and allied health professionals e.g. professional regulation and training and development.'***
6. This report seeks to describe an assurance system to enable the PHA to discharge its responsibilities. This framework has been developed in

partnership with the DHSSPS, HSC Trust and the Northern Ireland Practice AND Education Council for nurses and midwives.

Assurance System

7. This assurance system is unpinning by a number of significant publications and guidance including:

<p>Code of Professional Conduct (NMC) Guidance on Professional Supervision (NIPEC) HSC Framework Document (DHSSPS 2011)</p>	<p>Guidance for Employers (NMC) HSC Code of Conduct for Managers (DHSSPS) Health and Social Care (Reform) Act (NI) 2009.</p>
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Who does this assurance system apply to?

8. This assurance framework relates to nurses currently registered with the Nursing and Midwifery Council employed in HSC Trusts. Registered nurse is defined as a nurse who is currently registered on the Nursing and Midwifery Council Register.

9. The Assurance System is divided into the following sections:

- Entry into employment as a registered nurse
- Maintenance of registration
- Quality of Nursing Practice
- Managing performance

Entry into employment as a registered nurse.

10. The following describes the systems HSC Trusts must have in place, standards that must be adhered too and areas of best practice which Trusts should consider.
- a. All appointments to posts where there is a requirement to be a registered nurse must include an interview, the panel of which must include a registered nurse.
 - b. Each Trust must have a system to ensure that individuals employed by the Trust are registered with the NMC. This registration should be checked prior to confirmation of employment.
 - c. The development of any new nursing posts must be endorsed by the Executive Director of nursing prior to application for funding from commissioners or advertisement by the Trust.
 - d. Best Practice - Trusts should consider a) inclusion of questions that prompt disclosure of previous disciplinary or conduct issues prior to employment, b) requests for professional references prior to appointment, c) inclusion of core elements in all registered nurse job descriptions and d) development of best practice in interview techniques.

Maintenance of Registration

11. The following describes the systems HSC Trust must have in place, standards that must be adhered too and areas of best practice which Trusts should consider.
- a. Trusts must have a system in place to monitor the status of each nurse's registration.
 - b. Trusts must ensure supervision standard are met.
 - c. Trusts must ensure that nursing staff have access to appropriate continuing professional development to ensure fitness to practice within specific roles.
 - d. Trusts must ensure that nursing staff have access to mandatory training.
 - e. Best Practice – Trust should explore opportunities and barriers to future revalidation.

Quality of nursing practice

12. The following describes the systems HSC Trusts must have in place, standards that must be adhered to and areas of best practice which Trusts should consider to ensure safe effective nursing practice.
- a. Trusts must have appropriate professional governance arrangements led by the Executive Director of Nursing across the span of the Trust. These arrangements must be supported by sufficient appropriate resources and infrastructure including recognised lines of professional accountability at Assistant Director level.
 - b. Trusts should ensure the appropriate inclusion of nurses in internal Trust accountability processes.
 - c. Trusts will monitor and report on the following patient/client focused indicators, illustrating any emerging trends or learning and action taken in relation to nursing practice to include:
 - i. Patient/Client Experience standards
 - ii. RQIA Inspections
 - iii. Incidents and Serious Adverse Incidents
 - iv. Complaints
 - v. Medication compliance
 - vi. Staffing levels

Managing Performance

13. The following describes the systems HSC Trusts must have in place, standards that must be adhered to and areas of best practice which Trusts should consider to ensure the effective management of professional practice.
- a. Trusts will monitor and report on the following registrant focused indicators, illustrating any emerging trends or learning and action taken in relation to nursing practice,
 - i. Disciplinary Actions
 - ii. Referrals to the NMC
 - iii. Nurses in difficulty/capability
 - b. Where a nurse is subject to an investigation or disciplinary process a registered nurse must be a member of the investing or disciplinary panel.

- c. Trusts will ensure that there is a system in place to ensure that all referrals to the Nursing and Midwifery Council must be reviewed and signed off by the Executive Director of Nursing and ensure that all subsequent communication from or to the NMC is copied to the Executive Director of Nursing.

Reporting Process

14. The reporting process includes regular reports on nursing practice, mechanisms for escalation and an agreed professional communication process.

Regular Reporting

15. Executive Directors of Nursing will submit a report to the PHA biannually outlining adherence to the standards/systems and good practice described in this document.
16. The PHA has a responsibility to assist and support Executive Directors of Nursing where there are any barriers to good practice.
17. The PHA will submit these reports the DHSSPS to inform the normal governance process identifying any areas of concern and actions taken.

Escalation

18. Trusts will have in place a system which ensures that Executive Directors of Nursing have a mechanism to raise issues of significant professional concerns with the Chief Executive.
19. Executive Director of Nursing will utilise as appropriate the Early Alert system to the DHSSPS

Professional Communication

20. The HSC Framework document describes the complex accountability structure between the key organisations within the HSC system. The document also makes clear the expectation from the Department that all

stakeholders will work together in a spirit of cooperation and that the PHA and HSCB must work together to support provider to improve performance and deliver desired outcomes.

21. An agreed system of professional communication is central to the delivery of this objective.
22. Where an issue of significant professional concern is identified in a Trust the Executive Director of Nursing will inform the Chief Nursing Officer, DHSSPS and Director Nursing PHA. Where regional action is required the CNO may instruct the Director Nursing PHA to coordinate action/response.

DRAFT

**MUCKAMORE
ABBNEY
HOSPITAL
HSC ACTION PLAN**

April 2022

INTRODUCTION

The independent Serious Adverse Incident (SAI) review report into safeguarding at Muckamore made for stark reading. It exposed not only significant failings in the care we provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities. In short, it told us that, while we have achieved much through Bamford, there is much more we need to do.

This is our response, and sets out exactly what we now must do. It recognises that the events at Muckamore have caused much distress for the patients receiving treatment in the hospital and their families and carers, and has also damaged wider public confidence in how the HSC system provides care, treatment and support to people with a learning disability and their families. The measures set out in this document are intended to address the issues that the SAI report highlighted, but also to provide wider assurance to society that the HSC system is working together in a co-ordinated way to make life better for people with a learning disability.

As the Permanent Secretary made clear when he met with all HSC Chief Executives in January this year, we must effect lasting change, with reference to every single recommendation in the SAI report. It is right that this report acts as our barometer, and the success of our efforts should be measured against it.

This document therefore sets out what we are doing and plan to do in response to its call to action. Specifically, it reiterates the overarching recommendation of the report endorsed by the Permanent Secretary that Muckamore must return to being a hospital not a residential facility. This will require a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs.

This timeline will be monitored closely by the Muckamore Departmental Assurance Group, which will include representation from the HSCB, PHA, RQIA, the 5 Trusts, professional representatives, specialist accommodation providers, appropriate academic expertise and importantly the families of patients, which will also ensure the team in Muckamore and the wider community services have the necessary support and resources in place to achieve these goals. A first but critical step will be to develop and deliver enhanced services in the community to source, support and sustain people in the places where they live. This will be the key role of the Regional Learning Disability Operational Delivery Group led by the Health and Social Care Board.

However, this document also recognises that more actions will follow as we progress the co-production of a new service model for learning disability as part of our transformation agenda. When developed, this will bring with it a new set of actions to consult on and implement.

We are also conscious that the police investigation into the unacceptable events at Muckamore Abbey Hospital is still ongoing. We await the outcome of that investigation and will be ready to take any additional actions to ensure that lessons are learned and put into practice across the full spectrum of learning disability services in Northern Ireland.

In this context this plan should be considered a live document which will be subject to ongoing review and development to drive further and emerging improvements to current practice.

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RAG Rating	
Completed	
Work in progress	
Progress required	

SECTION A

COMPLETED ACTIONS

Permanent Secretary commitments						
PS1		HSCB / PHA	A3	By March 2021 , complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes.	Acute Care Review	
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	DOH	A4	By 31 August 2019 , establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming Minister) that the	Governance	

				resettlements commitments and recommendations of the SAI report are met (see full governance structures associated with this plan at Annex A).		
PS1		DoH/DoJ	A9	By 31 December 2019 , provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.	Governance	
PS1		HSCB/HSC Trusts	A10	By 30 December 2020 , review current forensic LD services, identify and address service development needs to support people in community settings.	Service Model	
SAI Independent Review Panel recommendations						
R1.	Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which	HSCB/PHA	A11	By December 2020 , deliver a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time, in the right place; along with a costed	Service Model	

<p>R.2</p>	<p>understand that ordinary lives require extraordinary supports – which will change over the life course.</p> <p>An updated strategic framework for Northern Ireland’s citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle</p>			<p>implementation plan, which will provide the framework for a regionally consistent, whole system approach. This should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on implementation.</p> <p>Postscript-October 2021</p> <p>The ‘We Matter’ final draft Learning Disability Service Model was formally presented to the DoH on 5 October for consideration.</p>		
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	<p>cited by so many, that is, “there are no community services”. A life course vision of “age independent pathways,” participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.</p>					
	<p>Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the “revolving door” which enables existing community</p>	<p>HSCB/HSC Trusts</p>	<p>A15</p>	<p>By 30 June 2020 review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex needs.</p>	<p>Accommodation</p>	

	<p>services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.</p>					
		<p>HSCTS</p>	<p>A16</p>	<p>By 31 December 2019 address security of tenure of people with a learning disability living in supported housing.</p>	<p>Accommodation</p>	
		<p>HSCTs</p>	<p>A17</p>	<p>By 31 March 2020 complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD.</p>	<p>Accommodation</p>	
<p>SAI Patients families recommendations</p>						

R3	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	Belfast Trust	A18	Appoint a carers consultant and co-produce a communications strategy with parents and carers. Completed		
R4.	Families and advocates should be allowed open access to wards and living areas.	Belfast, Southern and Western Trusts.	A19	Co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey).	Service Model (Assessment & Treatment)	
R5.	There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use of seclusion at the Hospital.	Belfast, Southern and Western Trusts.	A20	By 30 June 2020 , carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.	Service Model (Assessment & Treatment)	
R6.	The use of seclusion ceases.	Belfast, Southern and	A21	By 31 January 2021 , complete an urgent review of seclusion policy and practice in MAH (and	Service Model (Assessment &	

		Western Trusts.		Lakeview and Dorsey), to inform wider consideration of regional policy, and share outcomes with families.	Treatment)	
R6.	The use of seclusion ceases.	DOH	A22	By March 2021 , develop a co-produced and publish regional seclusion and restraint policy/guidance.	Governance (Mental Health Action Plan)	
R8.	People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.	Belfast Trust	A24	By 31 December 2019 , review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are fully involved, taking account of lessons emerging from Independent Review into Dunmurry Manor.	Service Model	
R9.	The Hospital's CCTV recordings are retained for at least 12 months.	Belfast Trust	A25	By 31 October 2019 , liaise with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation.	Governance	

R11.	Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	Belfast Trust	A27	By 31 October 2019 , provide an information booklet to families on the complaints process.	Governance	
R12.	Families receive regular progress updates about what is happening as a result of the review.	Belfast Trust	A28	By 31 October 2019 , a schedule of Trust meetings with families will be produced and circulated to families.	Governance	
SAI Senior Trust staff recommendations						
R16.	A shared narrative is set out.	HSCB/ PHA/HSC Trusts	A33	By December 2020 , the LD Service Model Transformation project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set out the road map for regional adult learning disability services in the future.	Service Model	
R17.	Commissioners specify what “collective commissioning” means.	HSCB	A34	By March 2021 , HSCB to write to BHSCT outlining the current position and status of commissioning for HSC	Governance	

				Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor.		
R18.	The transformation required in learning disability services must be values driven and well led.	HSCB/ PHA/HSC Trusts	A35	By December 2020 , the LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with people with learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.	Service Model	
R19.	The purpose of all our services is clear.	HSCB/ PHA/HSC Trusts	A36	By December 2020 , the LD Service Model Transformation project will inform the development of a regionally consistent model for community and acute services and will provide clarity around purpose.	Service Model	
R23.	Trusts and Commissioners must be knowledgeable about the	HSCB/ PHA/HSC Trusts	A42	By December 2020 the LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning	Service Model	

	“user experience” and that of their families.			disability, carers, and families. The future model for LD services will be designed around their aspirations, and will ensure effective structures are in place on an ongoing basis to fully operationalise this commitment.		
R24.	Trusts and Commissioners should set out the steps required in the Department of Health’s post Bamford plan: in the short and medium term.	DoH/HSCB/PHA/HSC Trusts	A43	By December 2020 , all parts of the HSC will have been involved in the development of the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent, whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.	Service Model	
LG4	The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought	HSCB/PHA	A47	This was taken to HSCB/PHA Quality, Safety and Experience meeting on 3/2/21.QSE were asked to discuss potential mechanism to seek Trust assurances. It was agreed that this will be listed for discussion at the quality, safety and		

	to the attention of the Trust Board.			experience meeting with Trusts.		
LG5	Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.	HSCB/PHA	A48	This work has been actioned by HSCB and is progressing and is being led by the Governance Lead in HSCB.		

SECTION B

RESETTLEMENT

Permanent Secretary commitments						
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	HSC Trusts	A1	By 30 November 2019 carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing contingency plans for their patients, including updated discharge plans for each individual assessed as medically fit for discharge, with a target date for the individuals' discharge, a timeline to deliver appropriate high quality placements matching each individual's assessed needs and identifying any barriers to	Resettlement	

				<p>discharge.</p> <p><u>April 2022</u> Independent Reviewers timeframe has been extended until April 2022 to progress the Resettlement review. The Northern, South-Eastern and Belfast Trusts have established the MAH Cross Trust Resettlement Leadership Group to focus on resettlement.</p>		
PS1		HSCB/HSC Trusts	A2	<p>By 30 November 2019 develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge.</p>	Resettlement	

				<p>Linked to A1.</p> <p><u>April 2022</u> Resettlement progress continued to be monitored via the Resettlement Review process, CIP and RLDODG meetings. One SE Trust patient remains on extended leave.</p>		
PS1		DoH/HSCB/HSC Trusts	A7	<p>By 30 September 2020, in conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability.</p>	Resettlement	

				<u>April 2022</u> Resettlement progress continued to be monitored via the Resettlement Review process, CIP and RLDODG meetings.		
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SECTION C

WORKFORCE

Permanent Secretary commitments						
PS1		DOH/HSCB/HSC Trusts	A5	<p>By 30 September 2021, develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care e.g. Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by June 2022 deliver training to an agreed cohort of staff.</p> <p><u>April 2022</u></p> <p>Community Assessment Rehabilitation and Treatment Draft Proposal has been prepared and is currently with Director SCCD SPPG for consideration. The South Eastern Trust have PBS service in the Intensive support Team,</p>	Workforce	

				<p>and plan to roll out across wider service in 2022.</p> <p>The Southern Trust are undergoing a change of management and plan to implement PBS across specialist service and community teams.</p> <p>The Belfast Trust operate PBS in MAH and are rolling out across community services.</p> <p>The Northern Trust have a PBS team and plan to roll out across community services.</p> <p>Additional funding required for all Trusts.</p>		
SAI Hospital Staff Recommendations						
R13.	An enhanced role for specialist nursing staff is set out.	Belfast Trust	A29	<p>By 30 June 2020, develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work.</p> <p><u>April 2022</u></p> <p>An interim Nurse Consultant has been appointed and has commenced post. The</p>	Workforce	

				<p>recruitment for a permanent post is ongoing.</p> <p>The recruitment processes for the Acute Liaison nurse and the Epilepsy Nurse Specialist are ongoing and at the stage of pre-employment checks.</p>		
		<p>DOH (Responsible Officer: Director of Disability and Older People)</p>	<p>A30</p>	<p>By September 2021, complete a review of Learning Disability Nursing.</p> <p><u>April 2022</u></p> <p>The Review is in final stages of drafting prior to being forwarded to the Chief Nursing Officer for consideration.</p>	<p>Workforce</p>	
<p>R20.</p>	<p>All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing.</p>	<p>DoH (Responsible Officer: Director of Disability and Older People)</p>	<p>A37</p>	<p>By September 2021, develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services.</p>	<p>Workforce</p>	

				<p><u>April 2022</u></p> <p>Three meetings have been held and the ToR has been signed off by the Project Team.</p> <p>An Online Survey has been produced and will be formally sent to all members of the Project team, HSC Trusts, Independent and Private Providers by 30th April 2022. This will provide a baseline overview of the current Learning Disability multi-disciplinary workforce.</p> <p>A Quality Assurance Subgroup has been formed that will quality assure and support interpretation of data collated.</p> <p>The Review has been funded for a further 12 months.</p>		
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SECTION D

TRANSFORMATION: [SERVICE MODEL; ACUTE CARE REVIEW; ASSESSMENT & TREATMENT]

Permanent Secretary commitments						
PS1		HSCB/PHA	A6	<p>By 31 March 2022, commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent</p> <p><u>April 2022</u> Community Assessment Rehabilitation and Treatment Draft Proposal has been prepared and is currently with Director SCCD SPPG for consideration. Further investment will be required in order for trusts to develop these services.</p>	Assessment & Treatment	AMEND TO RED – DEADLINE PASSED
PS1		HSCB/HSC Trusts	A8	By March 2021 , in the context of the Reform of Adult Social Care,	Service Model	

				<p>establish a regionally agreed framework for higher tariff placements which specifies what staff and service requirements justify a higher tariff.</p> <p><u>April 2022</u></p> <p>Adult Social Care consultation has commenced and the findings are awaited.</p>		
SAI Senior Trust staff recommendations						
		HSCB/ PHA/HSC Trusts	A38	<p>By March 2022, deliver community and home treatment services and support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in the community where possible and only in hospital when indicated/necessary.</p> <p><u>April 2022</u></p> <p>Community Assessment</p>	Service Model (Assessment & Treatment)	AMEND TO RED – DEADLINE PASSED

				<p>Rehabilitation and Treatment Draft Proposal has been prepared and is currently with Director SCCD SPPG for consideration.</p> <p>Further investment will be required in order for trusts to develop these services.</p>		
R21.	<p>The default “Friday afternoon and weekend admissions” to Muckamore Abbey Hospital have to stop.</p>	<p>HSCB/PHA/HSC Trusts</p>	<p>A39</p>	<p>By 31 December 2019 support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for learning disability services</p>	<p>Service Model (Assessment & Treatment)</p>	
R22.	<p>Time limited and timely Assessment and Treatment become the norm.</p>			<p><u>April 2022</u></p> <p>A workshop on regional admissions criteria for adults with LD was scheduled for 8 April 2022. However, this had to be postponed due to staff absence, and will be rescheduled on a date to be confirmed.</p> <p>The Bed Management Protocol which has been approved and circulated includes a section on</p>		

				LD admissions (Section 8.0).		
		HSCB/HSC Trusts	A40	<p>By 30 November 2019, appoint a regional bed manager for all 3 current in-patient units.</p> <p><u>April 2022</u></p> <p>The permanent 8B MHLD Bed Manager Post post was advertised and is currently at the short listing stage.</p>	Service Model (Assessment & Treatment)	
		HSCB/PHA/HSC Trusts	A41	<p>By March 2022, taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation. This should include community based assessment and treatment, clear thresholds for hospital admission and timely, supported discharge</p>	Service Model (Assessment & Treatment)	AMEND TO RED – DEADLINE PASSED

				<p>from hospital. (See Permanent Secretary commitments).</p> <p>April 2022</p> <p>Community Assessment Rehabilitation and Treatment Draft Proposal has been prepared and is currently with Director SCCD SPPG for consideration. Further investment will be required in order for trusts to develop these services.</p>		
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SECTION E

CHILDREN AND YOUNG PEOPLE

SAI Hospital Staff Recommendations						
		HSCB/PHA/ HSC Trusts	A12	By March 2021 develop a regionally consistent pathway for children transitioning from Children’s to Adult services, including:	Children and Young People	

				<ul style="list-style-type: none"> • People with learning disability and complex health needs. • People with Learning disability and social care needs. • People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours. <p><u>April 2022</u></p> <p>Initial scoping work on ADHD children and adult service needs has been completed and has been passed to EHWB Framework steering group for further work.</p> <p>Policy colleagues are currently reviewing the framework.</p>		
		HSCB/PHA/ HSC Trusts	A13	By 31 December 2020 finalise and develop a costed implementation plan for the new regional framework for reform of children’s autism, ADHD and emotional wellbeing services,	Children and Young People	Rating changed from Red to Green – No further

				<p>including consideration of the services required to support them into adulthood.</p> <p><u>February 2022 update</u></p> <p>Implementation costings have been prepared and are part of the three year budget exercise currently in preparation. An Emotional Health and Wellbeing Coordinator has been in post since December 2021.</p> <p><u>April 2022</u></p> <p>Completed as per last update in February 2022. Green rating.</p>		action required.
		HSCB/PHA/ HSC Trusts	A14	<p>By 31 December 2020 review the needs of children with learning disability that are currently being admitted to Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional review of children’s residential services.</p>	Children and Young People	

				<p><u>April 2022</u></p> <p>The new admissions procedure involving the creation of a panel has been presented to the monthly Iveagh meeting. This is due to be discussed with a view to sign off at the next meeting in April. The admissions panel will strengthen focus on admission for treatment and discharge plans.</p>		
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SECTION F

GOVERNANCE

SAI Patients Families Recommendations						
R10.	Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	Belfast Trust	A26	By 30 November 2019 develop an information paper and share with families and staff. <u>April 2022</u> All actions to date will be reviewed and progressed to completion.	Governance	

				<p>Dunmurry Manor.</p> <p><u>April 2022</u></p> <p>New documentation will be devised when the proposed Adult Protection Bill becomes law in 18 months (September 2023).</p> <p>In the interim, the Joint Protocol group, as part of the wider Procedures sub-group work, is continuing to review Joint Protocol procedures and associated documents. This work will complete in 9 months (November 2022).</p>		passed.
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SECTION H

Leadership And Governance Review Recommendations					
LG1	<p>The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.</p>	<p>DOH (Responsible Officer, Deputy Chief Social Work Officer)</p>	<p>A44</p>	<p>By March 2022, complete a review of the accountability arrangements for DSF.</p> <p>The HSCB are developing an outcomes based reporting template which will be the first stage of this process. In preparation for the Social Care Directorate moving into the Department following the closure of the HSCB in 2022, a review of the accountability arrangements for DSF will be undertaken.</p> <p><u>April 2022</u></p> <p>Revised circulars outlining the respective roles and responsibilities for Trusts and the DoH and a revised Scheme for the Delegation of Statutory Functions have been put in place to facilitate the migration of the SCCD in the HSCB into</p>	<p>AMEND TO RED – DEADLINE PASSED</p>

				<p>the Department of Health.</p> <p>Work on an outcomes based reporting template for DSF is underway but no timescale for completion has yet been agreed.</p>		
<p>LG2</p>	<p>The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.</p>	<p>DOH</p> <p>(Responsible Officer: Director of Quality, Safety and Improvement)</p>	<p>A45</p>	<p>The Department has carried out a fundamental review of the 2003 Order and the existing regulatory framework and has developed a new draft regulatory policy that includes the principles of regulation, along with the broad scope of services to be regulated and the proposal that the regulator should have wider powers of enforcement etc. This work has been the first phase of the process before moving on to phase 2, which will include the risk assessment of each provider type and consider the appropriate regulatory approach, including the range of enforcement and sanctions. Phase 2 will result in</p>		

			<p>a clear regulatory framework and legislation and this framework will reflect Departmental Policy.</p> <p>After restoration of the Assembly in January 2020, the Minister approved on 2 July 2020 the Consultation on Phase 1 of the Review of 2003 Order and the current Regulatory Framework, which would involve the proposed policy being launched for public consultation for a period of 16 weeks to allow sufficient time to engage with service users/providers/public during the current pandemic and its associated restrictions in terms of social distancing. As part of the Department’s continued response to the pandemic the Departmental Top Management Group (TMG) decided to reactivate the Department’s Business Continuity Plan in Autumn 2020. As a result the</p>		
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			<p>launch of the consultation was delayed.</p> <p><u>April 2022</u></p> <p>Subject to Ministerial approval, a review of regulation will be taken forward during the mandate of the next Assembly, 2022 – 2027. Whilst such a review remains a priority for the Department, there is a need for the parameters for such a review to be set and there will then be the need for engagement with the Health and Social Care Service to learn from and take into account experiences over the past 24 months. Whilst definitive timescales cannot be set at this time, it is hoped that this action will complete during the first three years of the next Assembly’s mandate by April 2025, but this is by no means certain.</p>		
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<p>LG3</p>	<p>The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.</p>	<p>DOH (Responsible Officer: Director of Disability and Older People)</p>	<p>A46</p>	<p>By June 2021, develop in partnership with patients, relatives and carers a plan for the future configuration of services to be delivered on the Muckamore Abbey Hospital site, including appropriate management arrangements.</p> <p><u>April 2022</u></p> <p>Work is continuing on the potential for on-site resettlement provision at MAH through a group chaired by the Belfast Trust and involving the Department. The Trust have advised that the feasibility study they have been undertaking is nearing completion. Work to identify suitable patients for the on-site facility is also continuing.</p> <p>Engagement is also continuing with the SPPG and Trusts on actions to help enhance processes around resettlements with the final report of the independent review team expected in the near future.</p>		
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LG6	Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.	HSCB/PHA	A49	<p><u>April 2022</u></p> <p>A new 8B Nurse Consultant will commence post in PHA in April and this work will be part of their remit.</p>		
LG7	The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.	Belfast Trust	A50	<p>By January 2021, complete disciplinary action in respect of first 7 individuals whose cases have been forwarded by PSNI to PPS.</p> <p>Action against a further 9 individuals will commence when PSNI confirm their cases have been forwarded to PPS.</p> <p><u>April 2022</u></p> <p>Disciplinary action is continuing in line with employment law regulations.</p>		
LG8	The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017.	Belfast Trust	A51	A Co-Director for Learning Disability services was appointed in June 2020. The dedicated Divisional Nurse post remains and a dedicated		

	<p>It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.</p>			<p>Service Manager and two permanent dedicated Assistant Service Managers for the hospital have been appointed. Substantive appointments at Band 7 and Band 6 Ward Manager and Deputy Ward Manager level are being progressed. The Interim Director for Learning Disability Services will review the existing managerial arrangements as part of the Chief Executive’s overall review of Directorate and Divisional structures which will take place in 2021.</p> <p><u>April 2022</u></p> <p>The interim Divisional Nurse is now in post, and the period of handover has been completed. A new interim Co-Director and Divisional Social Work are in place.</p>		
<p>LG9</p>	<p>Advocacy services at MAH should be reviewed</p>	<p>Belfast Trust</p>	<p>A52</p>	<p>By March 2021, complete a review of advocacy services.</p>		

	and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.			<p>The Trust is engaging with representatives of Families Involved Northern Ireland (FINI) to develop Terms of Reference for a review of its advocacy arrangements.</p> <p><u>April 2022</u></p> <p>The review of the advocacy service is ongoing and is at the stage of engaging with key stakeholders. Director lead progress meetings are in place.</p>		
LG10	The complaint of Mr. B of 30 th August 2017 should be brought to a conclusion by the Trust's Complaints Department.	Belfast Trust	A53	<p>The Trust have engaged with Mr B and written to him in an attempt to address his outstanding concerns. The resolution of these concerns is ongoing at this time and while every effort will be made to progress the investigation into the outstanding issues of concern, it is not at this stage possible to provide a definitive completion date.</p>		<p>ACTION COMPLETE - MOVE TO GREEN</p>

				<p><u>April 2022</u></p> <p>The Trust has written to the complainant via the legal representative to receive consent to refer to NIPSO and advise they are able to refer directly. No response over an eight week period and correspondence in relation to closure of complaint sent to the legal representative. Complaint considered as closed.</p>		
LG11	In addition to CCTV’s safeguarding function it should be used proactively to inform training and best practice developments.	Belfast Trust	A54	<p>CCTV is currently used to inform and amend staff practice. Contemporaneous CCTV footage is independently viewed and the accounts of this footage, which reflects good practice and highlights any areas for concern, are shared with staff.</p> <p>Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site.</p>		

				<p>These questionnaires specifically asked for views on the proposed extension of the use of CCTV into areas such as training and practice development. Feedback from the questionnaires will inform next steps.</p> <p><u>April 2022</u></p> <p>No further update.</p>		
LG12	<p>The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.</p>	Belfast Trust	A55	<p>The Trust Chief Executive is responsible for holding Trust Directors to account for achievement against their objectives, which are set on an annual basis and reviewed monthly (these are modified as issues arise). Directorate and Divisional management priorities, which are set, reviewed and reported on quarterly, are also in place as a framework for accountability. This is being supported by a developing quality management system (QMS) which will provide</p>		

				<p>a comprehensive overview of the performance of the Directorates and Divisions across a range of agreed metrics. The transparency of performance articulated via the quality management system will facilitate the Trust Board to provide ongoing challenge throughout the year, rather than being responsive to issues escalated to it.</p>		
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GLOSSARY OF TERMS

ASG – Adult Safeguarding

Bamford – the Bamford Review of Mental Health and Learning Disability in Northern Ireland

BHSCT – Belfast Health and Social care Trust

CIP – Community Integration Partnership

DfC – Department for Communities

DoF - Department of Finance

DoH – Department of Health

HSC – Health and Social Care

HSCB – Health and Social Care Board

LD – Learning Disability

MAH – Muckamore Abbey Hospital

MAPA - Management of Actual or Potential Aggression

NHSCT – Northern Health and Social Care Trust

NIHE – Northern Ireland Housing Executive

PBS - Positive Behaviour Support

PHA – Public Health Agency

PIPA - Purposeful Inpatient Admissions *Model*

RAID - Risks, Assumptions, Issues and Dependencies

RQIA – Regulation and Quality Improvement Authority

SAI – Serious Adverse Incident

SEHSCT – South-Eastern Health and Social Care Trust

SHSCT – Southern Health and Social Care Trust

WHSCT – Western Health and Social Care Trust

**From the Permanent Secretary
and HSC Chief Executive**



Valerie Watts, Chief Executive, HSCB
 Eddie Rooney, Chief Executive, PHA
 David Bingham, Chief Executive, BSO
 Martin Dillon, Acting Chief Executive, BHSCT
 Mairead McAlinden, Chief Executive, SHSCT
 Elaine Way, Chief Executive, WHSCT
 Hugh McCaughey, Chief Executive, SEHSCT
 Liam McIvor, Chief Executive, NIAS
 Tony Stevens (o/a), Chief Executive, NHSCT

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Our Ref: RP23

Date: 28 July 2014

Dear Colleagues

PROPOSED HSC SENIOR MANAGERS FORUM

1. Since my arrival here at the start of July, I have been struck by the multiple layers of engagement within and between our respective organisations. Whilst much of this is, of course, necessary and value adding, the current approach inevitably requires us to wear our organisational hats when together. This is often appropriate, however I feel we are perhaps missing an opportunity to take a more strategic view of the challenges and opportunities before us.
2. In this context, I feel there would be merit in us coming together as a group on a regular, if not necessary frequent, basis. My initial thoughts as to the terms of this engagement are that:
 - we would meet as the Senior Management Team of HSC in Northern Ireland, i.e. while we each would bring a particular knowledge of our own organisations, we are not there to represent them;
 - the meeting would absolutely not be an accountability forum – it would be a space for the senior team to discuss issues of common concern, and to do some horizon scanning to better prepare for the future;
 - to maintain the space for free and frank discussion, no substitutes should be allowed in the event of any of the principals being unable to attend;
 - we should give visibility to the group, as leaders of HSC, by rotating the venue around our organisations; and
 - a meeting frequency of around quarterly would be appropriate for this (at least to start with).

3. I would be very grateful for views from colleagues as to whether such an approach would be valuable and, in the event that it is, for any other thoughts as to the terms of the engagement. I would also be very grateful for a volunteer to host the first meeting (say, in September) – I am attracted to us starting outside Belfast as a clear signal of our intentions to be a regional and strategic group.

Yours sincerely



RICHARD PENGELLY